

Health Plan Performance Improvement Project (PIP)

CoventryCares of Kentucky

Decreasing Non-Emergent
Emergency Department Utilization
Performance Improvement Project

PIP Part IV: Final Report - 92

Submission to:
Commonwealth of Kentucky
Department of Medicaid Service

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MCO and Project Identifiers

1. **Name of MCO:** CoventryCares of Kentucky

2. **Select the Report Submission:**

PIP Part I: Project Proposal Date submitted: November 16, 2012

PIP Part II: Baseline Report: Date submitted: August 31, 2013

PIP Part III: Interim Report: Date submitted: August 31, 2014

PIP Part IV: Final Report: Date submitted: September 1, 2015

3. **Contract Year:** 2012/2013/2014

4. **Principal Contact Person:** John Ames

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5. **Title of Project:** Decreasing Non-Emergent Emergency Department Utilization

6. **External Collaborators** (if any): NA

7. **For Final Reports Only:** If Applicable, Report All Changes from Initial Proposal Submission: NA

8. Attestation:

The undersigned approves this PIP Project Proposal and assures their involvement in the PIP throughout the course of the project.

Medical Director

Thomas Hughes PhD, RN / 8/15/2013
Quality Director/Manager

NA
IA Director (when applicable)

CEO

Decreasing Non-Emergent Inappropriate
Emergency Department Utilization PIP Proposal 2012

DMS Proposal Approval Date 2-24-2014

DMS Signature Stephanie Pateker, Nurse Consultant Inspector

Dms Approval is granted contingent on
compliance by MCO Coventry Care of Kentucky
with EQRO (IPRO) recommendations.

S. Pateker

Abstract

1. Project Topic / Rationale / Aims

Non-urgent emergency department utilization was chosen as a focus for CoventryCares of KY as a result of the trends identified above showing increasing non-urgent ED use by our member population and the high costs associated with these visits. Encouraging our membership to manage their care with their primary care providers (PCP) versus visiting the ED for a non-urgent issue would free up access to ED for truly emergent issues, decrease the cost of healthcare, increase health and outcomes of insured members, and facilitate establishing a medical home for the member.

CoventryCares AIM Statements included:

- a. Will member education regarding appropriate ED utilization decrease non-emergent ED utilization as evidenced by a 2% point reduction in CoventryCares of Kentucky AMB HEDIS® ED Visits per 1000 Member Months rate?
- b. Does early outreach by Case Management (CM) per the CMT system as well as Quality Management (QM) referrals of the AMB HEDIS® measure of members with multiple non-urgent ED visits decrease the proportion of “high utilizers” (9+ AMB ED visits) in our member population by 2%?

2. Methodology

In order to best utilize consistent and reliable data, CoventryCares will use the HEDIS® Ambulatory Care: ED Utilization (AMB) measure out of Quality Spectrum Insight (QSI – formerly Inovalon) for the reporting purposes of this PIP. This AMB measure report will provide the “ED Visits per 1000 Member Months” calculation as well as the total number of ED visits without resulting in an inpatient stay per member. The “ED Visits per 1000 Member Months” is a standardized calculation that is analyzed on an annual basis without further need of explanation.

Per the IPRO/DMS suggestions, the second AIM statement/goal was adjusted in order to reflect the proportion of CoventryCares member’s that were “high utilizers” in having 9+ AMB ED visits throughout the calendar year. As CoventryCares member population has grown throughout this PIP, this calculation recommendation provided by IPRO/DMS made the most sense for comparable goals.

3. Interventions

CoventryCares believes that our initiatives including all of the quality management outreach efforts, pilot programs with hospitals, customer service provided by the McKesson nurse line, hiring of a case manager solely responsive for ED utilization, increasing our in network PCPs by 75% and a much expanded case management program have had a very positive effect on both the health of our membership and our quantifiable rates.

4. Results

According to the NCQA Quality Compass, the number of ED visits per 1000 member months has **increased** by 18.28% between 2012 and 2014. CoventryCares rates have **decreased** by 8.54% in that same time frame. While our revised and higher goal from 2013 to 2014 was not reached, CoventryCares is very proud that our plan saw such a large decrease from our baseline especially when the national average is trending in the other direction. CoventryCares percentage of “high utilizers” per the total member population also moved in a very positive direction in going from .87% to .61%. At first glance this is a small number, but this does show an improvement of 42.62%. With our large member population, this is not insignificant progress. The improvements over our baseline through our company wide efforts were also made apparent in the financial analysis based on our progress in the ED visits per 1000 member months in which we are reporting relative savings of \$7,775,200 in 2013 and \$8,959,200 in 2014.

5. Conclusions

CoventryCares is proud of the enhancements made on this PIP, and in our company overall, since 2012 when this was one of the first two PIPs that we proposed. This growth was made possible by the countless hours spend by our dedicated nurses and staff in assisting our membership and improving our systems and processes in place. We are also pleased that our quantifiable measures can attest to our improvements and look forward to continuing to provide the best care for our membership possible as we transition this topic into a focus study. CoventryCares will complete our migration with Aetna on 11/1/2015 and we believe that many positive changes due to this integration are on the way. The new systems will allow greater resources for us as well as our members and providers. An example of something that we can look forward to post migration will be an all new, more user friendly, more interactive, more thorough health risk assessment for our members that encourages healthy living.

Project Topic

1. Describe Project Topic

Updates/Changes to Project Topic in the Final Report

- Updated the NCQA national average for 2014 and compared to the baseline rate

The Commonwealth of Kentucky (KY) and CoventryCares of KY have identified Access to Quality Care as a top priority for their members. Without good access to health care, people will often delay care and resort to using the emergency department when non-emergent care and treatment was needed. According to the U.S. Centers for Disease Control and Prevention (CDC) National Health Statistics, the annual number of visits to Emergency Departments (ED) has increased by 23 percent since 1997 (1), and almost 20 percent of these are made by Medicaid beneficiaries (2). At least one-third of all visits to the ER are for non-urgent health problems. In 95 percent of the cases, the patients are treated and discharged, with no hospital inpatient admission (1, 2). In the case of Medicaid, 90 percent of all ER visits result in discharge from the ER (2). Overall Medicaid spent an estimated \$8 billion dollars for 22 million ED visits in year 2003 (1, 2). As overall ED visits continue to increase, this number continues to rise. In year 2007, there were 116.8 million ED visits or 394 per 1000 persons (1). Approximately 18.6 percent of visits are by children younger than 15 years of age (1, 2).

Over 111,000 Medicaid patients (29.3 percent) (3) contributed to approximately 380,000 ED visits for KY in 2011. According to national health statistics, the State ranks number 6 out of the 50 states in ED visits with 519 visits per 1000 persons (4). According to the NCQA Quality Compass Healthcare Effectiveness Data and Information Set (HEDIS) measure, national average of the members per 1000 member months Ambulatory Care (AMB) average rate has increase 53.17 in 2012 to 62.89 in 2014. This is an increase of 9.72 members per 1000 member months in just 2 years, which highlights that this is an increasing problem nationwide.

2. Rationale for Topic Selection

Updates/Changes to Rationale in the Final Report

- Per IPRO/DMS requests, removed the terms “avoidable” and “inappropriate” is using terminology such as non-urgent
- Changed “high flier” terminology to “high utilizer” throughout the report
- Included additional baseline data regarding ED visits and their severity to try and add to the case that most of the ED visits are non-urgent
- Added note that our focus will be on the AMB measure with members who have had an ED visit without a following inpatient stay.

Non-urgent emergency department utilization was chosen as a focus for CoventryCares of KY as a result of the trends identified above showing increasing non-urgent ED use by our member population and the high costs associated with these visits. Encouraging our membership to manage their care with their primary care providers (PCP) versus visiting the ED for a non-urgent issue would free up access to ED for truly emergent issues, decrease the cost of healthcare, increase health and outcomes of insured members, and facilitate establishing a medical home for the member.

Patients who receive care from their PCP and have an established medical home are more likely to have preventive services and health care screening tests consistent with evidence based guidelines and best medical practice recommendations (2). Healthcare can also be more thorough because the PCP is aware of medical needs and can respond from the vantage point of knowing the patient's history and conditions as evidenced by the diagnosis and treatment for the members.

