INTRODUCTION

In our age of information, knowledge is everything and everywhere. As consumers, the spread of reviews and quality information guides every type of purchase we make from haircuts to dream homes. This attitude toward informed purchasing creates a fundamental shift in how we spend every dollar, whether at home or work.

The importance of quality, and the perception of quality, in decision-making cannot be overstated.

For health plans, the gold standard for quality is the National Committee for Quality Assurance’s (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®). With its focus on the delivery of preventive services, acute and chronic condition management, and effective utilization, HEDIS® is a driving force behind the shift to value-based care.
Each year, NCQA rates and scores health plans and makes the results publicly available. Like all public reviews from a trusted source, a health plan’s NCQA score impacts purchasing decisions by:

- Employers and employer groups
- Brokers and consultants
- Consumers (increasingly important as employers shift more cost to employees via high deductible plans)

HEDIS® reporting and NCQA rankings create a competitive advantage or disadvantage. Health plans must be strategic in their approach to improving the delivery of preventive services, managing acute and chronic conditions, and controlling utilization to boost quality ratings to attract and maintain consumers across every market segment.

**It’s About Open Care Opportunities (Gaps)**

At its core, improving HEDIS® reporting means identifying and addressing the root causes of gaps in the delivery of preventive services and in the management of acute and chronic conditions. It is our experience that care opportunities, or gaps, present themselves in three distinct ways:

- Internal processes
- Provider relations
- Member engagement

Diving deeply into each of these areas reveals strengths to capitalize on and weaknesses to address. Internal processes, provider relations and member engagement must come into alignment around clear, measurable and reachable goals to improve quality of care and quality of reporting.
INTERNAL PROCESSES

Tip One:

Make HEDIS® Quality Reporting a Year-Round Program

There is no ‘off’ season. Health plans must be vigilant in their pursuit of understanding the root causes of gaps throughout the year to maintain and improve HEDIS® scores.

Each year the bar is higher, meaning the ‘average’ one year becomes ‘below average’ the next. Health plans must be relentless in their quality improvement activities.

Analytics provide data-driven insights to help health plans identify and address gaps in care. The constant identification and prioritizing of members in need of initial or follow-up services enable health plans to address concerns as information becomes available instead of waiting until the end-of-season rush.

Continuous quality monitoring results in:

- Flexibility to course correct early and often
- Direct line-of-sight into each measure and its closure rate at any given point in time
- Focused and effective use of resources to target measures with the greatest impact

Consider the value of a daily report in the period right before an official deadline. By way of example, one such report with measure-level summaries reveals the plan is only 11 mammograms from closure but 23 from closing colonoscopies. This single insight drives an informed decision – one that focuses limited resources at a realistic target (mammograms) and pulls back from a target (colonoscopies) that is out of reach given the timeframe.

Ultimately, as coordinated services are delivered (and reported) steadily throughout the year, members receive better care while reducing stress for health plans and providers.

A YEAR-ROUND HEDIS® PROGRAM

Define your HEDIS® activities to convey continuous action – use ‘Program’ not ‘Project.’

On-demand, data-driven insights to course correct early and often.

Increase internal report frequency as deadlines approach to identify and target most viable measures.

Continually review measure-level data to focus resources for maximum impact.

Motivate providers to deliver preventive services early to allow for member follow-up or rebooking of appointments to close care gaps.
Tip Two: Address Organizational Barriers

Every health plan has organizational barriers to overcome. Often, we find HEDIS® teams working in isolation from the rest of the organization. Isolation diminishes effectiveness and discourages the sharing of mutually beneficial data.

Ask your HEDIS® team members if they feel disconnected. Search for common ground between their work and the work of others. Encourage those with common ground to collaborate and provide them with the means and even incentives to do so.

HEDIS® is the foundation for many quality programs. Understanding the overlap enables health plans to focus resources where they will have the greatest impact.

WITH YOUR HEDIS® TEAM

Pause, reflect, celebrate accomplishments at end of season.

Debrief previous year – what worked? What didn’t? Lessons learned?

Provide process and mechanism for cross-functional data sharing.

Focus resources.

Reduce duplication of efforts.

