Participating Health Plans Quality Improvement Strategies

BridgeSpan Health Company

Community Health Plan of Washington

Coordinated Care

Group Health Cooperative

Health Alliance Northwest

Kaiser Foundation Health Plan of the Northwest

LifeWise Health Plan of Washington

Molina Health Care of Washington

Premera Blue Cross

Regence BlueShield

UnitedHealthcare of Washington, Inc.

QIS
October 2015

Improve health outcomes

BridgeSpan Health can help you live a healthier life, no matter where you are starting from. If you are healthy right now, we can remind you when it is time for important preventive screenings, tests and routine care. If you have a chronic condition, we work with you and your doctors to coordinate your care, which can lower your out-of-pocket costs. If you are sick or injured or just need a little extra care, such as during pregnancy, BridgeSpan offers special programs that can help.

At BridgeSpan, we are working to change the health care system to make it better and more affordable for you. While most insurance companies pay doctors based on the number of office visits or procedures they provide, our goal is to pay doctors based on how well they improve your health.

Prevent hospital readmissions

Sometimes a trip to the hospital is needed, but sometimes it can be avoided.

One reason people end up in the hopstial is because they are having trouble managing a long-term health problem. If you have a chronic condition, a BridgeSpan case manager will contact you by phone, mail or email to discuss your needs and help you develop a care plan for you and your doctor. Our online health library provides information to help you understand and manage your health conditions. You will also find tools to help you talk to your doctor in more detail about a treatment plan.

If you do have to be admitted to the hosptial, we will do our best to help you. Our case managers will assist in planning your release from the hospital so the right services and support are waiting for you, whether in your home or in another facility. After you have left the hospital, our disease management nurses will follow up with you about your medications, coordinate with your doctors, and make sure that you are getting recommended tests and services. At BridgeSpan, we want to make sure you are on the road to recovery - not the road back to the hospital.

Improve patient safety/reduce medical errors

The way we see it, there's nothing more important than receiving safe, effective care when you need it. And we work hard to make sure you do. Our tools let you check the safety and quality of hospitals, and how satisfied other patients are with their services. Our case managers review your prescriptions to look for harmful drug interactions, duplicate medications, or even recalled drugs. We support doctors who use electronic health records, which helps reduce medical errors. For some members, we even check to see if there are home safety concerns - for example, if you're at a risk for a fall, or whether you might need additional at-home support.

Improve wellness and health promotion

At BridgeSpan, we don't just want you to be healthy, we want you to be well. That means we do our best to offer you support no matter what your personal health situation. If you're in tip-top shape, we can help you stay there. If you are at risk, we can help you find your way to a safer, healthier place. If you have a chronic illness, an emergency or other major medical concern, we can help you get the care you need. From preventive care to disease management, we address your whole health.

Our health coaches will work with you to provide personal guidance and help you to set and reach goals for a healthier life. Our online wellness tools can help you improve your health. You can take a quiz to identify your health risks and join workshops to get you on track to a healthier lifestyle. You can use our exercise programs, meal plans and healthy recipes in your everyday life and can even track your progress as you work toward your goals.

Reduce health disparities and health care disparities

At BridgeSpan, we work hard every day to make sure all our members get the help and care they need. Our employees receive special training on how to help our members from other cultures and countries, including people who speak other languages. Our care managers and customer service staff can help you on the phone using interpreters and TTY/TDD, as well as provide written insurance benefit information in a language that you can understand. If you need a language interpreter to understand your doctor, we can help.

Community Health Plan of **Washington**

Health education and collaborative care improve member health outcomes.

Community Health Plan of Washington works to enhance health outcomes by offering members an extensive variety of services. An important part of improving health is connecting every member to their Primary Care Provider and getting them the care they need. In addition, Community Health Plan of Washington offers Case Management for those members with more serious physical and mental health conditions. Case Management services help members make appointments and organize care with their doctors. Community Health Plan of Washington also provides Disease Management for members with chronic conditions, such as diabetes, asthma, heart disease, or high blood pressure. Key features of the program include health education, health coaching, community support services, health assessments, and much more!

Community Health Plan of Washington makes sure you get the right care, at the right time, in the right place by identifying what service is most appropriate.

We're available any time, day or night.

Sometimes you may not be sure if you need to see a doctor. With our 24-hour nurse advice line, you can call and speak to a nurse about your concerns at any time, day or night. The nurse line can advise on common symptoms or complications, contact the provider office on your behalf, or direct you to urgent or emergency care when appropriate.

Integrated care and case management services help prevent unnecessary hospital readmissions.

Avoiding hospital readmissions is important to establish the right care happens in the right place, the first time. Community Health Plan of Washington accomplishes this by coordinating care across providers. Members who are admitted to a hospital are tracked by the plan's Utilization Management (UM) nurses. In complex cases, UM nurses use a special assessment to determine readmission risk. If a member is high risk for readmission, a referral is made for Transitional Care Management. The goal of Transitional Care Management is to ensure a smooth and successful transition from hospital to home. Before and after the member leaves the hospital, the UM nurse discusses all available resources, how to access social support services, and what to expect following hospital discharge. Services include scheduling follow-up appointments, post-discharge care calls, home visits, education, and connecting members to community resources.

Safety measures for patients taking prescription medications.

At Community Health Plan of Washington, the safety of our members is our top priority. To make decisions about which care to provide when treating various health conditions, Community Health Plan of Washington uses a set of standards called Clinical Practice Guidelines. These evidence-based guidelines have been developed by nationally recognized agencies, and are reviewed annually to ensure quality. Community Health Plan of Washington also strives to help members take their medications correctly and avoid medication errors. Complications from incorrect medication use can be very dangerous. Appropriate outreach is conducted with members and providers regarding individual usage and safety measures for optimum results.

Engaging members to take an active part in their health and wellness.

Community Health Plan of Washington promotes healthy behavior with advanced technology. Engaging members to take control of their health is at the core of various programs and services designed to personalize care.

For example, Community Health Plan of Washington offers CaféWell, a free online activity center that allows members to get expert coaching, join community chats, and participate in healthy games. Another valuable resource offered through Community Health Plan of Washington, is Health and Wellness A-Z. This online library delivers information on more than 8,000 health topics, and includes interactive tools like the symptom-checker, educational videos, and decision-making aids. Lastly, to help members struggling with quitting smoking, Community Health Plan of Washington provides the Quit for Life program. This smoking cessation program includes one-on-one coaching sessions and nicotine replacement therapies. Since member success depends on their active participation in their health, Community Health Plan of Washington helps them accomplish their goals through a variety of services and support programs.

Core to our mission, we work to improve the health of underserved populations in the local communities we serve.