CoventryCares of KY baseline claims data shows high utilization of the ED for both non-urgent and avoidable diagnoses. The top diagnoses groupings for non-urgent ED visits are: upper respiratory infection, otitis media, pharyngitis, lumbago/backache, abdominal pain, migraine and unspecified viral infection. These diagnoses make up approximately 80 percent of ED claims. The most common diagnoses for "high utilizers" (defined as having 9 or more ER visits per year) are migraine, abdominal pain and backache/lumbago; all of which may be effectively treated on a primary care level. CoventryCares of Kentucky High Volume data for 2012 Emergency room utilization indicates 182,000 episodes of ER visits with three of the top 5 diagnoses that include acute upper respiratory infections at 14.59%, otitis media at 13.89% and acute pharyngitis at 10.17%.

Baseline data showed that 64.64% of "high utilizers" ED claims were between minor to moderate severity according to their corresponding CPT codes and this number grew to over 70% in 2014. As explained further in the methodology sections, CoventryCares will focus our efforts on members from the Ambulatory Care (AMB) HEDIS measure, which only includes members that have had an ED visit without resulting in an inpatient stay. Through consistent review of our "high utilizer" demographics including the minor to moderate severities accounting for 70% of their visits, the diagnosis codes associated with these ED visits, the fact that they were sent home versus moved to an inpatient stay and the standardization of our HEDIS systems we believe that targeting these members from the AMB measure was our best direction to find and target members that potentially over utilize the ED for non-urgent purposes.

"Punishing" people for using EDs is one way some organizations try to reduce misuse. However, research has shown that it is likely that a marketing strategy works better (5). The challenge is to make access to urgent or simply convenient care far more available than EDs, enough so to attract people away from EDs, rather

than expecting EDs to drive them away through unaffordable pricing and ridiculously long waits.

Voiced concerns from CoventryCares of KY members have identified barriers to primary care also include a lack of transportation and inability to take off work during office hours. “For most patients, ED utilization is not driven by lack of other affordable options, but rather by the scope, quality and availability of ED services compared to other sources of health care” (6,7).

Non-urgent ED utilization negatively affects the quality of care and long term health outcomes for plan members and negatively impacts the cost of the healthcare. Focusing plan resources on reducing inappropriate ED utilization will help members access the most appropriate level of care at the right time, and help them establish a medical home. Research shows that establishing medical home results in better health on both an individual and population level as well as reduce healthcare disparities (8). On-going review of claims data can be used to identify and focus additional efforts on non-emergent ED visits and frequent flyers to provide education, and help members establish a medical home. Ongoing monitoring of the data and surveys also provides on-going information to identify overall member educational needs, such as first aid information or assistance in locating needed services.

3. Aim Statements

Updates/Changes to AIM Statements in the Final Report

- Per IPRO/DMS feedback, there was no clear indicator for the 2nd AIM and goal. CoventryCares has developed a new AIM with a clearer goal, calculation and indicators. This AIM/goal will reflect the proportion of the CoventryCares total membership that had 9+ AMB ED visits as IPRO/DMS has suggested. We will keep the same goals as were previously included for the 2nd indicator. With the large changes in CoventryCares member population, this is believed to be the best way to present consistent data. As this is not a large enough percentage to do a “percentage point” decrease as the goal, we have noted below that it will be a percentage decrease of the previous year’s rate. The calculations to further explain are below in the Results section:
 - a. Will member education regarding appropriate ED utilization decrease non-emergent ED utilization as evidenced by a 2% point reduction in CoventryCares of Kentucky AMB HEDIS® ED Visits per 1000 Member Months rate for year 2013?

This was successful for 2013 and we will continue the 2% point reduction goal against our 2013 rates for our 2014 goal.

- b. Does early outreach by Case Management (CM) from the CMT system as well as Quality Management (QM) referrals of the AMB HEDIS® measure

members with 6+ ED visits decrease the proportion of “high utilizers” (9+ AMB ED visits) in our member population by 10% in 2013?

This goal was successful in 2013. Will this rate improve by an additional 2% point reduction in 2014?

Please see the Results section Quantifiable Measure Tables 1 and 2 for full breakdowns

Methodology

1. Performance Indicators

Updates/Changes to Performance Indicators in the Final Report

- This section was rewritten and CoventryCares used this opportunity to clarify the performance indicators, especially the second to correspond with the amended 2nd AIM Statement and goal, per IPRO/DMS recommendation
- Included the 2015 HEDIS® Ambulatory Care: ED Utilization (AMB) measure Tech Specs for further definition of the services CoventryCares is targeting.

In order to best utilize consistent and reliable data, CoventryCares will use the HEDIS® Ambulatory Care: ED Utilization (AMB) measure out of Quality Spectrum Insight (QSI – formerly Inovalon) for the reporting purposes of this PIP. This AMB measure report will provide the “ED Visits per 1000 Member Months” calculation as well as the total number of ED visits without resulting in an inpatient stay per member. The “ED Visits per 1000 Member Months” is a standardized calculation that is analyzed on an annual basis without further need of explanation.

Per the IPRO/DMS suggestions, the second AIM statement/goal was adjusted in order to reflect the proportion of CoventryCares member’s that were “high utilizers” in having 9+ AMB ED visits throughout the calendar year. As CoventryCares member population has grown throughout this PIP, this calculation recommendation provided by IPRO/DMS made the most sense for comparable goals. Tables in the Results sections have been modified and clarified to reflect this more standardized calculation and definition of this indicator.

Ambulatory Care (AMB)

SUMMARY OF CHANGES TO HEDIS 2015

No changes to this measure.

• Description

This measure summarizes utilization of ambulatory care in the following categories:

Outpatient Visits.

ED Visits.

• Calculations

- Product lines** Report the following tables for each applicable product line:
- Table AMB-1a Total Medicaid.
 - Table AMB-1b Medicaid/Medicare Dual-Eligible.
 - Table AMB-1c Medicaid—Disabled.
 - Table AMB-1d Medicaid—Other Low Income.
 - Table AMB-2 Commercial—by Product or Combined HMO/POS.
 - Table AMB-3 Medicare.
- Member months** For each product line and table, report all member months for the measurement year. IDSS automatically produces member year's data for the commercial and Medicare product lines. Refer to *Specific Instructions for Utilization Tables* for more information.
- Counting multiple services** For combinations of multiple ambulatory services falling in different categories on the same day, report each service that meets the criteria in the appropriate category.
- Outpatient visits** Outpatient visits (Ambulatory Outpatient Visits Value Set). Count multiple codes with the same practitioner on the same date of service as a single visit. Count visits with different practitioners separately (count visits with different providers on the same date of service as different visits).
- Report services without regard to practitioner type, training or licensing.
- ED visits** Count each visit to an ED that does not result in an inpatient encounter once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits using either of the following:
- An ED visit (ED Value Set).
 - A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set).

Exclusions (required)

The measure does not include mental health or chemical dependency services. Exclude claims and encounters that indicate the encounter was for mental health or chemical dependency. Any of the following meet criteria:

A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set).

Psychiatry (Psychiatry Value Set).

Electroconvulsive therapy (Electroconvulsive Therapy Value Set).

Alcohol or drug rehabilitation or detoxification (AOD Rehab and Detox Value Set).

2. Procedures

Updates/Changes to Procedures in the Final Report

- Removed by ICD-9 codes, and reworked section for a clearer indication on the procedures.
- Included explanation as to why CoventryCares focused on all members above specific ED visit thresholds versus focusing on specific regions/demographics
- Included note that data is claims based vs real time and why this has been chosen

Data collection must ensure that data collected on PIPs are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. For the PIP, administrative data collection will be utilized through a programmed pull from claims and encounters per the HEDIS® Ambulatory Care: ED Utilization (AMB) measure. QSI (Quality Spectrum Insight – formerly Inovalon) provides the HEDIS® AMB ED visits reports. The AMB ED visit measure report from QSI is pulled and analyzed on a monthly basis and is based on claims data. Claims data is not “real time,” but as this is the HEDIS® industry standard AMB measure and we are looking to stop patterns of multiple non-urgent ED visits versus a 30 day hospital readmission where “real time” data is essential. This report provides both the “ED Visits per 1000 Member Months” calculation as well as the number of ED visits per member. Quality Management will review these reports in order to refer all members with 6+ ED visits with case management as well as provide outreach for all members newly showing 9+ visits. Full detailed demographic breakdowns and analysis are done annually when the December AMB rates are released as data is collected for a calendar year (January – December) for this HEDIS measure. No sampling is done for these administrative measures.