Compare annual reporting changes with organizational strengths & weaknesses to strategically prepare.
Tip Three:

Identify, Understand and Address Root Causes of Open Care Opportunities

Advanced analytical platforms like Geneia’s Theon® platform deliver a birds-eye view of the entire health plan and its provider network. Combining data from clinical sources, claims, pharmacy, labs and more within a single application reveals true patterns of all quality reporting, including HEDIS® compliance and progress.

Data-driven insights reveal root causes of open care opportunities across the provider network and within any particular provider site. For example, geographically concentrated, high out-of-network utilization by members seeking services from non-plan primary care providers (who are not obligated to submit medical records to the health plan) could mean a shortage of PCPs or a lack of effective communication with members in that area.

Provider Relations

Providers shoulder the responsibility for delivering and reporting services tied to HEDIS® measures. To improve provider reporting, health plans must make the process worthwhile and as easy as possible.

Across the United States, providers are expressing their dissatisfaction with administrative burden. Do them (and yourself) a favor and lighten the load.

Let technology do the heavy lifting and enable providers to focus on improving member health. Much like email has simplified and sped up communications, technology, such as the Theon® platform, speeds up and simplifies the HEDIS® process.
Tip Four:

Improve Communication & Collaboration with Providers

Health plans with high NCQA ratings regularly share their knowledge, data and analytical insights with their provider network. Historically, only health plans tracked and understood the wealth of useful information gleaned from claims data. Today, a deeper level of collaboration is required and achieved through technology, transparency, reliable data and education.

We suggest health plans establish monthly population management meetings with physician leadership. During this time, review quality measures and dive into the supporting data together. Helping providers to understand where their work falls out of alignment with their peers and national standards and providing trustworthy supporting data (claims-level detail that providers can see for themselves) along with strategies to improve will help drive the desired change in care delivery.

Finally, on a more granular level, health plans must deliver reminders about specific open care opportunities within the clinical workflow (via the EHR). Whenever people have to launch a new program to access information, the likelihood of that information ending up at the bottom of the to-do list increases. It’s just human nature.
Tip Five:

Improve Your Supplemental Data Submission Process

Often, supplemental data is required to close a gap. Traditional methods of gathering supplemental data include dispatching teams of nurses to chase down and review charts. This process is time-consuming, expensive and disruptive to provider practices.

Health plans must expand and improve their methods of collecting supplemental data. Again, the right technology can lessen the administrative burden of these tasks. For example, health plans can directly access laboratory results files, state or county-sponsored immunization registries and validated historic hybrid medical record results files (for example, colorectal cancer screening) to acquire supplemental data.

Health plans must also make it easier for physicians and their staff to submit supplemental data to them. Collaborative technologies with built-in, streamlined submission features within the clinical workflow are one proven way to reduce administrative burden and frustration with supplemental data submission.
Tip Six:

Improve Provider Incentives – Share the Wealth

One clear overarching lesson along the path to value-based care is that financial incentives provide a necessary nudge to affect behavioral change.

Achieving and maintaining an above-average quality rating requires everyone aligning behind common goals. When incentives reinforce goals, change will come easier.

We find physicians in fee-for-service arrangements are less engaged in HEDIS® reporting efforts than their counterparts whose payments are linked to quality.

It is becoming increasingly common for health plans to build HEDIS® compliance targets into payment contracts. These incentives provide measurable and trackable milestones to encourage providers to maintain the shared priority of delivering related services to improve member health and quality reporting throughout the year.
For example, health plans could offer a bonus for provider sites when 70 percent of their adult population has had a BMI screening and when 70 percent of adolescents receive a well-care visit.

Analytics platforms, like the Theon® solution, uncover patterns across the provider network and within each provider site, thus enabling health plans the flexibility to customize contracts best suited for each. Consider, the “Coastal Physician Group*” is new to the network and value-based reporting. The health plan may want to establish lower closure targets than “Mont Vernon Physician Group*”, a veteran group consistently hitting high targets. For Mont Vernon, a contract with more risk, broader or higher targets may be desired.

In all cases, continuous monitoring and tracking of measure reporting against a variety of targets and within the set timeframe ensures everyone understands progress toward each target at all times.