At Community Health Plan of Washington, we actively work to reduce health disparities. To match the diversity of our membership, all of our member materials can be translated into more than 40 languages and alternative formats, such as Braille and large-type font for those with visual impairments. Race, ethnicity, and language data are regularly tracked and studied to make sure that information is tailored to match the members' needs and cultural background. Community Health Plan of Washington also regularly coaches health care providers on meeting the unique needs of members. In addition, members are connected with doctors who understand their culture. In 2014, Community Health Plan of Washington partnered with two different community organizations in two different counties, to target specific health disparities by using Community Health Workers. Understanding the diverse needs of our membership and developing interventions is pivotal to reducing disparities and improving the overall health of the communities we serve.

Community Health Plan of Washington.
Improving member health, one service at a time.

2016 Quality Improvement Strategies

Coordinated Care Corporation

A. Improve Health Outcomes

It is the goal of Ambetter from Coordinated Care to help enrollees improve their quality of life through better management of their health care and social needs. Ambetter offers multiple programs and education to provide our enrollees with the tools to take control of and understand their health care needs.

Ambetter continues to maintain and improve the enrollee's access to essential services such as medical, behavioral/mental health, and social services. Ambetter has standards for the adequate numbers and geographic distribution of Primary Care Providers (PCPs), Specialists, Hospitals, Behavioral Health Practitioners, and Pharmacies to ensure availability and access. Ambetter has an enrollee health risk screening tool to help identify an enrollee's health needs when they are enrolled in our program. We also monitor claims data or lack of claims to help trigger an outreach when an enrollee may need preventive or guideline-based care. Our Ambetter plans provide a healthy pregnancy program (which includes case management support and a free car seat and breast pump for eligible members), as well as disease management programs for the following conditions: asthma, diabetes, depression, heart disease, high blood pressure and high cholesterol, and low back pain. In addition to our care management programs, the Ambetter plans also include a tobacco cessation program for enrollees who are ready to quit. Ambetter's physician network is held to current standards for quality, safety, and evidence-based medicine. In addition, all our contracted hospitals and facilities must meet these same stringent standards and guidelines.

In an effort to provide person-centered programs that provide quality care for the enrollee and the community, Ambetter conducts continuous quality improvement strategies based on experience with Ambetter enrollees.

B. Prevent Hospital Readmissions

Ambetter's goal is to ensure that enrollees are receiving the most appropriate care. As a part of this effort, our plan works to help prevent unnecessary readmission after hospitalization. A smooth transition for enrollees from one care setting to another is important in avoiding preventable readmissions. Ambetter works with enrollees, caregivers, hospitals, and providers at or before discharge from the hospital to ensure the following steps are taken: discharge instructions are understood and followed, medications are filled and taken appropriately, post-discharge services are ordered and initiated prior to discharge, and necessary follow-up care and appointments with the primary care provider and/or specialist are established. Overall planning actively includes the enrollee, family/caregivers, and support network. Our Transitional Care Unit staff is trained to identify enrollees likely to be readmitted and refer those individuals to case management during their hospital stay.

C. Improve Patient Safety/Reduce Medical Errors

Monitoring and promoting patient safety is integrated throughout many activities across the plan but primarily through identification of potential and/or actual quality of care events. A potential quality of care (QOC) issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based practices of care, or that signals a potential serious event. Potential QOC issues received in the Quality Improvement department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level. Ambetter from Coordinated Care improves patient safety and reduces medical errors through communication and collaboration with physicians, providers and the enrollee across the multi-specialty, multi-setting health care team. Ambetter's Medical Director and/or Pharmacist reach out to PCPs and specialty physicians to discuss the enrollee's care when there is evidence of non-compliance, polypharmacy, drug-drug interactions, drug-disease interactions, and/or adverse events due to medication errors. Patient safety is achieved through early intervention and education of enrollees. An example of this is our diabetic program which provides information to diabetic enrollees so they can be in control of their chronic condition and know the importance of HbA1c testing and other preventive tests, medication dosing and control, nutrition, and fitness. Ambetter also has a 24-hour, 7-day-a-week nurse line that allows enrollees to contact us at any time with questions about their care or health needs. This toll-free number increases availability of clinical staff to our enrollees and allows enrollees the chance to better understand a health condition or situation.

D. Improve Wellness and Health Promotion

Ambetter from Coordinated Care promotes enrollee wellness and health through early intervention and education. Educational materials are created that are tailored to enrollee needs in order to promote greater self-awareness about health conditions, treatment options, symptoms, side effects and general health needs. Also, our educational programs allow for the enrollee to become engaged in their care. For example, Ambetter offers a health education library on our website. Ambetter works with established and recognized sources by co-branding educational materials to help enrollees be well-informed about their health. Through annual and periodic outreach letters and/or phone calls, enrollees may also receive specific information based on their age, gender, or for preventive care such as a reminder to get a flu shot every fall or to get a pap smear for our female enrollees. Ambetter enrollees have access to the My Health Pays program that rewards them for completing a health risk assessment, obtaining routine care and getting a flu shot. The My Health Pays rewards can be used to help defray the cost of copays or other out of pocket expenses. Ambetter enrollees also have access to a gym program that rewards enrollees for regular use of their gym and provides discounts on membership at selected gym locations. These programs help us identify those who would benefit from additional support and reward those who are taking positive steps to improve and maintain health.

E. Reduce Health Disparities and Health Care Disparities

Ambetter from Coordinated Care provides health care services in a culturally competent manner that addresses our enrollees with respect. Ambetter utilizes the Office of Minority Health's National Culturally and Linguistically Appropriate Services (CLAS) standards. These standards help us provide the most appropriate care by: Interacting with the enrollee and his or her family by speaking their language, recognizing and applying cultural preferences, delivering culturally appropriate interventions and providing educational and

other informational materials in the preferred language of the enrollee. Through our CLAS Committee, Ambetter will assess the cultural, ethnic, racial and linguistic goals of our health plan, examine the needs of its enrollees and make recommendations for adjustments in programs, services of the availability of practitioners within the network if necessary. Ambetter facilitates linking enrollees with practitioners who can meet the enrollee's cultural, ethnic, racial and linguistic needs and preferences when requested. Ambetter works diligently in partnering with providers to engage enrollees and close care gaps (help members get the care they need in a timely manner). Through this partnership, Ambetter promotes a collaborative relationship among members and providers to improve health management and overall wellness.

INDIVIDUAL AND FAMILY PLANS

GroupHealth®

Quality improvement strategies at work at Group Health

To offer qualified health plans (QHPs), a health plan carrier must show that it has implemented each of the quality improvement strategies from Section 1311(g)(1) of the Affordable Care Act. Here are some highlights of Group Health's key strategies.

A. IMPROVE HEALTH OUTCOMES

We believe that improving health outcomes begins with preventing health problems.

No matter where you receive care, you can go online and get a personalized health status report that advises you about conditions you may be at risk for, and steps you can take to stay as healthy as possible. Annual and periodic outreach letters and/or phone calls remind you about needed preventive screenings and tests. A variety of tools are available to help you learn about your health issues and treatment options so you and your practitioner can make treatment decisions together.