As described in the Project Topic and Rationale sections, non-urgent ED utilization is an expensive and growing problem. With that, It is CoventryCares goal to provide

education and assistance to all members with 9+ AMB ED visits as well as share members with 6+ AMB ED visits with case management for initial assistance in an effort to avoid going back to the ED for the 9th plus time. Due to the importance of reaching out to all members having these troubles, CoventryCares did not focus on specific regions, gender, etc.

3. Member Confidentiality

Updates/Changes to Member Confidentiality in the Final Report

- N/A

CoventryCares of Kentucky will utilize administrative data for the source of PIP data. The reported information will be in summary or an aggregate format to protect member health information. If protected health information is utilized, that information would be de-identified. Coventry will consider the health information de-identified after removing the identifiers, as long as we have no knowledge that the information stripped of these identifiers could be used, alone or in combination with other information, to re-identify the member/individual.

Identifiers include the following:

- names;
- all geographic subdivisions smaller than a State, including street address, city, county, precinct, zip codes if the geographic unit formed by combining all the same three initial digits contain less than 20,000 people;
- if zip code area contains fewer than 20,000 people then change to 000;
- all elements of the dates (except year) for dates directly related to an individual, including birth date, admission date, and discharge date;
- date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;
- telephone numbers;
- fax numbers;
- electronic mail addresses;
- social security numbers;
- medical record number;
- health plan beneficiary numbers;
- account numbers;
- certificate/license numbers;
- vehicle identifiers and serial numbers, including license plate numbers;
- device identifiers and serial numbers;
- web Universal Resource Locators (URLs);
- Internet Protocol (IP) address numbers;
- biometrics identifiers, including finger and voice prints;

- full face photographic images and any comparable images; and
- any other unique identifying number, characteristic, or code.

4. Timeline

Changes/Updates to Timeline in Final Report

- Updated to match 2014 PIP template format

Baseline Measurement Period: January 1, 2012 – December 31, 2012

Baseline Measurement Report: September 1, 2013

Interim Period: January 1, 2013 – December 31, 2013

Interim Period Report: September 1, 2014

Final Measurement Period: January 1, 2014 – December 31, 2014

Final Measurement Report: September 1, 2015

Interventions/ Changes for Improvement

1. Barrier Analyses

Updates/Changes to Barrier Analyses in the Final Report

- Updated to match 2014 PIP template format, included demographic data regarding low-moderate levels of severity in 70% of ED claims
- To address the IPRO/DMS request for demographics inclusions (such as females having the 60% of these ED Visits despite only accounting for 54% of the population per baseline data) into the barriers, CoventryCares has chosen to pursue all “high utilizers” versus selecting a specific sub groups to only pursue. Demographics will be provided in the results sections for reporting and analysis purposes for the future of this focus study, but for the purposes of this PIP CoventryCares tried to include barriers that effect members of all demographics/regions

Category of Barrier	Target Group	Description of Barrier	Method of Identification
Lack of Knowledge	Member	<ul style="list-style-type: none"> - Member does not have the knowledge to know what resources/benefits are available to them - Member does not know who their assigned PCP is, and they believe that the ED is their best resource for care - Cultural/linguistic barriers such a low reading level or needs for multilingual assistance - Evidence of the member population not fully understanding what the ED should be used for is that 70% of all ED claims were for minor-moderate severity claims 	<ul style="list-style-type: none"> Member Feedback Observation
Lack of Access/Transportation	Member	<ul style="list-style-type: none"> - Lack of PCPs in network in certain areas - Member does not have time/transportation to receive the preventative care needed so they wait until their medical issues 	<ul style="list-style-type: none"> Member Feedback Observation QMUM committee meetings

		<p>become so bad that they need to go to the ED</p> <ul style="list-style-type: none"> - Appointment availability for members in rural areas are an issue. - Transportation and “inconvenient” appointment times add to a large issue in Medicaid members not showing up for their scheduled appointments. 	
Lack of Knowledge of Membership High Use of the ED	Provider	Providers may not be aware that their members may be using the ED for non-emergent issues instead of developing a relationship and wellness plan with their doctors	Provider Forum
Tracking in Health Plan	Health Plan	<p>At the beginning of this PIP, quality management (QM) and case management (CM) were each doing outreach to members with no method of communication between the two departments. This made it so there were duplicative efforts and missed opportunities to provide education and assistance to members in the most effective and efficient ways possible. A process for a synergized effort and tracking system was necessary to develop. Tracking system would need to account for:</p> <ul style="list-style-type: none"> - Outreach efforts made (i.e. calls/mailers) - Returned mail - Members enrolled in CM - Outreach/education provided to members 	Multi-Departmental Review

2. Interventions Planned and Implemented

Updates/Changes to Interventions in the Final Report

- Updated format to match 2014 PIP Template
- Removed annual numbers based by font/underline and created headers for this data
- Removed 2nd provider intervention. Upon review, it was the members that needed the assistance in knowing what resources are available to them and this provider brochure was not developed
- Many of these interventions address similar subjects and have been combined
- The CAHPS intervention was removed. This is a very valuable survey for CoventryCares of Kentucky, but the analysis of the survey findings did not result in any additional interventions for this PIP
- Updated CM interventions and outreach efforts to members beginning with non-urgent 3-5 ED visits

Timeframe	Description of intervention	Target Group	Barriers addressed
2 nd Quarters 2013 and 2014	<p>Educate providers about the volume of their patients potentially going to the ED for non-emergent purposes. Promote preventive and wellness activities by addressing member specific HEDIS measures regarding preventive health guidelines and immunization schedules. CoventryCares worked to educate network providers by communication via the web site updates, fax blasts, provider relations staff, and the new provider newsletters. Interventions included:</p> <ul style="list-style-type: none"> - The provider newsletter named "Provider Connection" went out on June 28, 2013 and has been posted on the Provider website This newsletter will be a quarterly publication - June 2013 - CoventryCares posted preventative health guidelines and immunization schedules to the provider website and sent a "Fax Blast" to providers regarding the posting. 	Providers	Lack of Knowledge of Membership High Use of the ED

	<p>- Provider Newsletter April 2014 included articles and updates on the HEDIS project, medical record review, and contact information for any questions regarding the HEDIS initiatives. Knowledge regarding the HEDIS measures and initiatives promote active involvement between the provider and member to encourage preventative services as well as well checks which could result in the member being healthier and not relying on the ED for treatment. Immunization guidelines were posted on the provider website as well. This was posted to the website and providers were notified by fax blast.</p> <p>- The Preventive and Clinical Guidelines was assessed for all ages on the CoventryCares provider web site. The Clinical Guidelines were refreshed 6/2014.</p> <p><u>Provider outreach for specific member utilization</u></p> <p><u>2nd Quarter 2013</u> - 455 targeted provider letters representing 52,898 Members were mailed to providers in all regions in the 2nd quarter from the Plan's VP of Medical Affairs, alerting them of their patients who have been identified as high ER utilizers.</p> <p><u>2nd Quarter 2014</u> - 1,763 targeted provider letters representing 42,694 Members were mailed to providers in all regions in the 2nd quarter from the Plan's VP of Medical Affairs, alerting them of their patients who have been identified as high ER utilizers.</p>		
1 st Quarter 2013 and ongoing	Member education and resource assistance outreach to all CoventryCares of Kentucky members with 9+ ED visits ("high utilizers") per the AMB HEDIS® measure. Newly	Members	Lack of Knowledge Lack of Access/Transportation

