EmblemHealth®

Quality Improvement Program

EmblemHealth's mission is to create healthier futures for our customers, patients, and communities. We do this through the following values:

- **Empower — acting as proactive self-starters and enabling our colleagues to succeed.**
- **Deliver — achieving our goals and taking accountability for our actions.**
- **Do it Together — caring for our customers, patients, and one another, while valuing diversity, equity, and inclusion.**

EmblemHealth has a comprehensive Quality Improvement Program that encompasses integrating quality from all parts of the organization. It establishes a framework and processes that continuously work to improve the health care and services our members receive, including the quality and safety of clinical care and services it provides. We routinely monitor and review the following areas to ensure that our members in all health plans, including specialty programs such as Health and Recovery Plans (HARPs), have access to the highest quality medical and mental health care and services:

- Quality of care, including continuity and coordination of care.
- Quality of service.
- Patient safety.
- Utilization Management program.
- Member and physician satisfaction.
- Accessibility.
- Availability.
- Delegation.
- Member complaints, grievances, and appeals.
- Member decision support tools.
- Cultural diversity and health equity.

EmblemHealth uses various data sources and software to measure quality improvement processes and outcomes, determine barriers to improvement, and identify ways to improve quality and overcome obstacles. Data sources include:

- Appeals data.
- Applicable Care Management programs/initiatives databases.
- Behavioral health data.
- CAHPS®[1] (Consumer Assessment of Healthcare Providers and Systems).
- Children's Consumer Perception Survey data.
- Claims data.
- Complaints from doctors and members.
- Encounter data (data showing use of provider services by health plan enrollees).
- Enrollment data.
- Health Outcomes Survey (HOS) data.
- HEDIS®[2] (Healthcare Effectiveness Data and Information Set).
- Home and community-based services data.
- Integrated data collection systems that collect member and provider information.
- Laboratory data.
- Medical records.
- National and regional epidemiological demographic, and census data. Epidemiology is the study of the distribution and causes/risk factors of health-related states and events in specified populations.
- Utilization review data.
- Pharmacy data.
- Population-based member information.
- Evidenced-based practice guidelines that comply with recommendations of professional specialty groups or the guidelines of programs such as the American Academy of Pediatrics, the American Academy of Family Physicians, the American Psychiatric Association, the U.S. Preventive Services Task Force, the New York State Child/Teen Health Program (C/THP), the American Medical Association, the U.S. Department of Health and Human Services, the New York State Office of Addiction Services and Supports (OASAS), American Society of Addiction Medicine (ASAM), U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), the American College of Obstetricians and Gynecologists, the American Diabetes Association, the National Standards for Culturally and Linguistically Appropriate Services (CLAS), and more.
- QARR (Quality Assurance Reporting Requirements).
- Quality Compass®[3].
- Quality improvement projects/studies.
- Telephone response data.
- Utilization review data.
- Various provider and member surveys.

[1]CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[2]HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[3]Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Quality Improvement Program

Highlights of the Quality Improvement Program include, but are not limited to, the following:

QUALITY OF CARE

Quality improvement, and clinical and health promotion activities are selected and prioritized. Interventions are based on accepted, evidence-based clinical guidelines and member-specific identified needs. Due to COVID-19, the way we conducted some of our quality of care activities, which focused on optimizing the health and well-being of EmblemHealth's members, now include virtual delivery. Activities include:

