2020 Quality Improvement Work Plan

Initiatives

Quality of Care

Resp Party/ Business Lead	Project Manager	Topic	Goal	Due Date/ Timeframe for Completion	Q1, 2020	Q2, 2020	Q3, 2020	Q4, 2020	Summary	Subcommittee	Projected Due Date	Plan Update	Date Completed	Name/Title
QI Director / QI Medical Director	Clinical Quality Manager	**HEDIS Rates MY 2019 - Continuation**	Increase the HEDIS AQFS rate by 1% 2019-2020 season	January 2020	No updates at this time.	Final AQFS score 79.	No updates at this time.			Internal Quality Improvement Committee	6/1/2020			S. Wakefield, RN, Sr. Dir. Quality Dr. Bhatt / Medical Director Jessica Pedden Clinical Quality Manager
QI Director/ QI Medical Director	Clinical Quality Manager	**HEDIS Rates MY 2020**	Increase the HEDIS AQFS rate TBD 2019-2020 season	January 2021	No updates at this time.	In April, the first rate report was run in Verscend.	On 7/1/2020, AAH was notified by NCQA that the following changes have been made to the HEDIS measures: 1. Retired measures! 1. Adult BMI Assessment (ABA) 2. CDC Nephropathy: Retired for Medicaid and Commercial 3. Medication Management for People With Asthma (MMA) 4. Children and Adolescents' Access to Primary Care Practitioners (CAP) 2. Well-Child Visits in the First 30 Months of Life (W30) is not a hybrid measure. Telehealth is allowed for this measure. 3. Child and Adolescent Well-Care Visits (WCV) is not a hybrid measure. Telehealth is allowed for this measure. Measure covers ages: 3 - 21 4. AMR and CBP: There are some changes in how members qualify for the eligible population Please note: 1. There will be an update in October 2020 for MY 2020 tech specs 2. There will be an update in March 2021 for MY 2021 tech specs During this quarter, QI notified the delegates at the JOMs of these changes. We'll start with the measures below. I'll add measures to the list later. For the measures you are assigned, please create a handout with the following to present to the HEDIS team. I attached a handout from last year as an example. • Explain the measure and numerators (if measure has multiple numerators) • Explain how a member qualifies for the eligible population • Explain the continuous enrollment criteria for the measure • Is the measure an admin measure or hybrid measure? o Explain criteria that would make a member admin compliant. o Explain criteria that would make a member hybrid compliant					S. Wakefield, RN, Sr. Dir. Quality Dr. Bhatt / Medical Director Jessica Pedden Clinical Quality Manager
QI Director / QI Medical Director	Clinical Quality Manager	**HEDIS Retrieval and Overreads MY 2019 - Continuation**	Alongside the analytics team, provide HEDIS support related to medical record retrieval, abstraction, and overreads. The goal is to overread 20% of the abstracted charts for the hybrid measures.	May 2020					In conjunction with the analytics team, the QI team provides HEDIS support related to medical record retrieval, abstraction, and overreads. Project and timeline are co-owned.	Internal Quality Improvement Committee	5/2020			S. Wakefield, RN, Sr. Dir. Quality Dr. Bhatt / Medical Director Jessica Pedden Clinical Quality Manager
QI Director / QI Medical Director	Clinical Quality Manager	**HEDIS Retrieval and Overreads MY 2020 Continuation**	Alongside the analytics team, provide HEDIS support related to medical record retrieval, abstraction, and overreads. The goal is to overread 20% of the abstracted charts for the hybrid measures.	May 2021	No updates at this time.	No updates at this time.	On 8/25/20, QI and Analytics met to review the 2019 retrival material to identify what needs to be updated for this retrival season.		In conjunction with the analytics team, the QI team provides HEDIS support related to medical record retrieval, abstraction, and overreads. Project and timeline are co-owned.	Internal Quality Improvement Committee	5/2021			S. Wakefield, RN, Sr. Dir. Quality Dr. Bhatt / Medical Director Jessica Pedden Clinical Quality Manager
QI Director / QI Medical Director	QI Director / QI Medical Director	**Pay For Performance (P4P) 2020 Continuation**	Incentives providers to improve care through P4P measures	December 2020	Direct and delegates were provided with the 2020 P4P billing and provider notification.	In June, all delegates and providers were notified about the changes made to AAH's P4P program due to COVID-19. The changes include the following: 1) The benchmarks are no longer based on prior year rates nor NCQA Benchmarks. They are now based on the overall Alliance rates for 2020. 2) The Member Satisfaction Survey – Non Urgent Appointment Availability measure has been removed. Please note that the removal of this measure does not impact the amount available to you for the P4P program. 