Our nationally recognized clinical practice guidelines help physicians in our network identify and recommend the most appropriate, evidence-based care. A physician-led committee selects drugs that are the safest and most effective to offer on our formulary. And we publicly report our quality data, so it's easy for you to make sure that our care is consistently high quality.

Group Health is a leader in the medical home model of care. Physicians and other skilled professionals at Group Health Medical Centers work together to provide personalized, coordinated care across multiple settings. When you come in for an office visit, our electronic medical records system reminds your provider if you're due for preventive care or tests. Providers at Group Health Medical Centers also receive ongoing performance results that identify which of their patients have gaps in their care.

If you have high-risk chronic conditions, we provide case management services to give you the help you need to learn to self-manage your condition, comply with your treatment plan, and track the use of multiple medications.

B. PREVENT HOSPITAL READMISSIONS

Group Health has a comprehensive program to make sure you get high quality care while you're in the hospital, and that you have a smooth transition when you're discharged—whether you're going home, to a skilled nursing facility, or to some other care setting.

Our hospitalists and/or care managers are on-site at seven major hospitals in our network to give you the support you need while you're hospitalized. Once you're discharged, a care management nurse or a member of your personal physician's staff will call you after about 48 hours to see how you're doing. Do you have any questions or concerns? Do you understand how to take your medications? Have you set up an appointment for the follow-up care you need?

If you're at high risk of being readmitted to the hospital because of your condition, or multiple health issues, the doctor may refer you for home health visits from a nurse, or to care management services. A care manager can help you connect with the resources you need and improve your ability to self-manage your condition. They may assist you with scheduling a follow-up visit with one of the doctors involved in your care, and will keep your personal physician updated on your condition and care.

Our goal is to help you get well, avoid being readmitted to the hospital, and get back to the activities you enjoy as quickly as possible.

C. IMPROVE PATIENT SAFETY/REDUCE MEDICAL ERRORS

All physicians in our network must meet rigorous criteria in training and board certification, and their performance is frequently evaluated to make sure they're meeting our standards for quality of care and safety. Hospitals we contract with are also closely scrutinized.

Physician-led committees evaluate the latest evidence-based medicine to determine which procedures and drugs are the most effective and safest for our plan

members. Our nationally recognized clinical practice guidelines help physicians recommend the most appropriate care. Our standards for the drugs we include in our formulary are often more strict than those of the U.S. Food and Drug Administration, and we encourage our network providers to double-check all your medications at each office visit.

We frequently provide our practitioners and patients with safety information, and we recommend that you stay well informed about your condition—and active in your own care.

At Group Health Medical Centers, use of electronic medical records means that everyone who's caring for you has easy access to the most up-to-date details about your medical history, medications, and tests. That reduces errors and enables well-coordinated and safer care. Physicians order prescriptions electronically, and the system immediately flags any potential drug interactions or drugs to avoid. Our physicians also check your medications at each office visit, and are alerted if you're on a high number of prescription narcotics.

Our staff is trained to recognize safety risks and find solutions. Our anonymous online reporting system encourages clinical employees to identify near misses or safety concerns. These reports trigger a review and are used to improve patient safety procedures.

D. IMPROVE WELLNESS AND HEALTH PROMOTION

Whether you have a simple cold or a serious illness, we're there for you when you're sick. But our primary goal is to prevent health problems in the first place.

All plan members can go online to fill out a Health Profile, a health risk assessment questionnaire. Once you complete it, you'll receive a personalized report on your health status that includes your risk for certain diseases, and suggestions for steps you can take to improve your health.

Annual and periodic outreach letters and phone calls remind you about preventive screenings, tests, and care that you're due for. Our website, ghc.org, provides a rich array of information about health care topics, as well as self-management tools, interactive health quizzes, and more. Patient education pamphlets on a wide variety of topics are available through our Resource Line.

If you have a condition where there's little evidence that one treatment works better than another, we provide the information and tools you need to become well informed about your options. This prepares you to help your doctor choose the treatment plan that best meets your lifestyle and preferences—a process called shared decision making.

If you receive care at Group Health Medical Centers, results from your Health Profile become part of your electronic medical record, making it easy for you to discuss the findings with your doctor. Summaries provided after office visits include your diagnosis and recommended treatment plan in easy-to-understand language, as well as information about resources that can support you in getting and staying well.

Other wellness services we offer include smoking cessation programs, discounts at fitness facilities, weight control programs, and more.

E. REDUCE HEALTH DISPARITIES AND HEALTH CARE DISPARITIES

Group Health has a racially and ethnically diverse network of practitioners. We understand that many of our members prefer to receive care from practitioners who share their racial or ethnic background and are familiar with their culture.

For that reason, we are continually assessing the makeup of our membership population so we can recruit providers for our plan networks who meet the specific racial, ethnic, and language needs of our members. We also include community health centers in our networks to make our services more accessible to a variety of cultures.

No matter where you receive care, our electronic Provider Directory allows you to search for providers based on gender, race, cultural backgrounds, and languages spoken. This information helps you select a practitioner who meets your individual needs and preferences. We also provide practitioner biography cards, which include care philosophy, special medical interests, gender, and languages spoken.

For members who don't speak English, Group Health provides oversight to ensure that physicians and other practitioners in our network provide oral interpretive services, free of charge. Interpreters are also available if you have sight, speech, or hearing difficulties.

Member benefit and educational materials are available in the languages that are common among Group Health members, and we offer written language translation, as needed, to understand our health plan materials.

At Group Health Medical Centers, all practitioners receive cultural competency training and educational resources to help them better understand cultures other than their own and provide culturally sensitive care.

Health Alliance Northwest

Improve health outcomes

In support of our commitment to quality, Health Alliance has been accredited by the National Committee for Quality Assurance (NCQA) since 1995. In 2007 our Commercial PPO and Medicare PPO products were brought forth for the first time and attained "Full" status (the highest available for PPO products at that time). Our current NCQA accreditation status (effective December 2013 through fall of 2016) is:

- Health Alliance Medical Plans
- Medicare HMO – Excellent
- Medicare PPO – Commendable
- Commercial HMO/POS combined – Excellent
- Commercial PPO – Commendable
- Health Alliance Midwest, Inc.
- Commercial HMO/POS combined – Excellent
- Commercial PPO – Commendable
- Medicare HMO – Excellent
- Medicare PPO – Excellent

The NCQA Private Health Insurance Plan Rankings 2013-2014 ranked Health Alliance Medical Plans so well nationally - #55 among the 484 private health plans evaluated – that we remain the top-ranked health plan in Illinois for our Private HMO/POS (commercial) plans. Our Medicare HMO and PPO plans also earned the title of #1 in Illinois. Our HMO plans ranked #33 among the 405 Medicare HMO health plans nationally and our PPO plans ranked #54 among 405 Medicare PPO plans nationally according to the NCQA's Medicare Health Insurance Plan Rankings 2013-2014. Health Alliance also earned the highest ranking in Iowa for its Private HMO/POS and PPO plans, #55 out of 484 private health plans nationally for HMO/POS, and #148 out of 484 for PPO.