	<p>identified “high utilizers” will receive outreach on a monthly basis. These are designed to inform the member of the importance of their post inpatient discharge PCP follow-up visit as well as provide resources to members for assistance in terms linguistic, understanding of their discharge orders, transportation needs, assistance setting up appointments, etc. All outreach materials will be per the state and NCQA required reading levels and include phone numbers for multilingual assistance. Outreach packets developed through the PIP will all now include:</p> <ul style="list-style-type: none"> - Targeted Mailer developed for adults and minors (embedded below) <div style="text-align: center;">  Adult - KYCM00162_Letter tc </div> <div style="text-align: center;">  Minor - KYCM00215_Letter tc </div> <ul style="list-style-type: none"> - Krames On-Demand “When to Use the Emergency Department (ED)” - 24-Hour Nurse Line Brochure - McKesson’s nurse line triages the calls in an effort to identify the most appropriate level of care and assist with connecting members to their PCP. This brochure/information was added to the member handbook and member website in the 2nd quarter 2014. Nurseline and Call Center breakdowns included in Process Measures - First Aid Tips Brochure (added to member website 2nd quarter 2014) - Non-Emergency Emergency room Facts magnet/card (this was originally a magnet and then due to the size/weight/expense it was changed to a card) <p>Quality management (QM) has developed a tracking system for the AMB “high utilizers” outreach by</p>		<p>Tracking in Health Plan</p>
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	<p>QM as well as the members referred to case management (CM) with 6+ visits (see the following intervention and Process Measures for additional CM details). QM “high utilizer” totals are:</p> <p>1,098 ED Packets sent by QM in 2013 1,852 ED Packets sent by QM in 2014</p> <p>Members can now view and receive health education from CoventryCares regarding ED avoidance activities through the Member Handbook, member website, member newsletters, and QM/CM outreach. While many of these preventative services may not seem directly related to non-urgent ED utilization, CoventryCares believes that the more information and participation that we can engage in with our membership for better managed care will have positive effects on their health and lead to decreases in non-urgent ED visits.</p>		
<p>2ND Quarter 2013 and ongoing</p>	<p>Quality management (QM) and case management (CM) collaborated to develop a referral process and tracking system for members showing 6+ AMB ED visits. These efforts are made to identify and provide outreach to members that may be using the ED for non-emergent uses and avoid the member reaching “high utilizer” status. CM will review the QM referred member data and provide the appropriate outreach with members with 6+ visits receiving phone calls. Acute needs such as access to a primary care provider are to be addressed as well as the long term needs and possible enrollment into CM. Referrals are made to MHNet, when appropriate.</p> <p>CM has developed and expanded the Care Management Tool (CMT) – A multi-dimensional, episode-based predictive modeling and case management system designed to use</p>	<p>Members</p>	<p>Lack of Knowledge</p> <p>Lack of Access/Transportation</p> <p>Tracking in Health Plan</p>

	<p>clinical, risk, and administrative data to provide targeted health care services to the members who will benefit the most. CM will outreach the identified members and if contact is successful, the members acute and long term needs are assessed. Case managers will assist members with specialty needs by working with those members to identify PCP's and specialty provider in-network. In an effort to provide earlier attention/assistance, starting in the 3rd quarter 2014 members showing a pattern of 3-5 non-urgent ED visits over a rolling 12 month period will receive mailers of educational information and additional resources including the 24-hour nurseline brochure and the "When To Use The Emergency Department" brochure. 6+ visits will receive phone calls to assist members in the understanding of their doctor's orders, transportation needs, assistance setting up appointments, etc.</p> <p>In the 1st Quarter 2014, CoventryCares hired a case management associate who is 100% dedicated to the ER initiative. The job responsibilities include: mailing educational information to assist members to understand how to get the right health care at the right time, making outreach calls to members to assist in locating PCPs for the member if they don't have one, and managing the CoventryCares "high utilizer" reports and tracking systems..</p> <p>The QM/CM collaboration now allows CM to support member specific assistance with State transportation broker in matters such as locating and scheduling transportation services to and from primary care provider office. Case managers will also follow up with the member to ensure member kept appointment and to address other needs. The Coventry Navigator Care Program was upgraded and a code</p>		
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	initiated for transportation to track and report the education of members regarding transportation resources.		
1 st Quarter 2014 and ongoing	CoventryCares is to partner with local hospitals to reduce non-urgent use of the ED. CoventryCares worked with 3 hospitals in this initiative which we receive member information from the facilities (Kosair Children's, Ephraim McDowell and Pikeville Medical) via fax and a phone call. These referrals will be due to members using the ED for non-emergent issues as well as the hospitals belief that the plan should investigate the member for possible enrollment in CM. The 3 hospitals in this initiative include Kosair Children's, Ephraim McDowell and Pikeville Medical. For a breakdown of the referrals please see the Process Measures section	Members and Providers	Lack of Knowledge Lack of Access/Transportation Tracking in Health Plan
1 st Quarter 2013 and Ongoing	Increase member access to PCP's via provider network recruitment. For a breakdown of CoventryCares PCP network growth please see Process Measures	Member	Lack of Access/Transportation

3. Process Measures

Updates/Changes to Interventions in the Final Report

- Newly added for Final Report per IPRO/DMS recommendations

Intervention Name/Description	Related Process Measure
QM "high utilizer" outreach packets	1,098 ED Packets sent by QM in 2013 1,852 ED Packets sent by QM in 2014 Less than 5% returned with bad addresses
QM/CM collaboration in referring AMB ED visits data	Of the "high utilizers" (members that had 9+ ED visits per the AMB HEDIS measure) that were identified by QM and referred to CM in 2014, 64.31% had received follow up phone calls/mailers from CM and 14.12% were enrolled in CM.
CM collaboration and referral pilot study with Kosair Children's Hospital, Ephraim McDowell and Pikeville Medical	<u>Kosair Children's Hospital</u> Total received for 2014 - 974 Assigned to CM with letter & educational info -

	<p>27 Letter & educational info - 72 Other primary insurance - 1 Termed coverage - 160</p> <p><u>Ephraim McDowell</u></p> <p>Total received for 2014 – 2,409 Assigned to CM with letter & educational info - 257 Letter & educational info - 257 Other primary insurance - 33 Termed coverage - 174</p> <p><u>Pikeville Medical</u></p> <p>Total received for 2014 - 202 Assigned to CM with letter & educational info - 115 Letter & educational info - 36 Other primary insurance - 0 Termed coverage - 12</p>
Increasing in network PCP availability for our membership	CoventryCares has increased our in network PCPs by 75.93% in going from 2,767 to 4,868 PCPs between 2012 and 2014 per our annual Geo Access Reports
Member services and McKesson Nurseline statistics. Resources provided in each outreach packet	Please see tables A-F below:

Member and Provider Services (CSO)

The CoventryCares CSO team is responsible for member and provider customer service, as well as accurate and timely medical claims payments. Table A is reflective of CSO customer service data and medical claims only.

Table A

CSO Member Services & Claim Metrics	Goal	2013	2014
Number of calls received	NA	303,533	446,678
% Calls Answered in Thirty (30) Seconds	75%	85%	78%
Abandonment Rate %	3%	1%	2%
Average Speed to Answer	30 seconds	13 seconds	21 seconds
Overall Call Quality	97%	96%	97%
Claims Processed (for CSO)	NA	5,126,217	5,377,300
Claims Processed within 30 Days (for CSO)	99%	99.30%	99.87%