- Mailings of preventive health reminders, preventive health guidelines, member newsletters, and health and wellness information to help members maintain and improve their health status.
- Calls to members to confirm certain diagnoses, as well as to encourage them to use appropriate medications and get needed tests completed.
- Medication adherence activities, including contacting providers whose members did not refill medications.
- Maintaining collaborative relationships with the quality teams and leadership of provider-practitioner groups in our network. Monthly gaps in care reports, provider report cards, and HEDIS® measure dashboards are distributed to provider groups highlighting performance and opportunities for improvement.
- Calls to members recently discharged from the hospital, including those discharged from the emergency room, to ensure they follow up with appropriate providers.
- Collaboration to promote HEDIS, QARR, and Stars measures identified by the Centers for Medicare & Medicaid Services (CMS) and the New York State Department of Health (NYSDOH) within internal departments including Care Management and Pharmacy.
- Partnerships with vendors who conduct at-home tests, such as bone mineral density and diabetic testing.
- Providing tailor-made health outreach programs both in-person and virtually in response to COVID-19 concerns, such as those offered at EmblemHealth Neighborhood Care locations, as well as our Care for the Family Caregiver program and the National Diabetes Prevention Program (National DPP).
- Analysis of member demographics to identify language, cultural, racial, ethnic, and other special (e.g., hearing, vision, or accessibility) needs by geographic area and availability of practitioners.
- Developing and maintaining regulatory-required reports and projects, including applicable interventions.
- Addressing continuity and coordination of care through multiple means, such as data exchange with primary care providers and specialists, to alert them to members who have not received certain services and tests, based on claims. Additionally, EmblemHealth addresses continuity and coordination of care through studies such as Comprehensive Diabetes Care: Diabetic Retinal Eye Exams; Reduction of Avoidable 30-day Readmission Rates; Primary Care Practitioners (PCPs) 7–30-day Visits after an Emergency Department Visit; and Postpartum Depression.
- Collaboration with physicians, pharmacists, and behavioral health practitioners within the Quality Improvement Committee and subcommittees.
- Engaging with community agencies to address specific needs of children, HARP members, Special Needs Plan (SNP) members, and special populations.

CARE MANAGEMENT

EmblemHealth has adopted a Population Health Management model. The model identifies high-risk members who would most benefit from Care Management programs and/or Population Health Management interventions. Relevant criteria for each Care Management intervention is reviewed and incorporated into the stratification process to identify the most critical members for whom we can make an impact.

EmblemHealth's strategy focuses on keeping members healthy and includes, but is not limited to, various wellness programs, managing members with emerging risk, assessing social determinants of health, patient safety initiatives, and supporting members with multiple complex health conditions.

The model also ensures the programs are fully integrated with one another so members with multiple conditions are supported holistically. Our programs work with members to help reduce barriers to care, ensure adherence to any treatment plans, and help with navigation to appropriate resources. They include:

Healthy Futures Program

This high-risk maternity program for all members aims to empower and educate members throughout their pregnancy and beyond, to keep themselves – and their baby – healthy. The program provides weekly pregnancy tips and resources starting from 6 weeks of pregnancy all the way through delivery and postpartum care. New moms also receive messaging throughout their child's first 12 months, educating them on immunizations, well-visits, nutrition, lead testing, developmental screenings, and other helpful topics. Members have free access to question-and-answer sessions with our medical experts and telephonic access to a nurse who can answer questions about pregnancy, childcare, family planning, and more. Members complete two health assessments with Care Management staff throughout their pregnancy and one after delivery to help identify and navigate a high-risk pregnancy or other chronic conditions.

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NICU Program
Our NICU program provides resources and caregiver support for members and their newborns while confined to the NICU and for up to a year after discharge, as appropriate. After discharge, babies who were in the NICU with continuing needs such as long-term care, home care, durable medical equipment, and/or chronic or disabling conditions are followed by the Care Management team until health goals are met or they reach one year of age.

HIV Program
The goal of the program is designed to provide support to members with home life, medical care, legal issues, finances, and psychological issues. The program aids with finding community resources and supports the member in navigating the medical system.

Transplant Program
The goal of the program is to provide members care coordination and Care Management services before and after a transplant. This includes collaboration with facilities and providers to ensure that members obtain the best care while navigating through the transplant medical process. In addition to these services, Case Managers will work with members and their caregivers to facilitate advanced care planning as needed.

Long-Term Services & Supports Program
The goal of the program is to drive member empowerment and assist with navigation to appropriate resources for Medicaid members identified with physical and developmental intellectual disabilities; children who are fragile and dependent on medical equipment (i.e. ventilators); and adolescents, adults, and elderly members with severe mental illness and multiple chronic conditions.