As part of the NCQA accreditation process and to support our commitment to quality improvement, Health Alliance annually submits Healthcare Effectiveness Data and Information Set (HEDIS) data to NCQA. HEDIS is the measurement tool used by the nation's health plans to evaluate their performance in terms of clinical quality and customer service.

Prevent hospital readmissions

A focus of Inpatient Care Coordination is collaboration with physicians, facility discharge planners, member and family to ensure optimal, timely cost effective care.

Inpatient Care Coordination includes:

- Complex inpatient/tertiary
- Extended LOS (over 7 days)
- Neonatal care

Inpatient Care Coordinators:

- Assess opportunities to transition to a lower level of care
- Identify and address discharge barriers by researching covered options or available community resources
- Ensure discharge planning is appropriate and in place to prevent unnecessary re-admissions.

The Inpatient Care Coordinators, with the support of medical directors, monitor these members closely to ensure that members are receiving quality, cost effective care.

Care Transition support involves a series of weekly calls to newly discharged members with a focus on follow up appointments, medications and reporting of early signs of worsening conditioning. This is an evidence-based approached designed to reduce readmissions within the 30 day post-discharge period.

Hospital readmissions are assessed at least annually via HEDIS for Commercial population and quarterly for Medicare Advantage members via naviHealth data. The key intervention in place to reduce readmissions focuses on care transition from the acute setting. For all Medicare Advantage members, and commercial members meeting criteria, four key elements (adopted from the Eric Coleman model) are a focus the first 30 days following discharge.

Improve patient safety/reduce medical errors

- Patient safety is facilitated in a variety of ways:
- continuity and coordination of care between practitioners and providers
- tracking and trending of adverse events
- evaluation of clinical care against aspects of evidence based guidelines that improve safe practices by de tecting under- and over-utilization
- implementation of health management systems that support timely delivery of care
- medication management evaluation through case management program
- review of patient safety/quality issues relevant to a provider applicant via the credentialing process
- review of aggregate adverse events identified through the Serious Reportable Adverse Event (CMS), Never Event and Sentinel Event processes within the Adverse Events Committee
- adoption and use of clinical practice guidelines relevant to our members for the provision of acute and chronic medical and behavioral health services (i.e. ICSI, ADA)

Improve wellness and health promotion

Website:

The Wellness Center at Health Alliance.org is a go-to site for our member that provides up-to-date health and wellness information on a number of topics including flu, immunizations and nutrition. The Wellness Center provides articles about chronic conditions like cardiovascular disease, diabetes, and asthma along with a variety of general health and wellness topics and healthy recipes.

- Preventive services are an important part of wellness and the Be Healthy wellness benefits brochure describes services included in the comprehensive wellness benefits for members. In addition, the Health Alliance website provides Preventive Care Guidelines annually, offering links to the Institute for Clinical Systems Improvement (ICSI), United States Preventive Services Task Force (USPSTF) and other trusted sites as resources to current medical literature.
- Also at the Wellness Center members will find the “Healthy Edge” blog that discusses hot topics such as “What’s a HITT Workout and Is It For You?”, the high intensity interval training craze and “Navigating the Diet Maze” which reviews some popular fad diets. The “Healthy Edge” is written by Karen Stefaniak, wellness program administrator at Health Alliance.
- Health Alliance recently transitioned from the WorldDoc online wellness tool to Audax Health’s Rally product. Through Rally, Health Alliance will be able to attract and engage individual members and employer groups through multi-touch programs that incorporate the latest web technology while continuing to meet regulatory requirements.

Reduce health disparities and health care disparities

Member Newsletters

- Housecalls – for Medicare Advantage members -information specific to the senior population
- For Your Health – for Commercial members – including children and teens.
- Simply Well – for all members - focuses on providing tips, insights and some science to help members be their best. Published twice per year and mailed to member homes as well as via the Health Alliance member website.

Weight Loss – Health Alliance promotes health and fitness by partnering with a number of fitness and weight loss centers to offer discounts on weight loss programs and fitness club memberships and our Be Well program offers free resources and programs for members at www.healthalliance.org/content/health-and-wellness

Quit for Life Smoking Cessation Program - Quit for Life® uses science based components of behavioral and pharmacological support. Each member enrolled receives a program tailored to their individual needs as assessed by a specially trained coach. Behavioral support lasts a full 12 months and consists of telephonic, web, email and Text2 Quit available 24/7. Access to the web based site is available for lifetime after enrollment for continuing support.

Anytime Nurse Line – provides member access to registered nurses 24 hours a day, 7 days a week. These nurses can direct members in an acute situation to the appropriate level of care, provide wellness information and answer general health questions. In addition, members can access an audio health library with information on over 1,100 health topics.

Reduce health disparities and health care disparities

Health Alliance provides all members access to the telephone translation service, Language Line. Interpreters are available to assist members with over 140 different languages. In addition, documents may be made available in alternate formats or languages. Contact the Health Alliance Medicare Services office for assistance.

An annual assessment of Health Alliance membership is accomplished to ensure that we are meeting the special and cultural needs of our members. Data includes stratification of demographic responses to surveys (CAHPS, complaints, and new members), translation requests for telephone (Language Line) and materials, CCMS tracking of members in case management who request translation or other assistance in completing documents or answering questions, and US Census Bureau data for Health Alliance service regions.

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KAISER PERMANENTE®

Quality Improvement Strategies

A. Improve health outcomes

The principles of the Patient Centered Medical Home are fundamental to the way we've been practicing medicine and delivering care for more than 65 years. At Kaiser Permanente, care is provided and directed by Northwest Permanente physicians. Because we're all part of one organization, we carefully coordinate care, sharing information among primary care and specialty physicians, pharmacies, and laboratories, and through to our hospitals and specialty care centers. It enables us to improve quality and drive innovation. The primary care physician initiates a treatment plan, refers the patient to specialists as needed; and ensures appropriate access and coordination of additional services.

Kaiser Permanente offers disease management programs for asthma, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease (cardiovascular risk factor management), diabetes, end stage renal disease, and high-risk pregnancy. Other disease states or chronic conditions are managed through Kaiser Permanente's case management programs. Case Managers work with patients, families, clinicians, and community resources to coordinate care delivered within our facilities, and through contracted providers. Our case managers include physicians; registered nurses with specialized training; social workers; respiratory therapists; and pharmacists.

So that our members and the public have reliable information to better understand the quality of care we deliver, we share quality measurement outcomes on kp.org. As a way to compare our performance to other health plans, members and non-members both have easy access to data about our quality and medical outcomes.