**Member Engagement**

It is often the role of health plan clinical teams to bring everything together and engage members in a timely fashion, whether for preventive services or ongoing care required to manage chronic and acute conditions. Health plan clinical resources, however, are limited in efficacy when directed too frequently at chasing down charts for HEDIS® reporting. Clinical resources serve member populations better when aimed directly and consistently at facilitating member outcome improvements throughout the year.

In addition to end-of-season pressures on health plans and providers, it is important to realize the end of the calendar year is also a busy time for members due to:

- Personal and family obligations
- Professional end-of-year business obligations
- Flexible spending accounts expiring triggering an uptick in demand for services
- High deductibles met triggering even more demand before deductibles reset

Engaging members and coordinating care throughout the year helps avoid this end-of-year rush — a rush that often results in more demand than providers can meet. Increased demand can lead to member frustration with wait times and services being sought out of network or beyond the required time frame for HEDIS® reporting.
Tip Seven: Identify and Understand Member Barriers

Beyond being busy, members must be willing to come into their providers’ offices and receive the identified services within the allotted time frame. When possible, providers map services to existing appointments and no extra effort is required from the member.

Other times, the member must be contacted and encouraged to make and keep a new appointment. It is important to understand and address the variety of barriers faced from the member perspective.

Underlying most barriers is health literacy. Low health literacy is expensive, as people lack understanding of how their bodies work, how to accurately assess risk, and how to appropriately utilize preventive and specialist care instead of costly emergency servicesiii.

Low health literacy exacerbates additional barriers such as:

- Perception of expense
- Fear of diagnosis
- Accessing care outside of work hours
- Obtaining transportation
- Cultural and language barriers

To complicate matters further, people carry a stigma related to feelings of embarrassment about their low literacy and gaps in their healthcare. These feelings often lead to people covering up their low literacy, limiting their conversational interactions with healthcare professionals, sending misleading signals and ultimately, reducing the value of such interactions.

LOW HEALTH LITERACY

9 out of 10 adults struggle to understand and use health information when unfamiliar, complex or jargon-filled.

Leads to increased ED utilization and overall costs, decreased use of preventive services and specialists.

Leads to entering healthcare system only when sick.

Leads to poorer health outcomes for themselves and their children.

CDC 2016, Devillanova 2016
Tip Eight:

Help Members to Overcome Barriers

As a primary touchpoint between health plan and member, clinical teams must be trained to effectively, but compassionately, help members overcome barriers and engage in preventive services. For example, clinicians should have plain-English descriptions of all services, the value of those services and clear instructions on next steps. When appropriate, clinicians should consider conferencing in the correct provider’s office to book an appointment together with the member.

Descriptions should be jargon free, available in member-facing printed materials, and refined for primary sub-populations within the total member population. For example, childhood immunization schedules in multiple languages.

In addition to keeping outreach jargon-free, effective communication strategies to motivate members to seek preventive services include sensitivity training, OARS techniques (open-ended questions, affirmations, reflection and summary), and MI.

Motivational interviewing is a technique showing demonstrable success in improving patient/member outcomes. It is client-centered and helps uncover intrinsic motivations and aspirations. MI works with members to design a series of small, realistic steps of progress to achieving a health-related goal.

Additionally, analytical platforms provide useful population-level insights when they consume and interpret demographic, socio-economic and psychographic information.
WELLNESS PROGRAMS

Financial incentives often tied to completion of health risk assessments, biometric screening, and chronic condition screening.

55% of employer wellness programs provided through group health plan.

Employers feel overwhelmingly positive about cost and utilization savings.

More than 60% stated their program reduced costs.

More than 75% reported reduction in absenteeism.

Nearly 80% reported an increase in productivity.

RAND Health Study

Providing clinical teams with training, tools and resources required to improve member health through the delivery of identified services and drive targeted, effective HEDIS® strategies is key. Specifically, the Theon® platform facilitates effective member engagement by:

- Identifying members with open care opportunities (including HEDIS® measures) and prioritizes them by degrees of risk, enabling clinical teams to create a systematic, targeted approach beginning with those most in need and working down the list.
- Combining claims and clinical data to create a more complete understanding of each member and therefore, more helpful care plans.
- Facilitating coordinated collaboration between health plan and provider clinical resources.
- Identifying patterns within demographic, socioeconomic and psychographic information to uncover barriers to care and predict a ‘most-likely-to-succeed’ course of action.

