blue california
Promise Health Plan

2019 Dual Special Needs Plan Model of Care Evaluation
Summary of Findings

What is a Dual Special Needs Plan Model of Care?

A Dual Special Needs Plan Model of Care (D-SNP MOC) describes how we provide healthcare services to our low income senior (65+) members and members who have special needs. Our purpose is to provide them with access to care that is reliable, convenient, and accessible. Annually, we check the quality of the care and service we make available to these members. We set goals and follow steps and actions to correct our process if we do not meet those goals.

Here are some checkpoints we used to evaluate the quality of the services we made available to our senior members who qualify as D-SNP members:

- Member Satisfaction Survey
- Accessibility to doctors and appointments
- Availability and location of primary care doctors and specialists near the members' home
- Grievances (complaints) related to access to care
- Complex case management (CCM)
- Transitions of care
- Health Effectiveness Data and Information Set (HEDIS) Measures

What happens if we do not meet our goals?

We continue to evaluate and look for the best possible means of meeting our goals

How did we do in 2019?

1. **Member Satisfaction Survey**
   Our goal is to ensure members are satisfied with the care they receive from their doctors and their health plan, improving year over year.

   The satisfaction rating improved from the previous year (2018) for Rating of Health Plan, Rating of Health Care, and Rating of Drug Plan.

   We did not meet our satisfaction goals for Rating of Personal Doctor, Rating of Specialist, Getting Care Quickly, Getting Needed Care, Getting Needed Prescription Drugs, How Well Doctors Communicate, Health Plan Customer Service, Coordination of Care, and Annual Flu Vaccine.

We know these services are important to our members. We will focus on ways to improve services and make members' experience a positive one.

We want to be a trusted health plan and listen to what members tell us on surveys. This is an important way of making positive changes for our members. As remediation, we will foster a team solely dedicated to member experience with the goal of helping to drive our strategy for improving the member's experience.

2. **Accessibility to Doctors and Appointments**
   Our goal is to ensure members have easy access to their doctors and timely access to urgent and routine appointments.

   We met goals to ensure that culture and language needs and preferences were met. There is a 95% language and ethnicity match between our members and doctors. We received member complaints regarding interpreter services, and we will be improving our interpreter services and educating doctors on how to support access to those services.

   We did not meet goals for access to urgent and routine appointments. As remediation, we will increase awareness of doctors' office staff about access to care standards. These standards include timeliness of referrals and urgent/routine appointments with primary care and specialty care doctors, behavioral health doctors, and other types of care. We will continue to review timely access to medical and behavioral health care by completing additional surveys to see if we are improving.

3. **Availability and Location of Primary Care Doctors and Specialists Near Members' Homes**
   Our goal is to ensure members have access to primary care and specialty care doctors near their homes.

   We met our goals for ratio of primary care doctors to members (one doctor for every 2,000 members in 100% of the counties) and specialty care doctors to members (one doctor for every 10,000 members in 90% of counties).

   We also met our goals of ensuring that primary care doctors and specialty care doctors are located within 10 miles of 90% of our membership's homes.

   If a doctor is not available in a member's area, we offer free transportation services from the member's home to the doctor.

4. **Grievances (Complaints) Related to Access to Care**
   Our goal is to identify whether there are patterns of complaints related to access and availability of providers.

   We had fewer than 10 grievances related to access to care during 2019, but we did not meet our goal.

   We did not find any significant pattern of complaints related to access to care and/or availability of doctors. We will continue to watch for patterns and work to improve our ways of identifying all types of complaints so that we can quickly correct them.

5. Complex Case Management

Our goal is to improve member health outcomes through coordination of care and seamless transitions of care across healthcare settings.

Coordination of Care

All members are contacted for completion of a Health Risk Assessment (HRA), which is a questionnaire to identify health care needs, and an Individualized Care Plan (ICP), which is a plan of action on how to meet health care needs. Members are also invited to participate in a meeting with their care team to discuss goals and interventions for their health.

We did not meet HRA, ICP, and care team goals. We strive to conduct outreach to 100% of members for an HRA and have set a monitoring plan in place to provide strict oversight of our HRA vendor's operations. In addition, we will create an ICP and hold a care team meeting for every member, regardless of the member's active participation.

Reduction of Hospital and Emergency Room Utilization

We met our goal to reduce hospital admissions and readmissions by 10%. Hospital admissions were reduced by 11%, and readmissions were reduced by 24%.

We did not meet our goal to reduce emergency room visits by 10%. We will continue to identify and contact members with complex needs to promote preventive screenings, regular doctor appointments, and positive lifestyle changes that support optimal health.

Member Satisfaction of Case Management Services

Overall member satisfaction with case management services is 89.1%. Survey results show that we improved by 11% compared with 2018. However, we did not meet our goal to improve by 20%. We will review comments made by survey respondents to help further improve these services.

6. Transitions of Care

Our goal is to improve transition of members' care across all healthcare settings.

We work with hospitals and **skilled nursing facilities (SNFs)** to make sure our health plan provides timely and efficient care for all members. We track the following measures:

- Within one day of discharge from a hospital to a SNF, the plan of care is communicated by the health plan to the SNF.
- Within three business days of discharge from the hospital or SNF to the member's home, the primary care doctor is notified.
- Within three business days of discharge from a hospital or SNF to the member's home, the discharge plan is discussed with the member.

We did not meet goals for these measures. Our remediation is to create a tracking sheet to more effectively monitor all members who are transitioning across healthcare settings.

7. Health Effectiveness Data and Information Set (HEDIS®) Measures

Our goal is to improve member health outcomes with access to preventive health services.

Health plans use data to see how well they are doing with their care for members. The goals for the following topics were met:

- Smoking Cessation: Helping members to quit smoking.
- Care for Older Adults - Advance Care Planning: Ensuring members have a care plan for when they are in the position of being unable to make and/ or communicate their own healthcare choices.

The goals for the following topics were not met:

- Care for Older Adults - Medication Review, Pain Assessment, and Functional Status Assessment: Ensuring members complete a group of questionnaires used as preventive screenings for adults over 65.
- Colorectal Cancer Screening: Ensuring members receive a colorectal cancer screening.
- Controlling High Blood Pressure: Ensuring members control their high blood pressure.
- Antidepressant Medication Management: Ensuring members who need an antidepressant start and stay on the medication.
- Adults' Access to Preventive/Ambulatory Health Services: Ensuring members receive preventive services from their doctor.
- Medication Reconciliation Post Discharge: Ensuring members have their medications reviewed after a hospital stay.

To meet goals on these measures, we will educate and conduct outreach to our doctors to get members the help and services they need to prevent chronic health problems. Our goal is to ensure that members stay as healthy as possible all year long.

The above summary is an excerpt from the full evaluation. A full version of the evaluation is available upon request.

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