B. Prevent hospital readmissions

The Kaiser Permanente Transition in Care strategy is dedicated to decreasing 30-day hospital readmissions, while also improving patient satisfaction with their transition out of the hospital. The Transition of Care team with the help of the Care Management Institute, created an integrated end-to-end process featuring five key tactics to keep people safely in their homes (or other care facility) after a hospitalization:

1. Conduct an in-hospital readmission risk assessment
2. Focus on preventing medication errors
3. Standardize patient instructions, including a phone hotline for post-discharge questions
4. Establish a follow-up appointment in 5 days for high-risk patients and 10 days for standard-risk patients
5. Ensure a good handoff to the next care team with a revamped discharge summary. As a result of this team's work, and the participation of many across our organization, Kaiser Sunnyside Medical Center now has lower hospital readmission rates and higher patient satisfaction with discharge and follow-up care than any hospital across all of Kaiser Permanente.

C. Improve patient safety/reduce medical errors

To maintain our commitment to quality and safety for all our patients, our goal is to eliminate all medical mistakes, including the never events identified by the National Quality Forum , a not-for-profit membership

organization created to develop and implement a national strategy for health care quality measurement and reporting.

We have built a systematic patient safety program to prevent adverse events and are committed to providing our patients and members with safe, effective care. We want to assure that as a provider, the costs of these events are not passed along to our members and patients, and as a payor, we do not pay these costs, nor do we pass them along to purchasers. On rare occasions, serious adverse events occur to members and patients under our care. When one of these events occurs at a Kaiser Permanente facility, it is reported to Regional Risk and senior leadership who implement action plans to correct identified issues.

We are dedicated to providing care that is reliable, effective, consistent, and safe. We have numerous measures underway—headed by our Department of Care and Service Quality—that aim to eliminate never events.

D. Improve wellness and health promotion

To encourage members to become more proactive in maintaining good health, we offer a number of consumer engagement tools, including:

My Health Manager, a personal health record that features members' medical histories along with evidence-based medical and healthy habit information, members can manage their health care needs online. My Health Manager provides critical time-saving features for members, including online appointment scheduling and prescription refills. In addition, users have online access to selected lab test results, eligibility and benefits information, and even their children's immunization records, 24 hours a day, seven days a week. With secure e-mail messaging, members can also communicate with their doctor's office at any time, from anywhere.

Members have several healthy lifestyle programs available at kp.org. To decide which programs are right for them, members begin with HealthMedia® Succeed™, an online total health assessment , which is commonly known as a health risk assessment that evaluates their needs, motivation, and ability to modify their behaviors. Succeed™ generates a customized health guide to help members select programs that will be most beneficial to them. Members receive follow-up e-mails to help them stay on track. Additional resources such as exercise videos and healthy recipes are available for download.

We offer more than 3,800 classes and programs to help members lead healthier lives. Members get information about classes at kp.org or by calling their local medical facility. Online, members search by keyword, class location, program type, or subject. Some classes or programs have fees for attending, most are offered at no cost to members.

E. Reduce health disparities and health care disparities

Our approach to culturally competent care is to include diversity and inclusivity as core organizational values that guide our health-care delivery and business strategies so we can provide members with effective, individualized health care. With a national Health Plan membership comprised of nearly 40 percent people of color; linguistic diversity exceeding 130 languages; and a total workforce composition that reflects and frequently exceeds the diversity of the communities we serve, we are ideally positioned to lead the nation's efforts in providing culturally competent care to reduce, and ultimately, eliminate health disparities. Our programs and materials provide the

tools that address the diverse social, cultural, and linguistic needs of our membership. Our culturally competent care programs are free for members and address such issues as:

- Communication—creating bilingual and multilingual literature and signage, and providing both onsite and telephone language interpreters specially trained in health care
- Culture awareness—creating a culturally competent workplace by educating providers on issues, health concerns, and customs of various populations, including sensitivity training in topics such as race and sexual orientation
- Special needs—targeting diverse populations with our Centers of Excellence in Culturally Competent Care; located in the communities where they can be most effective and addressing concerns most pertinent to that population

To further serve the needs of our ethnically diverse membership, we established the Institute for Culturally Competent Care to incorporate cultural awareness into our integrated health care delivery system. By training providers and staff, assessing member needs, and developing targeted materials and measurement tools, we have instituted best practices in culturally competent care throughout our facilities.

A. Improve health outcomes

At LifeWise, we're more than a health plan. We are your partner committed to supporting your healthy decisions. We provide you access to high quality healthcare when and where you need it, as well as programs and tools to help you take the next step forward on your health journey. LifeWise is committed to improving your health outcomes through plan features focused on preventive care. LifeWise encourages members to take an online health risk assessment and select a primary care physician. We also give members two free doctor's visits to support them in making healthy decisions by seeking medical care when necessary.

We support our members' healthy lifestyles by providing exclusive member discounts through Peak Living. There's over 10,000 discounts and a wide variety of activity categories including: gym memberships, fitness classes, and local running and cycling events.

We also have online tools such as a personal health assessment, medical library, symptom checker, health trackers and other interactive tools, so you can track your health the way that is most comfortable for you.

B. Prevent hospital readmissions

If you've been hospitalized, the transition from hospital to home can be a vulnerable time for you. We work with your doctors and hospital to make sure you receive the care you need during this critical period. Our pre-admission program provides information to help you plan for your hospital stay and for your care once you're out of hospital. A care transition manager also helps you develop a plan with your family or caregivers. The program also makes sure your hospital stay is appropriate by preventing unnecessary or unsafe care.

The discharge planning program (for certain conditions) helps you transition back to your home by helping facilitate the right follow-up care, safe discharge plans, and referrals. We work with you and your family, doctors, and hospital to ensure you get the best care possible and help prevent readmissions to the hospital. You receive an outreach call within 48 hours of discharge to provide education, support, assessment, monitoring and referrals to case management when longer-term follow-up is needed.

C. Improve patient safety/reduce medical errors

Patient safety is extremely important to us. That's why we measure care outcomes and promote the use of clinical best practices and evidence-based medicine. We work closely with our contracted doctors and hospitals, and encourage the use of nationally recognized standards and guidelines as a benchmark for ensuring you receive appropriate care. We encourage you to select a personal doctor to help you with your healthcare needs.

For example, one such significant safety risk is when you are taking multiple prescriptions that may interact negatively with each other. With our highly successful "Brown Bag" program, you're encouraged to take all of your medications, over-the-counter medicines, and herbal supplements with you (in a brown bag) to your next doctor visit or to your pharmacist. This allows the prescriber to see all the medicines and supplements you may be taking and reduces the risk of a negative drug interaction.

We also use medical and pharmacy claims data to alert your doctors and pharmacists about potential conflicts in drug therapy, when appropriate.

D. Improve wellness and health promotion

Health means something different to everyone. That's why we support you anywhere you happen to be on your health journey. We have a number of online tools available to you including an interactive symptom checker, health trackers, healthy living programs and a built in medical library if you want more information around a topic or medical condition. Our website also provides you with health and wellness tools including a personal health assessment that provides immediate feedback. The tool makes action-based recommendations specific to your score and areas of risk.