3) We have reduced the percentages required to earn points. Please refer to the enclosed guide for specifics on each measure. 4) DHCS is temporarily waiving the requirement for Initial Health Assessments (IHAs) to be completed within 120 days of enrollment. Completion of the IHA is required once the public health emergency is over. This applies to members who have enrolled or re-enrolled from December 2019 forward, until further notice. Your IHA completion rate will be adjusted accordingly. We will provide further guidance once it has been issued by DHCS.	During Q3, delegates were reminded of the adjustments made to the 2020 P4P at the JOMs.		The 2019, the P4P measures were chosen earlier with the goal of early distribution. Also, gap lists are distributed. P4P measures include: CIS, CAP, WCC, AMR, CCS, CDC, CBP, MPM and Opioid Education, IHA, ED Visits / 1000, Pharmacy Generics Utilization. Ongoing conversation and assistance with delegates and direct providers to improve rates year over year.	Internal Quality Improvement Committee	12/2020			Dr. Bhatt / Medical Director
QI Director / QI Medical Director	QI Director / QI Medical Director	**Pay For Performance (P4P) 2021 Continuation**	Incentives providers to improve care through P4P measures	January 2021	No updates at this time.	No updates at this time.	No updates at this time.	On 8/4/2020, Analytitics and QI started planning for the 20201 P4P program.						Dr. Bhatt / Medical Director
QI Director / QI Medical Director	Clinical Quality Manager	**QIP #1: Improve Adolescent Access to Care PIP**	Adapt the strategy that was utilized in the 2017 PIP to improve adolescent access to preventive healthcare services by improving AWC rates.	December 2020	In Q1, the QI team began to evaluate the MY2020 rates for AWC for all delegates after the first data refresh	The QI team identified an opportunity to work with Tri-City Health Center to improve its AWC rates by offering a $25 member incentive for AMC. The QI Department contacted Tri-City Health Center on June 24th, to discuss the possibility of partnering on the quality improvement project. Tri-City Health Center is in the process of reviewing the proposal and will update QI once a decision is made.	On 8/28/20, QI met with Tri-City to share the current pediatric measures and their current performance rate. Tri-City agreeded to participate and provide member incentives at the completion of a well-child exams starting 9/1/2020.		DHCS mandates that MCPs need to performed at the 50% MPL for AWC measure.	Internal Quality Improvement Committee	12/2020			Jessica Pedden Clinical Quality Manager
QI Director / QI Medical Director	Clinical Quality Manager	**QIP #2: Improve A1C Testing in AAM**	Adapt the strategy that was utilized in the 2017 PIP to improve HbA1c rates in the African American male diabetic population.	December 2020	No updates at this time.	No updates at this time.	On 8/28/2020, QI leadership met to discuss how to adapt the previous strategy to include a partnership with local barber shops.		This project targets African American men with DM to undergo HbA1c testing annually.	Internal Quality Improvement Committee	12/2020			Jessica Pedden Clinical Quality Manager
QI Director / QI Medical Director	Clinical Quality Manager	**QIP #3: Tdap Completion Rates - Continuation**	Working with DPH, improve Tdap immunization rates among pregnant women to 90% by January 1, 2021	January 2021	Given COVID-19 AAH's partners at ACDPH are not available to continue the work on this QIP.	No updates at this time.	AAH QI Department will be begin reevaluating the current Tdap data to determine if there is a provider that should be targeted to help improve immunization rates.		In conjunction with the DPH, this projects targets pregnant women in their third trimester and aims to improve Tdap vaccination rates; low performing, high volume delivery sites will be identified and targeted for resources and education.	Internal Quality Improvement Committee	1/2021			Jessica Pedden Clinical Quality Manager
QI Director / QI Medical Director	QI Director / QI Medical Director	**PDSA Cycle Continuation**	Ensure that all divisions within HCS utilize the PDSA performance improvement model to develop and evaluate activities	Ongoing					In order to encourage all divisions within HCS to utilize the PDSA cycle, a reporting template that lists out barriers, interventions, and next steps has been developed. This reporting template has been distributed. QI has worked with each division to encourage the use of this template.	All Sub-Committees				S. Wakefield, RN, Sr. Dir. Quality Dr. Bhatt / Medical Director

