Humana®

2019 Quality Improvement Program Description Overview

Introduction

Humana's quality improvement (QI) program guides activities to improve care and treatment for the company's members. In doing so, the program aligns with Humana's corporate vision of ***helping people achieve lifelong well-being*** which supports continuous quality improvement companywide.

The QI program sets up a plan to monitor and measure the quality of care our members receive. Data is tracked and analyzed for trends monthly, quarterly and annually. Opportunities for improvement are identified, and root-cause analysis is performed as needed.

Purpose

The QI program monitors, evaluates and facilitates improvement in the quality of services offered to members. The program is based on contractual, governmental, accreditation and organizational requirements and guidelines.

Scope

The QI program's scope includes all of Humana's many plans:

- Commercial health maintenance organization (HMO)
- Preferred provider organization (PPO)
- Point of service (POS)
- Administrative services only (ASO)
- Medicare HMO
- Medicare PPO
- Special needs plan (SNP)
- Medicare private fee for service (PFFS)
- Medicaid and Medicare/Medicaid dual-demonstration plans in select markets
- Medicare/Medicaid dual-eligible plans

Goals and Objectives

The QI program has the following goals and objectives:

- Promote activities that result in better communication between departments, and improved service and satisfaction for members, physicians and other health care providers, and Humana associates
- Identify and resolve issues related to member access and availability of health care services
- Serve as a mechanism whereby members, physicians and other health care providers can express concerns to Humana regarding care and service
- Provide effective customer service for member, physician and other health care provider needs and requests
- Provide a process through which pertinent member information is collected and analyzed and improvement actions are implemented by a health plan committee composed of participating physicians and health plan staff
- Monitor coordination and integration of member care across practitioner and provider sites
- Help members with complex needs and multiple chronic conditions achieve optimal health outcomes
- Guide members to achieve optimal health by providing tools that help them understand their health care options and take control of their health needs

Ongoing Quality Improvement Services

Humana has programs that focus on your health and wellness. They can help you identify and manage conditions that may cause possible future issues with your health, work to make sure your care is delivered safely and efficiently, and help you manage chronic diseases and complex health conditions. The programs and services are available to you if you choose to participate. You may stop receiving any program or service at any time by just telling us. For more information about programs and services that you are eligible for, how to use the programs, and to start or stop a program you may visit our member website for health and wellness information, or call Humana's Health Planning and Support team at 1-800-491-4164. Nurses are available Monday-Friday, 8:30 am – 5:00 pm in your time zone.

Some of the programs Humana uses in our effort to improve the quality of care members receive are:

- **Population Health Management (PHM)**
  Humana uses a variety of systems that deliver actionable data to providers for use in improving their patients' health and wellness.

- **Member Safety Program**
  Safety initiatives throughout Humana are prioritized, reviewed and aligned with national safety issues. Humana focuses on four key areas:
  - Reduction of 30-day readmissions
  - Prevention of falls
  - Elimination of medication errors
  - Avoidance of inpatient and surgical complications

  The program uses claims information and case reviews to identify opportunities for improvement in each of the four areas.

- **Continuity and Coordination of Care**
  Humana collects and analyzes data from various delivery sites and throughout each disease process. This data is used to determine where opportunities exist to improve the coordination of care and transitions of care from one provider to another.

- **Behavioral Health (BH)**
  A review of the most prominent types of behavioral health diagnoses for which individuals receive treatment allows Humana to better serve our members, identify gaps in services, and implement services for more effective and efficient member behavioral health care.

- **Pharmacy Management**
  Humana follows a proven process to ensure that it promotes clinically appropriate, safe and cost-effective drug therapies. This process requires evaluations for safety and efficacy when developing formularies, procedures to ensure appropriate drug class review and inclusion, and a regular review of drug policies.

- **Special Needs Plans (SNP)**
  Humana continues to focus on implementing the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requirements with regard to the SNPs. Humana has multiple dedicated model of care (MOC) implementers. Each implementer is required to develop quality performance metrics and share results with stakeholders. Full results are available upon request by calling Customer Care.

- **Chronic Care Improvement Programs (CCIPs)**
  CMS requires the implementation of CCIPs as part of the mandated Quality Improvement (QI) program under the federal regulations. Humana attests each year that CCIPs are in progress for each Medicare Advantage and SNP contract. Each study contains an analysis of the outcomes and intervention data collected, as well as barriers to meeting goals, plans to reduce barriers, best practices, and lessons learned.

- **Service and Availability**
  Humana assesses member satisfaction through internal call and claims quality observations, member complaints and satisfaction survey reviews. Humana continuously monitors these service indicators and determines appropriate action to address concerns and needed improvements.

Conclusions

Humana's Quality Improvement program continues to develop and implement health solutions that provide consumers with choice, independence, education and guidance in their health benefit and health care decisions. Humana is committed to creating solutions that engage customers in health and health care with better outcomes and lower cost with an over-all goal to help people achieve lifelong well-being.

Quality Improvement reporting of activities by all areas within the company continues to focus on evaluation of effectiveness of interventions, learning from past responses and sharing of best practices. This includes a move from operational metrics to outcome metrics where possible.

Humana continues to maintain NCQA accreditation in 56 commercial, Medicare, and Medicaid Humana health plans, as well as retained its Go365 Wellness and Health Promotion accreditation with performance reporting. One Medicare plan also maintains accreditation with the Accreditation Association for Ambulatory Health Care (AAAHC).

Humana's Quality Improvement Program will continue to:

- Work closely with Medicaid implementation teams to develop QI oversight in new Medicaid markets and to maintain QI oversight in existing Medicaid markets
- Ensure that behavioral health QI remains a key component in reports from all of the various business areas
- Evaluate progress to goals, evaluate barriers, evaluate effectiveness of interventions and implement changes as needed with a focus on outcomes
- Evaluate compliance to regulations through internal monitoring of processes