We offer health-focused blogs and social media sites for those who enjoy an interactive, community experience:

Facebook: We post information about local health and wellness events and opportunities on our Facebook page. It provides a place for you to talk about the health issues that touch your life and receive support from the community.

Actively Northwest: Our online lifestyle magazine that provides a local spin on healthy living.

Twitter: Our twitter feed provides information about health, fitness and inspiration, as well as wellness tips and healthcare trends.

YouTube: We have informative videos on benefits, member experiences, and wellness that you can access on YouTube.

Our mobile app on Windows, iOS and Android, includes a virtual ID card, on-the-go access to claims and benefits information, and puts LifeWise's comprehensive Find a Doctor tool in the palm of your hand.

E. Reduce health disparities and health care disparities

We're committed to ensuring that you have access to high-quality healthcare, when and where they need it most. In certain circumstances, language can be a significant barrier, so to address this disparity we provide interpreter and translation services if needed, when contacting our customer service center. Translation assistance service is provided for more than 160 languages. This same translation assistance service is also available for personal health support coaching.

Our $15 per visit unlimited access to Virtual Care offers quick and convenient access to a consultation with a board certified physician by phone or video chat whenever you need it.

Our 24-Hour NurseLine service also provides access to translation services in more than 140 languages. In addition, written translations of important information such as Explanations of Benefits, Prior Authorizations, and denial or appeal letters is also available if requested. For the hearing-impaired, TDD services are available through our customer service center, and we review these services annually to make sure we're meeting your needs.

We also maintain a strong commitment to supporting the health of the communities we serve including the uninsured, low income, and underserved. We sponsor and actively participate in community events focused on enhancing the health and wellbeing of populations throughout the Pacific Northwest. Please visit our website if you'd like more information around our community stewardship.

Improve health outcomes

Molina has a variety of programs dedicated to supporting, improving and maintaining member's health. The programs listed below are offered to Molina members:

1. Complex Case Management and Care Coordination: Registered Nurse (RN) and Social Work Case Managers work directly with members to:
    a. Identify and eliminate barriers interfering with member's ability to manage their condition
    b. Develop a comprehensive care plan for care coordination
    c. Develop health goals for improving or maintaining health
    d. Refer members for needed services

2. Transitional Care Program: RN's and Social Workers engage members while they are in the hospital and follow-up with members after discharged to help ensure the member understands medical advice and schedules PCP follow-up visits as directed.

3. Disease Management: This program helps members prevent onset of disease and stabilize chronic disease. Health Educators:
    a. Use culturally appropriate educational materials to help members understand and manage their condition
    b. Identify and eliminate barriers interfering with member's ability to manage their condition
    c. Refer member to their provider for support and access to specialists

4. Pharmacy Department: Dedicated pharmacists work with members to help them understand the medication their provider prescribed and how best to take them

5. Community Connectors: Provide information about housing, food, and transportation to help support basic needs and get to medical appointments

6. Quality Improvement (QI): Members who miss important exams and services will be contacted by QI staff and offered support and incentives for following up with needed care

Prevent hospital readmissions

Molina staff work with members to help prevent hospital readmissions in the following ways:

1. Transitional Care nurses contact members while they are still in the hospital and again after discharge to help ensure the member understands discharge instructions, fills prescriptions, schedules follow-up medical appointments and has what they need to recover successfully at home

2. The Nurse Advice Line: Available to our members by telephone and TTY 24-hours a day, 365 days a year in 23 different languages, connects members to a qualified nurse, who gives health care advice to help with answering questions or concerns after their hospital stay
    a. Recommending where to go for care after the hospital stay
    b. Provide needed referrals and resources for care

3. Case Managers contact members not in the Transitional Care Program after they have been discharged from the hospital to ensure they understand their discharge instructions and have scheduled a medical follow-up appointment

4. Members readmitted for specific chronic conditions will receive additional education and support for managing their disease by disease management Health Educators. Outreach and education will also be offered to the member's medical provider to help ensure they have the most up-to-date care guidelines and support medical management efforts.

Improve patient safety/reduce medical errors

Molina has a Patient Safety Program that helps to keep members and their families healthy and safe. This program gives members safety facts so they can make better health care choices. Some of the things included in the program are:

1. Tracking member concerns about safety problems in their providers office or hospital

2. Educating members about what questions to ask when they see a provider. For example, what to ask a surgeon prior to surgery and questions to ask about drug interactions

3. Educating members about home safety such as how to keep poisons and medicines out of the reach of children

4. Informing providers about the use of known national medical standards of care. These guidelines support best practices from across the country and are considered by Molina when making decisions about member treatment, including hospital stays and procedures. Using these guidelines helps prevent errors and avoids putting members at risk.

Improve wellness and health promotion

Molina has several activities we use to improve wellness and promote the health of our members. These include:

1. Reminding members about important services they need to keep them healthy including: vaccines, well-child exams, pap and mammogram screenings, diabetes care, hypertension and prenatal care

2. Providing assistance with scheduling appointments, and if needed, transportation

3. Offering members smoking cessation, weight control and 24-hour Nurse Advice Line services to promote healthy living

4. Free disease management programs, such as asthma and diabetes. The Motherhood Matters Program - Motherhood Matters is a special program that guides pregnant women through their pregnancy. The program provides information to members about how to care for themselves and their unborn child. The program includes education on recommended foods they should eat, other support services available, provider visits and when to call their provider. It also incorporates a stop smoking program, which is important to their baby's health.

Reduce health disparities and health care disparities

Health disparities refer to differences between groups of people and their health. Molina is committed to reducing health care disparities and providing members access to the following:

1. The Community Connector Program – This program is designed to improve the quality of a member's health and access to care. Members who have difficulty accessing health care services can get extra help from Molina's Community Connectors. The Community Connectors are trained professionals that live in the community, and understand the local area, language and resources. Community Connectors provide:

a. Face to face contact

b. Assistance finding a provider and medical home

c. Arrangements for extra help for homebound members who are frail including extra help at home or in-home medical care

d. Assistance with housing, food, clothing, heating, transportation, scheduling appointments, medication refills and financial assistance

2. Our Nurse Advice Line – Molina has nurses available to our members by telephone, 24-hours a day, 365 days a year to provide support in 23 different languages, including English, Spanish, Russian and Vietnamese. The Nurse Advice Line uses traditional relay services for deaf, hard of hearing, and speech loss individuals who use a teletypewriter, or TTY, as a communication device. The Nurse Advice Line connects members to a qualified nurse, who gives health care advice in their language to help with:

a. Getting care they may need when their Primary Care Provider office is closed or after hours

b. Deciding if they or their child should see a provider right away

c. Questions they may have about their health

d. Getting an appointment if they need to see a provider quickly

e. Getting care for medical or emotional problems

PREMERA BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

A. Improve health outcomes

At Premera, we're committed to helping you live your healthiest life by providing you access to the high quality healthcare you need, as well as programs and tools to help you reach your health goals. Our programs are personalized to help you set and achieve goals such as getting more active, stopping smoking, making better food choices, losing weight or other areas of interest to you. If you have a chronic condition such as diabetes or heart disease, need complex medical care support, or need help navigating the healthcare system, we're here to support you. We also offer virtual care options for your convenience, including our NurseLine and telehealth.