Special Needs Program
The goal of the program is to assist members with special health care needs, including older or disabled members; at-risk populations; low-income individuals; and those with multiple medical-psychosocial issues or multiple chronic conditions, and behavioral health issues. Holistic, dynamic, and integrated Care Management services and support are provided.

Transition of Care Program
The goal of the program is designed to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional. The primary goal of the program is to help members manage their health care needs during transitions from one setting to another and reduce the potential for hospital/facility readmissions.

Emergency Room (ER) Avoidance Program
The goal of the program is to reduce avoidable ED utilization, achieve improved outcomes, engage members in the primary care system, assist in care coordination, and reduce health care costs.

Palliative Care Program
The goal of the program is designed to support members and help their caregivers navigate the clinical, psychosocial, and logistical impacts of serious or terminal illness. Palliative care consult services are also available to members who are enrolled in other Care Management programs and in need of palliative care-specific interventions such as advanced care planning documentation and establishing goals of care. These members will have intervention-specific assessment and care plan documentation completed during their consult. The Palliative Care program will take referrals to support members transitioning into hospice and will take utilization management referrals to support discharge planning for members that meet palliative care criteria and are being discharged from a facility.

Kidney Companion Care
The goal of the program focuses on members diagnosed with stage 4 or 5 chronic kidney disease (CKD) or end-stage renal disease and receiving dialysis at home or at a facility. For members diagnosed with CKD, the program is designed to help delay progression to dialysis and avoid comorbidities.

Medication Therapy Management Program
The goal of this program is to address medication adherence barriers with Medicare members with Part D prescription coverage to help improve adherence with diabetes, hypertension, and statin medications. Members may be referred by one of the following Care Management programs that require ongoing support for the medication regime: asthma, chronic obstructive pulmonary disease, coronary heart disease, diabetes, ESRD/CKD, and HIV/AIDS.

Quality Improvement Program

EmblemHealth's Care Management programs were developed to create an alliance among EmblemHealth's network practitioners, clinicians, hospitals, facilities, and ancillary services to meet our members' health care needs. The programs utilize a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options, services, and resources.

The programs provide interventions based on the assessment of members' needs. They are deployed using a multidisciplinary team made up of network practitioners, nurses, registered dieticians, certified diabetic educators, social workers, mental health care specialists, and non-clinical care specialists. Services include, but are not limited to:

- Regularly scheduled telephonic or face-to-face contacts to help members who have complex medical needs reach health care goals. This is done by assessing health status and developing care plans that include long-term and short-term goals that address barriers or gaps in care.
- Educational mailings sent to promote members' self-management of their conditions.
- Assistance in care coordination, including home care and guidance to appropriate resources, including durable medical equipment (DME).
- Ensuring post-discharge primary care provider (PCP) and/or specialist appointments are made.
- Comprehensive discharge planning and post-discharge plan of care reinforcement.

HEALTH AND WELLNESS PROGRAMS

Health and Wellness programs are offered to EmblemHealth members with conditions that benefit from monitoring and clinical support. These include:

- The smoking cessation program, called the Tobacco-Free Quit-Smoking program, offers a telephonic-based behavior modification program to members 18 years and older who want to stop smoking. Members who engage in the program receive a comprehensive educational kit and support calls from a smoking cessation specialist.
- The Healthy Living program offers a toll-free line available to members 24 hours a day, seven days a week. It is staffed by registered nurses trained in telephone triage. This line gives eligible members access to immediate clinical support for everyday health issues and questions that may have otherwise led to unnecessary doctor or emergency room visits. Nurses guide callers in making informed decisions about many health conditions and how best to handle medical concerns.
- Health and wellness programs are offered through WellSpark. This encompasses chronic disease self-management, diabetes prevention, and lifestyle coaching.