2020 Quality Improvement Work Plan

Initiatives

QI Director / QI Medical Director	Clinical Quality Manager	**PIP #1: Improve Compliance Rate for the African American Pediatric Population for W15**	To address the disparity that exists with W15.	June 2021	On 2/23/2020, QI submitted Module 2 to HSAG and DHCS for review. AAH received feedback from HSAG that the following information needed to be adjusted in Module 2: The MCMC plan must revisit the FMEA table and ensure that the failure modes and causes are documented accurately. The MCMC plan must revise the key drivers and also ensure that using arrows, each intervention listed is linked to a key driver. AAH sucustully addressed the identified issues and the module was accepted by DHCS and HSAG on 3/30/2020.	On 5/11/2020, QI submitted Module 3 for DHCS and HSAG to review. On 5/20/2020, AAH received the following findings from HSAG: • How will the members know about the gift card (GC) incentive? Will the MCMC plan/provider inform the members about the incentive? • It was unclear who will be offered the GCs? Will the GCs be given to only those 15-month-old members who completed 6 well visits or any member up to 15 months of age who come in for a well visit? • The MCMC plan must also include the amount of the gift card that would be given to the members receiving a well visit. • For the monthly gaps report, the MCMC plan must include the age range of the members for whom data will be pulled. If the gap report has African American members who have already turned 15 months of age, then the opportunity to make those members numerator compliant is already lost. The targeted members for the intervention should be those below 15 months of age. It appears the denominator may be the African American members who were identified as due for a well visit in the gaps in care report for the identified provider and were informed about the GC incentive. The MCMC plan must also include the age range of the members targeted for the intervention in the denominator. The numerator may be the number of African American members who came in to receive a well visit during the measurement month/period and received a gift card. • The data source for the intervention effectiveness measure should be based on real time data such as medical record data in order to understand the effectiveness of the intervention in a rapid manner. Please note that the intervention effectiveness measure is different than the SMART Aim measure. • The data collection for the intervention effectiveness should be collected frequently such as weekly, biweekly or at a minimum on a monthly basis. The MCMC plan must	Starting Q3, the Plan does not have to continue with the PIP. The following notification was issued by DHCS: We have heard from a number of MCP, PSP and SHP partners regarding the challenges of conducting performance improvement projects (PIP) during the COVID-19 public health crisis, particularly when the PIPs were developed prior to the advent of this crisis and without any of the attendant complications in mind. Given this, and the fact that DHCS is approaching the end of its current External Quality Review Organization (EQRO) contract, DHCS has elected to end the current PIPs as of June 30, 2020. DHCS will have the MCPs and PSPs start new PIPs as soon as the new EQRO contract is in place in mid to late summer. DHCS will maintain the current PIP topics for the new PIPs that start in the summer; namely, Child and Adolescent Preventive Health, and Health Equity. These topics are very much aligned with DHCS' and MCPs'/PSPs' priorities during the COVID-19 public health crisis.	No further updates	This was identified as the focus for the DHCS Equity PIP.	Internal Quality Improvement Committee				
QI Director / QI Medical Director	Clinical Quality Manager	**PIP #2: Improve Compliance Rate for Members Assigned to 5 Direct Providers for W34**	To ensure that members age 3-6 receive preventive care services.	June 2021	On 3/18/2020, QI submitted the completed Module 2 to DHCS and HSAG for review.	On 4/8/2020, the following feedback was given from HSAG: General Comment: Mailers for informing the members about incentive is listed as a potential intervention. HSAG noted that lack of updated member accurate contact information was one of the failure causes identified in the FMEA table. The MCMC plan may want to consider addressing that failure cause before proceeding with this intervention. Additionally, based on the FMEA table, HSAG recommends that as the PIP progresses, the MCMC plan may revisit the key driver diagram and identify additional potential interventions for the PIP, if needed. On 5/22/2020, QI submitted the completed Module 3 to DHCS and HSAG for review. The following issues were identified: The MCMC plan must ensure that all the data elements needed for calculating the intervention effectiveness measure are included. For example, the MCMC plan should include the data element used to track the members who were sent and received the mailer. Additionally, the data source for collecting the intervention effectiveness measure should not be based on claims. The MCMC plan may pull the GIC report based on claims; however, the tracking of the mailers sent to members and the members receiving a well visit and a gift card should be based on real time data without claims lag. This will ensure that the intervention effectiveness is evaluated in a rapid-cycle manner. The MCMC plan documented, "AAH Analytics Dept generates gap in care (GIC) report, providing list of eligible members who need a well-child visit for the current measurement year." What does the MCMC plan mean by current measurement year? Is it until the SMART Aim end date or the end of calendar year (CY) 2020?	Starting Q3, the Plan does not have to continue with the PIP. The following notification was issued by DHCS: We have heard from a number of MCP, PSP and SHP partners regarding the challenges of conducting performance improvement projects (PIP) during the COVID-19 public health crisis, particularly when the PIPs were developed prior to the advent of this crisis and without any of the attendant complications in mind. Given this, and the fact that DHCS is approaching the end of its current External Quality Review Organization (EQRO) contract, DHCS has elected to end the current PIPs as of June 30, 2020. DHCS will have the MCPs and PSPs start new PIPs as soon as the new EQRO contract is in place in mid to late summer. DHCS will maintain the current PIP topics for the new PIPs that start in the summer; namely, Child and Adolescent Preventive Health, and Health Equity. These topics are very much aligned with DHCS' and MCPs'/PSPs' priorities during the COVID-19 public health crisis.	No further updates	This was identified as the focus for the DHCS Access PIP.	Internal Quality Improvement Committee				
QI Direct / QI Medical Director	QI Director	**Pediatric Care Coordination**	To improve the Plan's pediatric population access to care and services ensuring service utilization to timely and appropriate EPSDT services.	Ongoing					In order to address the 2018 Auditor Report findings of underutilization of preventive healthcare services by the pediatric population	Internal Quality Improvement Committee	12/2020			S. Wakefield, RN, Sr. Dir. Quality
QI Direct / QI Medical Director	QI Direct / QI Medical Director	**Population Health Management**	Maintain and update an cohesive plan of action that addresses the Alliance member/population needs across the continuum of care	Ongoing										
QI Director / QI Medical Director	CMDM Manager	**HRA/HIF-MET - Continuation**	Ensure timely screening of new members to capture members at greater risk for adverse health events. Health Risk Assessment (HRA) is sent to all new Seniors and Persons with Disabilities (SPDs) and annually thereafter. HIF/MET is sent to all new members. The oversight of HIF/MET will permently transition to CM/DM.	June 2020	No updates at this time.	On 6/30/2020, the HIF/MET process and oversight transitioned to AAH's Case Management Department	No updates at this time.	No further updates	HIF/METs will permently transition to CM/DM by the end of fiscal year 19/20.	Utilization Management Subcommittee	6/2020			Jessica Pedden Clinical Quality Manager