Table B

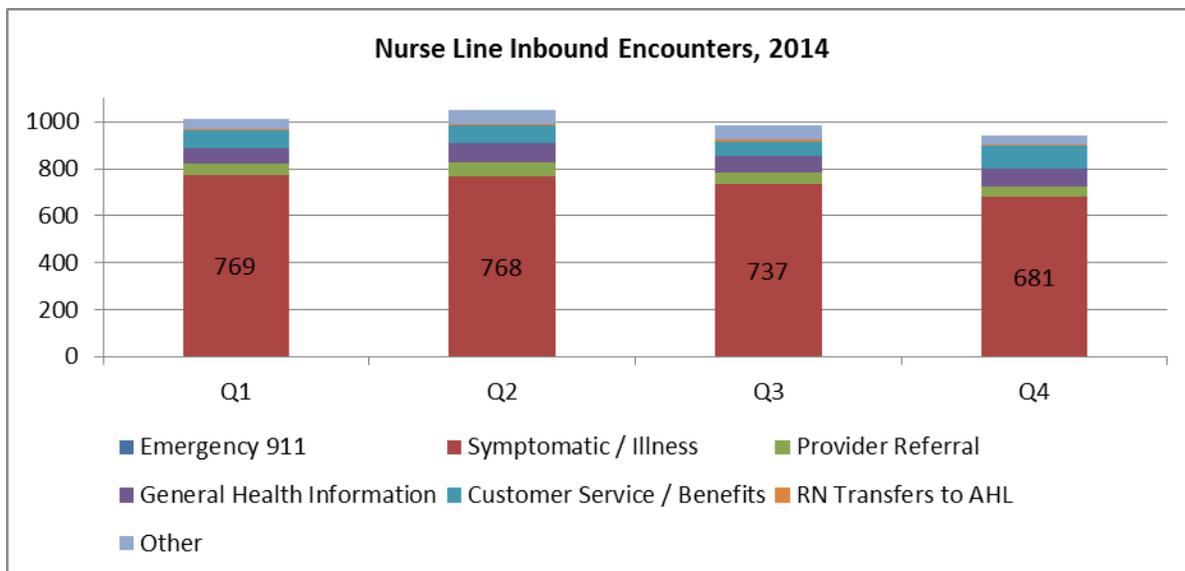


Table C

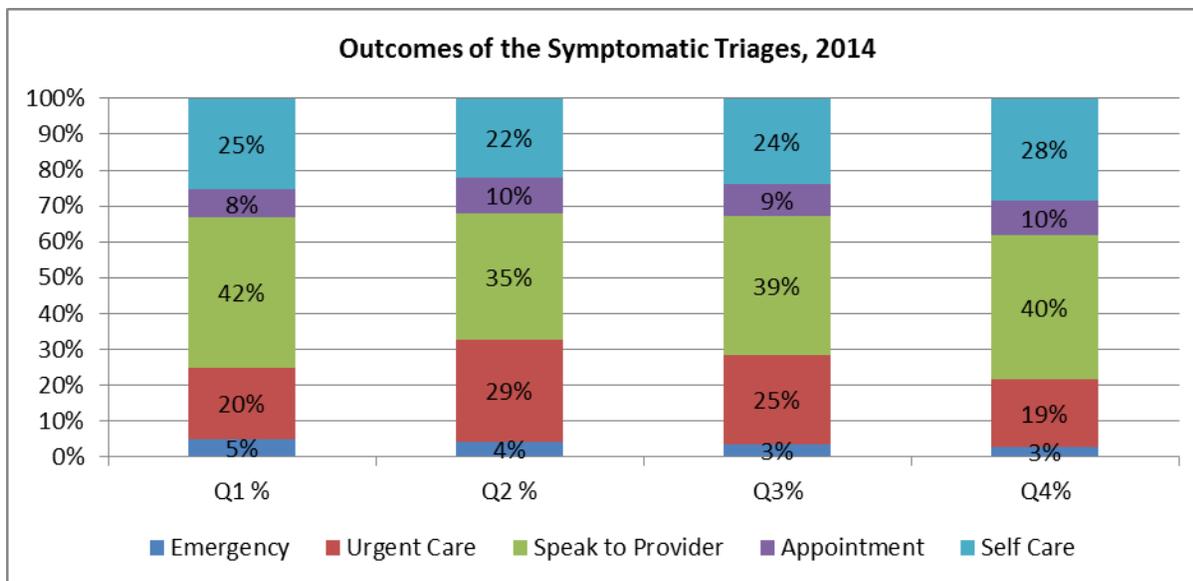


Table D

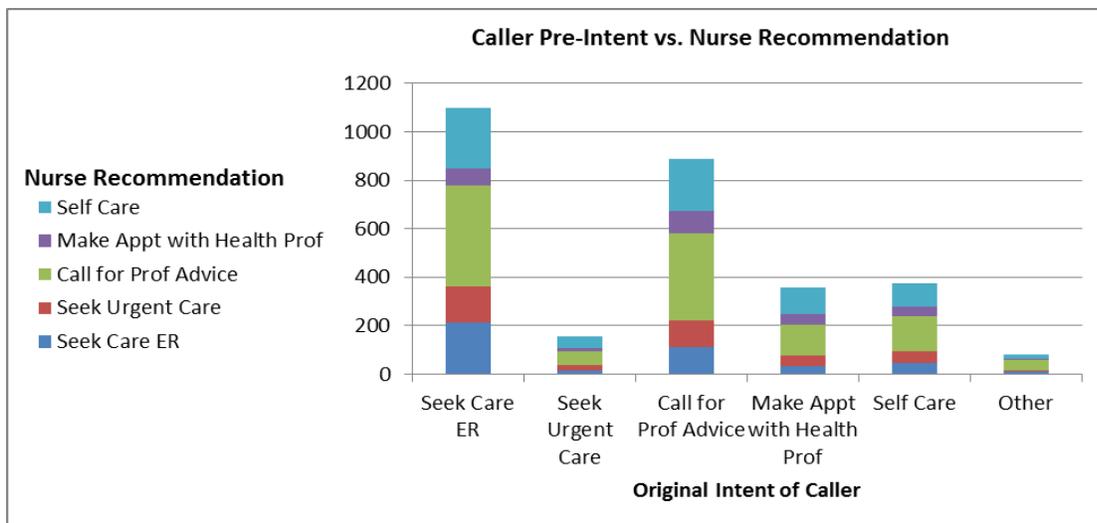


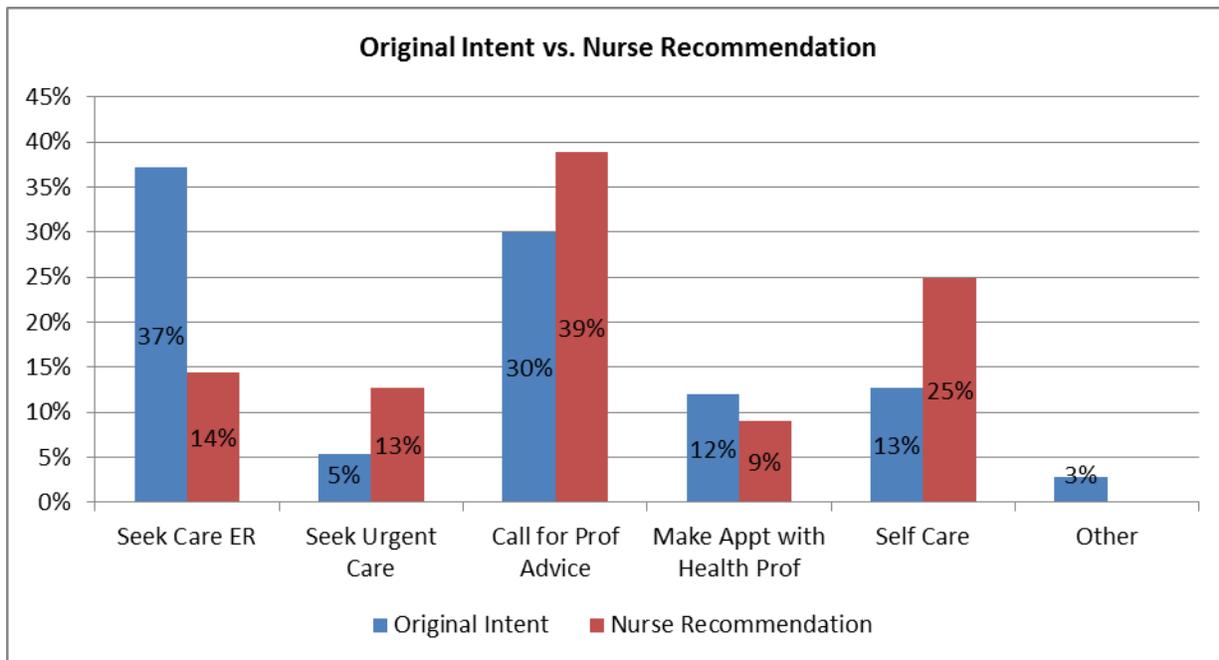
Table E

Caller Pre-Intent

Nurse Recommendations

	Seek Care ER	Seek Urgent Care	Call for Prof Advice	Make Appt. with Health Prof	Self Care	TOTAL
Seek Care ER	211	151	416	72	249	1,099
Seek Urgent Care	14	21	58	12	52	157
Call for Prof Advice	110	112	358	95	212	887
Make Appt. with Health Prof	33	43	128	44	107	355
Self Care	46	47	144	42	96	375
Other	10	3	46	2	21	82
TOTAL	424	377	1,150	267	737	2,955
Agrees with Nurse	415	370	1,126	261	731	2,903
Disagrees with Nurse	9	7	24	6	6	52