PATIENT SAFETY

EmblemHealth continues to address patient safety through a variety of activities and initiatives, including the following:

- Targeted provider and member communications addressing patient safety topics such as the use of high-risk medications.
- Encouraging members to complete health assessments.
- Articles in member and provider newsletters about patient safety topics and medical safety issues.
- Alerts for members and practitioners through EmblemHealth's website. Alerts have been posted on topics including FDA or voluntary drug recalls, communicable disease outbreaks, and new immunizations.
- Concurrent drug utilization review at the time prescriptions are dispensed that alert the pharmacist to potential safety concerns such as drug-drug interactions, drug-disease interactions, high doses, pregnancy, age and/or gender restrictions, and therapy duplication.
- Documenting medication errors or potential medication errors as part of the Medication Errors Reporting Program.
- Provide language line translation and print translation.
- Credentialing and recredentialing process that ensures access to qualified practitioners and facilities.
- Contract with physicians and providers who address members' cultural, language, gender, family, and custom needs.
- The Quality Risk department reviews, addresses, tracks, and trends clinical complaints and grievances.

Patient Safety — Pharmacy Management

EmblemHealth monitors the utilization and appropriate use of prescription drugs. Pharmacy Services addresses opportunities for improvement by encouraging the prescribing of appropriate medications by providers, educating members about medications that may have been prescribed to them, and promoting the safe use of medications – including following the medication schedule. Pharmacy Services monitors members to ensure they take their medications as prescribed and consult with their health care providers to optimize therapeutic outcomes. Pharmacy Services also coordinates with our Care and Disease Management programs to ensure appropriate prescription utilization by targeted members through one-on-one support and intervention. EmblemHealth's Medication Therapy Management (MTM) program targets members with a high-prescription drug spend, multiple chronic conditions, and multiple covered medications.

Quality Improvement Program

Monitoring and Evaluation

EmblemHealth collects and analyzes data to continually monitor its performance and identify areas for improvement, using HEDIS® scores to determine if members are getting needed preventive screenings and treatments and to identify areas of improvement in members' care and service. EmblemHealth compares the plan's HEDIS scores to relevant industry benchmarks, such as National Committee for Quality Assurance (NCQA) Quality Compass®, CMS Medicare Star Ratings Program, and New York State averages, to measure its performance compared to other health plans. Improved scores year over year indicate that EmblemHealth is continuing to reduce gaps in the health care its members receive, as needed interventions are developed and implemented to address member quality and safety of clinical care and services, as well as satisfaction with the care and services.

EmblemHealth also uses Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and the Enrollee Experience survey to survey its members about the interpersonal aspects of their health care, as well as the members' relationship with their doctor and experiences with their health plan. CAHPS results are publicly reported on various forums and used by consumers to guide their selection of health plans. CAHPS is required by CMS for Medicare, and the Qualified Health Plan Enrollee Experience Survey for Qualified Health Plans. They are also required by the NYSDOH, Federal Employees Health Benefits (FEHB) Program, Medicaid (including HARP), and NCQA. Additionally, CAHPS results impact the Medicare Stars Quality Bonus Program and the NYSDOH Medicaid Quality Incentive Program, and the potential revenue associated with both programs. The NYSDOH also assesses member satisfaction. These results are shared with the Quality Improvement Committee to address member satisfaction.

EmblemHealth also addresses compliance and reports from regulatory and other agencies such as, but not limited to, the NYSDOH, New York State Department of Financial Services, OASAS, New York State Office of Mental Health (OMH), and CMS.

ACCREDITATION

EmblemHealth remains an NCQA health plan accredited for HIP Commercial HMO/POS, HIP Medicare HMO, HIP Exchange HMO, and EmblemHealth Plan, Inc. formerly known as GHI PPO Commercial lines of business. The NCQA accreditation status remains in effect through Sept. 10, 2022. Collection, review, and analysis of documents as part of the ongoing quality oversight and in preparation for the next NCQA submission continues. Submission for the next review is June 2022; file review is scheduled for August 2022.

Additional highlights of EmblemHealth's combined HEDIS, CAHPS, and NCQA accreditation status can be viewed at **NCQA Health Insurance Plan Ratings**.