Our health support programs help you by giving you a health coach to help you manage chronic conditions like diabetes or heart disease. For more complex medical conditions where you might be at risk for complications or require hospitalization, a nurse helps you work through the barriers getting in your way of getting the care you need.

We also have online tools such as a personal health assessment, medical library, symptom checker, health trackers and other interactive tools, so you can track your health the way that is most comfortable for you. In addition, we offer health-related discounts such as fitness club memberships, family safety products, eye glasses and contacts, vitamins, and more.

B. Prevent hospital readmissions

If you've been hospitalized, the transition from hospital to home can be a vulnerable time for you. We work with your doctors and hospital to make sure you receive the care you need during this critical period. Our pre-admission program provides information to help you plan for your hospital stay and your care once you're out of hospital. A care transition manager also helps you develop a plan with your family or caregivers. The program also makes sure your hospital stay is appropriate by preventing unnecessary or unsafe care.

The discharge planning program (for certain conditions) helps you transition back to your home by helping facilitate the right follow-up care, safe discharge plans, and referrals. We work with you and your family, doctors, and hospital to ensure you get the best care possible and help prevent readmissions to the hospital. You receive an outreach call within 48 hours of discharge to provide education, support, assessment, monitoring and referrals to case management when longer-term follow-up is needed.

C. Improve patient safety/reduce medical errors

Patient safety is extremely important to us. That's why we measure care outcomes and promote the use of clinical best practices and evidence-based medicine. We work closely with our contracted doctors and hospitals, and encourage the use of nationally recognized standards and guidelines as a benchmark for ensuring you receive appropriate care. We encourage you to select a personal doctor to help you with your healthcare needs.

For example, one such significant safety risk is when you are taking multiple prescriptions that may interact negatively with each other. With our highly successful "Brown Bag" program, you're encouraged to take all of your medications, over-the-counter medicines, and herbal supplements with you (in a brown bag) to your next doctor visit or to your pharmacist. This allows the prescriber to see all the medicines and supplements you may be taking and reduces the risk of a negative drug interaction.

We also use medical and pharmacy claims data to alert your doctors and pharmacists about potential conflicts in drug therapy, when appropriate.

D. Improve wellness and health promotion

Health means something different to everyone. That's why we support you anywhere you happen to be on your health journey. We have a number of online tools available to you including an interactive symptom checker, health trackers, healthy living programs and a built in medical library if you want more information around a topic or medical condition. Our website also provides you with health and wellness tools including a personal health assessment that provides immediate feedback and makes action-based recommendations specific to your score and areas of risk.

We offer health-focused blogs and social media sites for those who enjoy an interactive, community experience:

- Facebook: We post information about local health and wellness events and opportunities on our Facebook page. It provides a place for you to talk about the health issues that touch your life and receive support from the community.

- Blog: Premera News, the official news hub of Premera Blue Cross, gives up-to-date company and healthcare news, tips on staying healthy, as well as a forum for you to engage in the conversation.

- Twitter: Our twitter feed provides information about health, fitness and inspiration as well as wellness tips and healthcare trends.

- YouTube: We have informative videos on benefits, member experiences, and wellness that you can access on YouTube.

Our mobile app on Windows, iOS and Android, includes a virtual ID card, on-the-go access to our NurseLine, claims and benefits information, and puts Premera's comprehensive Find a Doctor tool in the palm of their hand.

E. Reduce health disparities and health care disparities

We're committed to ensuring that you have access to high-quality healthcare. In certain circumstances, language can be a significant barrier, so to address this disparity we provide interpreter and translation services if needed, when contacting our customer service center. Translation assistance service is provided for more than 160 languages. This same translation assistance service is also available for personal health support coaching.

Our 24-Hour NurseLine service also provides access to translation services in more than 140 languages. In addition, written translations of important information such as Explanations of Benefits, Prior Authorizations, and denial or appeal letters is also available if requested. For the hearing-impaired, TDD services are available through our customer service center, and we review these services annually to make sure we're meeting your needs.

We also maintain a strong commitment to supporting the health of all community residents, including the uninsured, low income, and underserved. Please visit our website if you'd like more information around our community stewardship.

Regence BlueShield

Improve health outcomes

Regence BlueShield can help you live a healthier life, no matter where you are starting from. If you are healthy right now, we can remind you when it is time for important preventive screenings, tests and routine care. If you have a chronic condition, we work with you and your doctors to coordinate your care, which can lower your out-of-pocket costs. If you are sick or injured or just need a little extra care, such as during pregnancy, Regence offers special programs that can help.

At Regence, we are working to change the health care system to make it better and more affordable for you. While most insurance companies pay doctors based on the number of office visits or procedures they provide, our goal is to pay doctors based on how well they improve your health.

Prevent hospital readmissions

Sometimes a trip to the hospital is needed, but sometimes it can be avoided.

One reason people end up in the hospital is because they are having trouble managing a long- term health problem. If you have a chronic condition, a Regence case manager will contact you by phone, mail or email to discuss your needs and help you develop a care plan for you and your doctor. Our online health library provides information to help you understand and manage your health conditions. You will also find tools to help you talk to your doctor in more detail about a treatment plan.

If you do have to be admitted to the hosptial, we will do our best to help you. Our case managers will assist in planning your release from the hospital so the right services and support are waiting for you, whether in your home or in another facility. After you have left the hospital, our disease management nurses will follow up with you about your medications, coordinate with your doctors, and make sure that you are getting recommended tests and services. At BridgeSpan, we want to make sure you are on the road to recovery - not the road back to the hospital.

Improve patient safety/reduce medical errors

The way we see it, there's nothing more important than receiving safe, effective care when you need it. And we work hard to make sure you do. Our tools let you check the safety and quality of hospitals, and how satisfied other patients are with their services. Our case managers review your prescriptions to look for harmful drug interactions, duplicate medications, or even recalled drugs. We support doctors who use electronic health records, which helps reduce medical errors. For some members, we even check to see if there are home safety concerns—for example, if you're at a risk for a fall, or whether you might need additional at-home support.

Improve wellness and health promotion

At Regence, we don't just want you to be healthy, we want you to be well. That means we do our best to offer you support no matter what your personal health situation. If you're in tip-top shape, we can help you stay there. If you are at risk, we can help you find your way to a safer, healthier place. If you have a chronic illness, an emergency or other major medical concern, we can help you get the care you need. From preventive care to disease management, we address your whole health. Our health coaches will work with you to provide personal guidance and help you to set and reach goals for a healthier life.