Table F



Results

Updates/Changes to Results in the Final Report

- Updated Quantifiable Measure Tables 1 and 2 for clarity and removed unnecessary columns. Quantifiable data and goals based on the AIM Statements should be much better defined with the changes.
- Added 2014 demographics tables
- Removed any mid-year statistics and any assumptions/claims made on those statistics as this is all based on end of year data, per IPRO/DMS request.
- Removed mentions of the “8 diagnosis” as CoventryCares has focused on all members with high numbers of AMB ED visits regardless of demographics or diagnosis

Quantifiable Measure 1 from AIM Statement

Will member education regarding appropriate ED utilization decrease non-emergent ED utilization as evidenced by a 2% point reduction in CoventryCares of Kentucky AMB HEDIS® ED Visits per 1000 Member Months rate for year 2013? This was successful for 2013 and we will continue the 2% point reduction goal against our 2013 rates for our 2014 goal.

Time Period	Baseline Project Indicator Measurement	Goal	Actual Rate
1/1/2012-12/31/2012	Baseline	N/A	81.97 (Dec 2012)
1/1/2013-12/31/2013	Interim Year 1	80.33	73.53 (Dec 2013)
1/1/2014-12/31/2014	Interim Year 2	72.06	74.97 (Dec 2014)

Quantifiable Measure 2 from AIM Statement

Does early outreach by Case Management (CM) from the CMT system as well as Quality Management (QM) referrals of the AMB HEDIS® measure members with 6+ ED visits for further action decrease the proportion of “high utilizers” (9+ AMB ED visits) in our member population by 10% in 2013? This goal was successful in 2013. Will the 2013 rate improve by an additional 2% reduction in 2014?

Time Period	Baseline Project Indicator Measurement	Number of High Utilizers	CoventryCares Member Population	Goal	Actual Rate
1/1/2012-12/31/2012	Baseline	1,733	199,980	N/A	0.87%
1/1/2013-12/31/2013	Interim Year 1	1,098	241,218	0.78%	0.46%
1/1/2014-12/31/2014	Interim Year 2	1,852	303,180	0.45%	0.61%

Increase in the NCQA Quality Compass ED Visits per 1000 Member Months Rate

Time Period	Rate
2012	53.17
2014	62.89

2012 Baseline Statistics and Demographics

* Unfortunately, the QSI version that contains 2012 data is no longer available, so providing a full demographics breakdown is not possible. Please see below for what we were able to provide:

2012 AMB High Utilizer Statistics	
Total Number of members that went to ED	98,646
CoventryCares 2014 Member Population	199,980
% of Members that went to the ED	49.33%

2012 AMB High Utilizer Gender Breakdown		
Gender	Total	%
Male	726	41.92%
Female	1007	58.08%
Total	1,733	100%

2012 AMB High Utilizer Regional Breakdown		
Region	Number	%
Region 1	86	4.98%
Region 2	176	10.16%
Region 3	7	0.39%
Region 4	281	16.19%
Region 5	386	22.27%
Region 6	135	7.82%
Region 7	191	11.02%
Region 8	471	27.17%
Total	1,733	100%

The following 2 tables represent the Top 10 diagnosis code ED claims for 2012, broken down by gender.

Rank	Female	Dx Code
	Dx Description	
1	URINARY TRACT INF NOS	599.0
2	ABDOMINAL PAIN-SITE NOS	789.00
3	CHEST PAIN NOS	786.50
4	ACUTE URI NOS	465.9
5	ACUTE PHARYNGITIS	462
6	OTTITIS MEDIA NOS	382.9
7	CHR AIRWAY OBSTR NEC	496
8	HEADACHE	784.0
9	DM2 UNCOMP NSU	250.00
10	LUMBAGO	724.2

Rank	Male	Dx Code
	Dx Description	
1	OTTITIS MEDIA NOS	382.9
2	ACUTE URI NOS	465.9
3	ACUTE PHARYNGITIS	462
4	CHEST PAIN NOS	786.50

5	FEVER, UNSPECIFIED	780.60
6	CHR AIRWAY OBSTR NEC	496
7	COUGH	786.2
8	DM2 UNCOMP NSU	250.00
9	ASTHMA W/O STATUS ASTH	493.90
10	ABDOMINAL PAIN-SITE NOS	789.00

2013 AMB High Utilizer Statistics and Demographics

2013 AMB High Utilizer Statistics	
Total Number of members that went to ED	98,467
CoventryCares 2014 Member Population	241,218
% of Members that went to the ED	40.82%

2013 AMB High Utilizer Age Breakdown		
Age	Total	%
Age 0-17	198	18.03%
Age 18-30	325	29.55%
Age 31-44	306	27.88%
Age 45-64	268	24.44%
Age 65+	1	.10%
Total	1,098	100%

2013 AMB High Utilizer Gender Breakdown		
Gender	Total	%
Male	315	28.72%
Female	783	71.28%
Total	1,098	100%

2013 AMB High Utilizer Regional Breakdown		
Region	Number	%
Region 1	81	7.34%
Region 2	169	15.43%
Region 3	48	4.37%
Region 4	161	14.68%
Region 5	251	22.86%
Region 6	102	9.29%
Region 7	72	6.51%
Region 8	214	19.52%
Total	1,098	100%

2013 Top 25 ED diagnosis codes for overall population and “high utilizers”

*This data is pulled by Coventry Data Warehouse (CDW) based on Place of Service (POS) 23 diagnostic codes. The AMB measure does not provide the types of diagnosis, so the following tables include member ED visits that did and did not result in inpatient stays. As CoventryCares has focused on all members with high numbers of AMB ED visits regardless of demographics or diagnosis, these tables are to highlight the cost and high number of claims related to non-urgent care that are treated in the ED.

2013 CoventryCares Top 25 Emergency Department Diagnosis (Dx) Codes		
Dx Code	Diagnosis	Number of ED Claims
786.5	CHEST PAIN NOS	76,156
789	ABDOMINAL PAIN-SITE NOS	52,994
599	URINARY TRACT INF NOS	49,560
786.59	CHEST PAIN NEC	48,148
465.9	ACUTE URI NOS	41,944
780.6	FEVER	35,754
486	PNEUMONIA	26,431
784	HEADACHE	26,384
789.09	ABDOMINAL PAIN-SITE NEC	25,925
558.9	OTHER AND UNSPEC NONINFECTIOUS GASTROENTERITIS AND COLITIS	25,118
382.9	OTITIS MEDIA NOS	24,214
466	ACUTE BRONCHITIS	23,311
491.21	OCB W ACUTE EXACERBATION	23,118
787.03	VOMITING ALONE	20,231
787.01	NAUSEA WITH VOMITING	20,177
462	ACUTE PHARYNGITIS	19,968
780.2	SYNCOPE AND COLLAPSE	17,506
79.99	VIRAL INFECTION NOS	17,126
648.93	OTH CCE-ANTEPARTUM	16,136
490	BRONCHITIS NOS	15,615
487.1	FLU W RESP MANIFEST NEC	15,528
786.52	PAINFUL RESPIRATION	15,064
786.2	COUGH	15,025
729.5	PAIN IN LIMB	14,607
346.9	MIGRAINE	12,895
	Total	678,935

2013 CoventryCares “High Utilizer” Top 25 Emergency Department Diagnosis (Dx) Codes		
Dx Code	Diagnosis	Number of ED Claims
786.5	CHEST PAIN NOS	16,081
786.59	CHEST PAIN NEC	11,588
789	ABDOMINAL PAIN-SITE NOS	8,723