QUALITY OF SERVICE

Translating EmblemHealth's mission and core values into every customer's experience is important to the delivery of quality services. At every point of contact, EmblemHealth aims to improve the customer experience. This includes but is not limited to:

- Using simple language and appropriate reading levels and being aware of culture and language to make EmblemHealth's communications easy to understand.
- Providing online tools to help members manage their health care.
- Providing information about services available to members, brokers, providers, and administrators.
- Getting the fundamentals right with fast and accurate claims processing.
- Answering phone calls and email inquiries promptly, courteously, and effectively.

Service encompasses both operations (claims and enrollment) and customer service. The experience that members, providers, practitioners, and customers have during these routine interactions influences their perspective and impacts their satisfaction with us. Striving to improve this experience, as measured and monitored by CAHPS®, Enrollee Experience Survey (EES), and other internal and external satisfaction survey tools and key performance indicators, through innovative activities resulting from root cause and barriers analysis, helps guide EmblemHealth in developing a more satisfying customer experience.

Customer Service

EmblemHealth monitors member and provider telephone service standards, including specific service levels. The results are tracked and trended. After-call survey data is reviewed to ensure the member's questions were addressed, procedures were followed, accurate information was provided, the response met quality requirements and was legally compliant, and there was resolution accountability (for example, if a member's existing referral is ending, the representative reminded the member to get a new referral from their PCP).

Claims Operations

EmblemHealth continually monitors claims processing standards to ensure specific service levels are met.

Quality Improvement Program

Cultural Diversity
EmblemHealth is committed to clinical and non-clinical services being available and accessible to members in a culturally competent manner to accommodate members' needs.

When they enroll, and thereafter, members can select from a practitioner network and plan services that meet the member's cultural, ethnic, racial, gender, age, and linguistic needs. Member requests for practitioners who speak a specific language are directed to Customer Service. Customer Service matches the request based upon need and provider availability. Members can also use our web directories to find practitioners based on gender and languages spoken.

Providers also have available to them services to assist them in addressing their patients' individual cultural, racial, and ethnic language needs and preferences. Examples of services available to providers include:

- Translation services, including translation of materials that EmblemHealth provides.
- Cultural competency continuing education and resources on EmblemHealth's website.

EmblemHealth identifies, reviews, and analyzes metrics; develops, prioritizes, and implements activities; and evaluates outcomes to address gaps in member receipt of services and member satisfaction based upon cultural, ethnic, racial, language, and gender needs. Some of the ways EmblemHealth determines that services are received, and needs are met are through:

- CAHPS® and Exchange survey analysis by race and ethnicity.
- Language translation line utilization.
- Customer service including marketing services.
- Provider directories that include information collected during the credentialing/recredentialing process such as wheelchair accessibility, languages spoken, gender, practice hours, and locations.
- Practitioner availability such as the number and/or percent of PCPs, obstetricians, and mental health providers by county, gender, language and, as available, by race/ethnicity, to determine network adequacy.
- Member materials, which can be provided in large print, non-English translations of printed materials, or braille.
- Complaints, grievances, and appeals are tracked to determine the percent of issues regarding culture, race, ethnicity, age, or gender as applicable to receipt of care or service.
- QARR and HEDIS® Effectiveness of Care measures are analyzed to determine health care disparities in member use of services.
- Data collection through health assessments, regulatory agencies, disease and Care Management teams, and surveys including the annual Cultural Diversity Survey.
- Employee and practitioner training in cultural competency, disparities in health care, health literacy, and other relevant topics.
- Member satisfaction with the cultural diversity of the network survey that includes complaints, appeals, CAHPS, and a member survey.
- The Plan's Diversity Equity and Inclusion Council's (DEIC) goals and ongoing activities address the Plan's commitment to building an inclusive culture that's as diverse as the communities being served. Through focus groups, coffee office hours, employee feedback, training, and identified employees who are the champions of the Plan's culture, the DEIC gains insights and ideas to further support this commitment.

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