Tip Nine:
Prepare Clinical Teams to Succeed
Tip Ten:
Motivate Members through Incentives

Whether the fear of expense of any particular medical service is real or perceived, a financial barrier remains, and the negative impact is significant for many members.

Members may simply not understand their actual cost of a service (especially if full coverage was ‘recently’ mandated by the Affordable Care Act) or the long-term value of regular, ongoing care for a chronic condition.

Either way, a financial incentive may be the nudge they need to obtain timely HEDIS®-measured services.

Wellness programs are offered at nearly every large employer in the United States, and financial incentives within these wellness programs are linked to an increase in services included in HEDIS® measures™.

As part of a comprehensive HEDIS® strategy, health plans should consider making wellness products more widely available to employers and consumers alike.

The Theon® Platform

Geneia’s flagship solution, the Theon® platform, supports the population management needs of health plans, hospitals, groups and providers in a wide variety of payment models including accountable care arrangements, patient-centered medical homes, integrated delivery networks and employer groups.

Our single platform, single database structure, powered by advanced analytics and workflow engines, drives down costs, eliminates waste and redundancy, increases value for clients and improves the quality of care provided throughout each cost and care setting.

SIX WAYS THE THEON® PLATFORM IMPROVES HEDIS® REPORTING

1. On-demand measure-level HEDIS® reporting throughout the year.

2. Automatic population of key report information within health plan and provider workflow.

3. Health plan leverages reminders to facilitate collaboration with appropriate providers.

4. Providers receive and access reminders within their clinical workflow.

5. Easy mapping of open measures to upcoming appointments or outreach activities.

6. Seamless reporting of delivered services & supplemental data to health plan.
Putting It Together – One Health Plan’s Experience

One health plan client formed value-based relationships with numerous primary care providers and integrated delivery networks to allow for a collaborative approach to improving member health. Recognizing the need to activate and motivate the provider network, the health plan made key strategic decisions:

- Deploy Geneia’s Theon® platform to PCP network providers:
  - Provide a new way to display, process and address care gaps
  - Integrate care gap information into existing clinician workflow
  - Improve collection of supplemental data
  - Establish shared clinical data feeds between health plan, Geneia and provider partners
- Create regular, ongoing population health management meetings between Geneia population health experts and physician leadership
- Deliver care coordination, disease and case management, and member outreach through Geneia’s clinical innovation team

The Theon® platform tracked 25 key HEDIS® measures that align with accreditation, CMS 5 Star Ratings (STARS), Quality Rating System (QRS) and the Federal Employee Program (FEP).

From December 2015 to November 2016, the health plan’s value-based provider partners were markedly outperforming their fee-for-service peers in 18 of the 25 tracked measures, including, to a statistically significant degree in:

- Breast cancer screenings
- Cervical cancer screenings
- Colorectal cancer screenings
- Childhood immunization status
- Comprehensive diabetes care (HBA1C testing and attention to nephropathy)
Additionally, the group of members attributed to value-based providers saw a statistically significant reduction in ambulatory care - emergency department visits per 1000 members, which can be attributed to the improved access to their providers who are available to effectively and competently manage non-emergent conditions.

Overall, the health plan achieved its immediate objective of delivering cost-controlled, quality-enhanced care to members through the combination of technology, education, support and transparency with provider partners.

*Illustrative example based on real Geneia clients. Information provided for illustrative purposes only. Names are fictional and not intended to represent any specific person or entity. Any direct similarities to any real entity are purely coincidental and unintentional.


ABOUT GENEIA:

At Geneia, we’re focused on one thing: transforming healthcare – for the better. Our physicians, nurses, technologists, analytics experts, and business professionals have created a suite of solutions that enable health plans, hospitals and employers to better understand, evaluate and manage the health of their populations. Using our advanced analytics platform, remote patient monitoring tool, and education and research institute, we work with you to improve outcomes, lower cost and restore the Joy of Medicine. The company has offices in Harrisburg, PA, Manchester, NH, and Nashville, TN.

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