599	URINARY TRACT INF NOS	5,665
784	HEADACHE	5,416
789.09	ABDOMINAL PAIN-SITE NEC	5,288
491.21	OCB W ACUTE EXACERBATION	5,188
346.9	MIGRAINE, UNSPEC, W/O INTRACTABLE MIGRAINE W/O STATUS MIGRAINOSUS	5,012
780.2	SYNCOPE AND COLLAPSE	3,522
787.01	NAUSEA WITH VOMITING	3,131
558.9	OTHER AND UNSPEC NONINFECTIOUS GASTROENTERITIS AND COLITIS	2,804
789.01	RUQ ABDOMINAL PAIN	2,613
786.52	PAINFUL RESPIRATION	2,509
787.03	VOMITING ALONE	2,462
789.03	RLQ ABDOMINAL PAIN	2,437
648.93	OTH CCE-ANTEPARTUM	2,246
466	ACUTE BRONCHITIS	2,246
465.9	ACUTE URI NOS	2,243
724.2	LUMBAGO	2,029
789.06	EPIGASTRIC ABD PAIN	2,003
486	PNEUMONIA, ORGANISM NOS	1,986
780.39	OTHER CONVULSIONS	1,820
786.09	RESPIRATORY ABNORM NEC	1,733
414	COR AS- GRAFT TYPE NOS	1,641
	Total	100,386

2014 AMB High Utilizer Statistics and Demographics

2014 AMB High Utilizer Statistics	
Total Number of members that went to ED	128,567
CoventryCares 2014 Member Population	303,180
% of Members that went to the ED	42.41%

2014 AMB High Utilizer Age Breakdown		
Age	Total	%
Age 0-17	205	11.07%
Age 18-30	634	34.23%
Age 31-44	577	31.16%
Age 45-64	434	23.43%
Age 65+	2	0.11%
Total	1,852	100%

2014 AMB High Utilizer Gender Breakdown		
Gender	Total	%
Male	572	30.89%
Female	1,280	69.11%
Total	1,852	100%

2014 AMB High Utilizer Regional Breakdown		
Region	Number	%
Region 1	127	6.86%
Region 2	248	13.39%
Region 3	158	8.53%
Region 4	258	13.93%
Region 5	411	22.19%
Region 6	200	10.80%
Region 7	110	5.94%
Region 8	340	18.36%
Total	1,852	100%

20104 CoventryCares Regional Breakdown		
Region	Number	%
Region 1	17,528	5.78%
Region 2	35,457	11.70%
Region 3	26,950	8.89%
Region 4	54,123	17.85%
Region 5	66,523	21.94%
Region 6	28,596	9.43%
Region 7	21,091	6.96%
Region 8	52,912	17.45%
Total	303,180	100%

2014 Top 25 ED diagnosis codes for overall population and “high utilizers”

*This data is pulled by Coventry Data Warehouse (CDW) based on Place of Service (POS) 23 diagnostic codes. The AMB measure does not provide the types of diagnosis, so the following tables include member ED visits that did and did not result in inpatient stays. As CoventryCares has focused on all members with high numbers of AMB ED visits regardless of demographics or diagnosis, these tables are to highlight the cost and high number of claims related to non-urgent care that are treated in the ED.

2014 CoventryCares Top 25 Emergency Department Diagnosis (Dx) Codes			
Dx Code	Diagnosis	Number of ED Claims	Total Amount Paid
786.5	CHEST PAIN NOS	24,764	\$ 4,436,797.11
465.9	ACUTE URI NOS	19,031	\$ 2,110,578.89
789	ABDOMINAL PAIN-SITE NOS	17,420	\$ 2,874,920.07
780.6	FEVER, UNSPECIFIED	15,466	\$ 1,689,690.30
784	HEADACHE	14,338	\$ 1,746,427.61
786.2	COUGH	12,183	\$ 422,198.68
789.09	ABDOMINAL PAIN-SITE NEC	12,117	\$ 1,864,849.19
382.9	OTITIS MEDIA NOS	12,082	\$ 1,459,464.58
729.5	PAIN IN LIMB	11,374	\$ 597,035.53
599	URINARY TRACT INF NOS	10,485	\$ 2,265,928.33
462	ACUTE PHARYNGITIS	9,927	\$ 847,569.88
786.59	CHEST PAIN NEC	9,877	\$ 3,439,053.56
787.03	VOMITING ALONE	9,592	\$ 1,349,911.92
724.2	LUMBAGO	9,498	\$ 921,609.26
786.05	SHORTNESS OF BREATH	7,975	\$ 398,128.26
466	ACUTE BRONCHITIS	7,635	\$ 1,398,190.94
487.1	FLU W RESP MANIFEST NEC	7,248	\$ 1,122,204.03
845	SPRAIN OF ANKLE NOS	7,206	\$ 1,208,803.79
787.01	NAUSEA WITH VOMITING	7,026	\$ 1,383,221.47
782.1	NONSPECIF SKIN ERUPT NEC	6,421	\$ 394,113.77
558.9	NONINFECTIOUS GASTROENTERITIS AND COL	5,958	\$ 1,509,471.39
959.01	HEAD INJURY, UNSPECIFIED	5,932	\$ 1,131,849.26
346.9	MIGRAINE, W/O INTRACTABLE MIGRAINE	5,887	\$ 767,139.97
79.99	VIRAL INFECTION NOS	5,825	\$ 801,744.49
34	STREP SORE THROAT	5,438	\$ 623,974.46
Total		260,705	\$ 36,764,876.74

2014 CoventryCares High Utilizer Top 25 Emergency Department Diagnosis (Dx) Codes		
Dx Code	Diagnosis	Number of ED Claims
786.5	CHEST PAIN NOS	6,138
789	ABDOMINAL PAIN-SITE NOS	3,762
784	HEADACHE	2,513
724.2	LUMBAGO	2,145
789.09	ABDOMINAL PAIN-SITE NEC	2,006
346.9	MIGRAINE, W/O INTRACTABLE MIGRAINE W/O STATUS	1,925
786.59	CHEST PAIN NEC	1,856
729.5	PAIN IN LIMB	1,578
599	URINARY TRACT INF NOS	1,563
786.05	SHORTNESS OF BREATH	1,501
780.39	OTHER CONVULSIONS	1,463

465.9	ACUTE URI NOS	1,316
787.01	NAUSEA WITH VOMITING	1,181
724.5	BACKACHE NOS	1,084
786.2	COUGH	1,017
401.9	HYPERTENSION NOS	1,000
496	CHR AIRWAY OBSTR NEC	999
V22.1	SUPERVIS OTH NORMAL PREG	966
300	ANXIETY STATE NOS	921
719.46	JOINT PAIN-L/LEG	884
466	ACUTE BRONCHITIS	828
789.01	RUQ ABDOMINAL PAIN	779
780.2	SYNCOPE AND COLLAPSE	770
787.03	VOMITING ALONE	765
592	CALCULUS OF KIDNEY	726
	Total	39,686

Discussion

1. Discussion of Results

The “Decreasing Non-Emergent Emergency Department Utilization Performance Improvement Project” was one of the first two PIPs that CoventryCares of Kentucky proposed as a new plan that was less than a year old in 2012. Since the original proposal three years ago, CoventryCares’ understanding of what it takes to create, evaluate, quantify and present a PIP has grown immensely. This PIP has also gone through many changes and improvements over the last three years. CoventryCares first priority is the health of our membership, and this PIP has helped us put systems and processes in place to help our membership greatly. After two years of work on this topic, it is clear that the best way to get our members with health issues to avoid non-urgent ED visits is through our member having a continuous relationship with their PCP. All of our interventions were focused on achieving this goal and providing our membership with education on their conditions, knowledge on what resources are available to them, contact numbers and direct access to cultural and multilingual resources, when it is appropriate to utilize the ED, assisting in understanding their doctors orders, assisting with transportation and even setting up appointments for our members. CoventryCares believes that our initiatives including all of the quality management outreach efforts, pilot programs with hospitals, customer service provided by the McKesson nurse line, hiring of a case manager solely responsive for ED utilization, increasing our in network PCPs by 75% and a much expanded case management program have had a very positive effect on both the health of our membership and our quantifiable rates.