Our online wellness tools can help you improve your health. You can take a quiz to identify your health risks and join workshops to get you on track to a healthier lifestyle. You can use our exercise programs, meal plans and healthy recipes in your everyday life and can even track your progress as you work toward your goals.

Reduce health disparities and health care disparities

disparitiesAt Regence, we work hard every day to make sure all our members get the help and care they need. Our employees receive special training on how to help our members from other cultures and countries, including people who speak other languages. Our care managers and customer service staff can help you on the phone using interpreters and TTY/TDD, as well as provide written insurance benefit information in a language that you can understand. If you need a language interpreter to understand your doctor, we can help.

Quality Improvement Strategies

UnitedHealthcare of Washington, Inc.

A. Improve health outcomes

At UnitedHealthcare, we are dedicated to **helping people live healthier lives.™** We use billions of data points of information and innovative thinking to help doctors and individuals make better health care decisions. No matter your stage of life, we're committed to helping you get the quality health care you need, as well as access to programs and tools to help you reach your health goals. Whether you have a chronic condition such as diabetes or heart disease, you need complex medical care support or you simply need extra help navigating the health care system, we are here for you.

- **Managing Disease** – The UnitedHealthcare Diabetes and Coronary Artery Disease (CAD) Disease Management program teaches you how to work with your doctor and other health care professionals to manage your condition. We'll teach you why your best defense is a healthy lifestyle – and that includes medication compliance, self-treatment plans and more.
- **Case Management** – Our case managers focus on identifying people with complex conditions who could benefit from extra guidance and support. The goal is to make sure a person receives care from a doctor best qualified to deal with their condition and that the care is appropriate and will lead to better outcomes.
- **Transitional Care Management** – Transitional Care Managers (TCM) help keep those who've recently been discharged from the hospital from needing an additional hospital stay for the same condition. We work with members and their primary care physicians to identify helpful services and create a plan to keep members healthy and out of the hospital.

B. Prevent hospital readmissions

It may come as a surprise, but once you've been hospitalized, you are at high risk for another hospital stay. We work with hospitalized individuals, who are considered high risk for readmission or who have complex discharge planning needs, to proactively monitor and assist with a safe transition to home. This includes post discharge case management or disability management. The following five key areas are the focus in reducing readmissions:

1. **Care** – Is the person getting the right care?
2. **Self-Care** – Does the person understand how to take care of his or her treatment needs? Does the person understand the condition, and other factors that could make it better or worse? Can community services or local support groups provide additional support?
3. **Medications** – Does the person have the right medications and understand how to take them?
4. **Access to Care** – Does the person have a primary care physician who coordinates care? Is an appropriate specialist or sub-specialist monitoring the person's progress?
5. **Equipment/Supplies** – Does the person need home care services, equipment or supplies that will allow him or her to better manage at home?

UnitedHealthcare®

C. Improve patient safety/reduce medical errors

The UnitedHealthcare Patient Safety Program puts patients first by making sure that our health care providers, pharmacies and hospitals follow best practices to help reduce mistakes. The Patient Safety Program accomplishes this by:

- Working with pharmacy partners to promote safe, appropriate, and cost-effective medication use.
- Evaluating and distributing the Clinical Practice Guidelines.
- Educating members about the importance of patient safety.
- Keeping "progress reports" that help us identify opportunities for improvement.

UnitedHealthcare advances appropriate care, evidenced-based medicine (EBM) and patient safety by analyzing scientific evidence and using innovative technology. Key programs include:

- The Misuse and Abuse Drug Monitoring Program, which notifies doctors when a member may be taking too many narcotics. That member will then be restricted to one pharmacy and one physician to decrease the potential for continued abuse.
- Monitoring of the United States Food and Drug Administration website for "Black Box" warnings, recalls and alerts.
- The Point-of-Sale Drug-to-Drug Interaction Program, which alerts the pharmacist at the point-of sale when a newly prescribed drug may negatively interact with drugs the patient is already taking. This reduces medical errors while keeping the patient safe.

D. Improve wellness and health promotion

Good health is a life-long journey, so it helps to have all the support you can get! And we support our members with simple, relevant, easy-to-use tools. We want to help you make the most informed decisions that bring better health outcomes and lower costs. The following are just some of the many tools and resources available to our members:

- **myuhc.com®** – Our personalized member website helps you get the most out of your benefits: Functions include a doctor search, online statements and bill-pay and access to a round-the-clock nurse hotline.
- ***Healthy Mind Healthy Body®*** – A customizable, members-only newsletter gives you just the health info you want.
- **Health Discount Program** – Get healthy savings with this program that offers from 5 to 20 percent off a variety of health and wellness service and products, including gyms, nutritional supplements, therapeutic massage and more.
- **Online health coaching programs** – Program options include: asthma, back pain, high blood pressure, diabetes lifestyle management, heart healthy lifestyle, exercise, nutrition, weight management, tobacco cessation, stress management, healthy pregnancy and preventive care.
- **NurseLine℠** – Accredited by the American Health Care Commission/URAC, nurses are available 24 hours a day, 7 days a week to provide health information and personal support for a wide variety of concerns.
- **myHealthcare Cost Estimator** – A tool that helps you plan your medical care by providing reliable cost estimates so you can select an option based on price, quality and convenience.
- **UnitedHealthcare Health4Me™** – A mobile app that allows members to easily and conveniently access their health plan benefits information. View and share health plan ID card, find doctors and facilities, and connect with customer care professionals.

E. Reduce health disparities and health care disparities

UnitedHealth Group's Health Equity Services Program was created to make sure all people are treated fairly, regardless of ethnicity, nationality or gender, and get access to the programs, physicians and tools that address their unique needs. Our parent company, UnitedHealth Group®, created the Health Equity Services Program to ensure that all people are treated fairly, regardless of ethnicity, nationality or gender and get access to the programs, physicians and tools that address their unique needs. The program has two primary goals:

1. Reduce health disparities to improve health and health care for consumers and communities
2. Provide culturally sensitive program and services that promote good health

At UnitedHealthcare, we are paying particular attention to two health care concerns among our African American and Hispanic/Latino members: gaps in diabetes care and colorectal cancer screening disparities. As well, we have developed specific programs to address health disparities.

- **PlanBien® –** Bilingual materials and services are available to better serve Spanish speaking individuals.
- **Generations of Wellness®** – Provides culturally relevant health information to help African Americans live their best lives.
- **Enhanced Bilingual Service –** Includes phone routing and in-language messaging to seamlessly route Spanish-speaking members to a dedicated Spanish-language call center. Best practices for the translation and standardization of member materials have been implemented in the Benefits and Services (OptumHealth) businesses.
- **Health Literacy Innovations Program –** This program helps us create easy-to-understand, easy-to-read materials for Hispanics and Latinos, Asian Americans and aging adults.

UnitedHealthcare®