As CoventryCares moved from focusing on 8 ED diagnosis codes (per the proposal) to all members with multiple non-urgent ED visits, our demographics breakdowns became more for reference than for outreach. The first item of note is the consistency of the Top ED claims per year as well as the point that most of these could be considered non-urgent uses. The percentages of regional ED visits stayed fairly consistent with the member population, even as our member population shifted throughout the life of the PIP. The jump in the percentage of females in the AMB measure was also large as the baseline went from 58% to around 70% for both interim years. Females make up 54% of our member population and a large percentage of the difference could be explained by pregnancy related issues. CoventryCares will continue to monitor this trend. The 2013 “high utilizer” numbers were much lower than the baseline as well as 2014. The best analysis CoventryCares can provide for this is the addition of 67,000 KY Spirit members mid-2013 and many of these members did not have the full amount of time to accumulate 9 ED visits without an inpatient stay. While the mid year addition of the KY Spirit may have effected the large discrepancy in our “high utilizer” numbers, the 2013 and 2014 ED visits per 1000 member months (which makes any population increases/decreases irrelevant) were very similar in only being 1.44 points apart.

According to the NCQA Quality Compass, the number of ED visits per 1000 member months has **increased** by 18.28% between 2012 and 2014. CoventryCares rates have **decreased** by 8.54% in that same time frame. While our revised and higher goal from 2013 to 2014 was not reached, CoventryCares is very proud that our plan saw such a large decrease from our baseline especially when the national average is trending in the other direction. CoventryCares percentage of “high utilizers” per the total member population also moved in a very positive direction in going from .87% to .61%. At first glance this is a small number, but this does show an improvement of 42.62%. With our large member population, this is not insignificant progress. The improvements over our baseline through our company wide efforts were also made apparent in the financial analysis based on our progress in the ED visits per 1000 member months in which we are reporting relative savings of \$7,775,200 in 2013 and \$8,959,200 in 2014.

CoventryCares is proud of the enhancements made on this PIP, and in our company overall, since 2012. This growth was made possible by the countless hours spend by our dedicated nurses and staff in assisting our membership and improving our systems and processes in place. We are also pleased that our quantifiable measures can attest to our improvements and look forward to continuing to provide the best care for our membership possible as we transition this topic into a focus study.

2. Limitations

One of the biggest issues faced with this topic was being able to quantify the improvements with our “high utilizer” population. As IPRO/DMS accurately stated, by the time we are outreaching to members with 9+ AMB ED visits it is too late as they have already reached “high utilizer” status which is why QM and CM worked to develop a referral system to begin outreach to members at an earlier stage. CoventryCares saw a large issue with the same

“high utilizer” members, who account for less than 1% of our member population, account for 7-10% of all AMB ED visits. While this may not help in our quantitative numbers, our goal was to get them assistance to try and avoid going from a member that has 9 AMB ED visits to 20. While the actual number of non-urgent ED visits saved by CoventryCares initiatives throughout this PIP can not be quantified, we are proud that we have improved our measures significantly against our baseline while the national NCQA QC trend is going the in a negative direction.

The initial focus of this PIP as written in the proposal was to address 8 over used non-urgent ED diagnosis codes. As we began our work in early 2013, it did not take long to see the issues such as do we only count ED visits for these 8 codes? If so, does it have to be the main diagnosis on the claim or can it be another line item? The methodology was confusing and the number of members that we would be targeting was limited so we decided to remove this criteria. The AMB HEDIS measure allowed CoventryCares to utilize an accepted system with standardized results as well as expand our outreach to members beyond those original 8 health issues.

3. Member Participation

Member participation was captured through interactions with case management. The feedback that was received was included in the barriers as well as noted above in the limitations section.

4. Financial Impact

According to the American Academy of Family Physicians, Partnership for Medicaid, Reducing Inappropriate Emergency Room Use among Medicaid Recipients by Linking Them to a Regular Source of Care Report from 2010 (2), the average cost of an ED visit is \$400. As this study is 5 years old, we believe that this number is conservative, but we will use this for our calculations. Upon analysis, we have shown progress in decreasing the percentages of “high utilizers” among our member population. The financial impact of these improvements, however, would be difficult to quantify in terms of how many ED visits were avoided by our efforts. CoventryCares believes that a better representation of our improvements would be based on the improvements from our first quantifiable measure, the ED visits per 1000 member months:

2013 Financial Impact vs Baseline

- $1 - (\text{Interim Year 1 rate } 73.53 / \text{Baseline rate } 81.97) = 10.30\% \text{ Improvement}$
- $188,720 \text{ Total AMB ED visits} \times 10.30\% \text{ Improvement} = 19,438 \text{ avoided ED visits}$
- $19,438 \text{ avoided ED visits by improvement} \times \$400 \text{ per ED visit} = \mathbf{\$7,775,200}$

2014 Financial Impact vs Baseline

- $1 - (\text{Interim Year 2 rate } 74.97 / \text{Baseline rate } 81.97) = 8.54\% \text{ Improvement}$
- $262,269 \text{ Total AMB ED visits} \times 8.54\% \text{ Improvement} = 22,398 \text{ avoided ED visits}$
- $22,398 \text{ avoided ED visits by improvement} \times \$400 \text{ per ED visit} = \mathbf{\$8,959,200}$

Next Steps

1. Lessons Learned

Throughout the life of this PIP, CoventryCares saw a direct correlation between providing early education, resources and greater access to care to our members and decreasing non-emergent ED visits. Feedback from members and case management showed that many members either did not know who their PCP was, or they didn't have a relationship with them and felt that the ED was their best option. We have seen the positive affects of assisting members to get started with treatment plans and developing a relationship with their PCP's and decreasing non-emergent ED visits, but there is still work to be done. We have found that an area in need of additional attention is the assignment of PCPs to meet the member needs. If the member has a role in choosing or approving their PCP based on their location or availability then the member is more likely to see them and receive a better plan for their health care needs. We believe hat the new health risk assessment tool that will be available to our membership post migration will assist us in identifying our members needs so that we can assist in providing the proper care as well as assigning a PCP that the member will utilize.

2. Dissemination of Findings

Findings will be shared with the Department of Medicaid Services, IPRO and will be presented at the 3rd Quarter QMUM committee meeting. This report will also be shared with Aetna corporate with a summary of what was successful, unsuccessful, what barriers were faced, etc. for other Aetna health plans across the country to access and learn from.

3. System-level Changes Made and/or Planned

CoventryCares will complete our migration with Aetna on 11/1/2015 and we believe that many positive changes due to this integration are on the way. We believe that these new systems will allow greater resources for us as well as our members and providers. An example of something that we can look forward to post migration will be an all new, more user friendly, more interactive, more thorough health risk assessment for our members that encourages healthy living. This tool will provide members access to many educational resources tailored for their lifestyle needs whether it involves a healthier diet, increased exercise or mental health needs.

References:

1. Niska R, Bhuiya F, Xu J., National Hospital Ambulatory Medical Care Survey, 2007 Emergency Department Summary. National Health Statistics Reports; no 26. U.S. Department of Health and Human Services Centers for Disease Control and Prevention (CDC). 2010.
2. American Academy of Family Physicians, Partnership for Medicaid, Reducing Inappropriate Emergency Room Use among Medicaid Recipients by Linking Them to a Regular Source of Care. 2010. Available from http://thepartnershipformedicaid.org/our_issues.cfm. Accessed November 9, 2012.
3. Commonwealth of Kentucky Cabinet for Health and Family Services Office of Health Policy, 2011 Kentucky Annual Administrative Claims Data Report, January 1 through December 31, 2012.
4. Health Statistics, Emergency Room Visits by State. Available from http://www.statemaster.com/graph/hea_eme_roo_vis-health-emergency-room-visits. Accessed November 5, 2012
5. Smith-Campbell, B, “Emergency Department and Community Health Center Visits and Costs in an Uninsured Population,” *Journal of Nursing Scholarship* 37(1): 80-86 (March 2005).
6. American College of Emergency Physicians. Available from <http://www.acep.org/>. Accessed November 12, 2012.
7. Robert Wood Johnson Foundation, “Study Finds Medical Necessity, Perceived Quality, Convenience and Cost Drive Emergency Department Visits,” (March 2004).
8. Starfield B., Shi L., Macinko J., Contribution of Primary Care to Health Systems and Health, *The Milbank Quarterly*, Vol. 83, No. 3, 2005 (pp. 457–502)