Quality of Service

Business Lead	Project Manager	Topic	Goal	Timeframe for Completion	Q1, 2020	Q2, 2020	Q3, 2020	Q4, 2020	Summary	Subcommittee	Projected Due Date	Plan Update	Date Completed	Name/Title
QI Director / QI Medical Director	Clinical Quality Manager	**QIP #4: IHA - Continuation**	To properly capture IHA completion rates, validate IHA completion, and promote IHA education	Ongoing					IHAs (consisting of a history, PE, and SHA) are to be completed within 120 days of new membership. Of recent, IHA Codes have been validated, a P&P has been approved, Gap Lists are being shared, and IHA completion is now a P4P measure. In addition IHA monitoring, CAP, and education has been created and is ongoing.	Internal Quality Improvement Committee	Ongoing			Jessica Pedden Clinical Quality Manager

2020 Quality Improvement Work Plan

Initiatives

Safety

Business Lead	Project Manager	Topic	Goal	Timeframe for Completion	Q1, 2020	Q2, 2020	Q3, 2020	Q4, 2020	Summary	Subcommittee	Projected Due Date	Plan Update	Date Completed	Name/Title
QI Director / QI Medical Director	Clinical Quality Manager	**QIP #5: Opioid / SUD - Continuation**	Develop an opioid / SUD continuum of care that supports: 1. Prevention 2. Intervention and Treatment 3. Recovery Support	Ongoing					Develop an opioid / SUD continuum of care that supports: 1. Prevention 2. Intervention and Treatment 3. Recovery Support	Internal Quality Improvement Committee	Ongoing			Jessica Pedden / Clinical Quality Manager Dr. Bhatt / Medical Director
QI Director / QI Medical Director	Clinical Quality Manager	**Potential Quality Issues (PQIs) Continuation**	Monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on behalf of the Alliance in any setting	Ongoing	On 1/8/2020, the new PQI application was released in the Quality Suite Enviornment.		On 8/3/2020, the PQI Dashboard CR was implemented and the update was deployed on 8/14/2020.		Potential Quality Issues are suspected deviation from expected provider performance, clinical care or outcome of care which requires further investigation; further investigation can determine whether an actual quality issue exists.	Internal Quality Improvement Committee	Ongoing			Jessica Pedden / Clinical Quality Manager Dr. Bhatt / Medical Director
QI Director / QI Medical Director	Access to Care Manager	**Facility Site Review (FSR) Continuation**	Develop a strategy to ensure back up staff to complete FSR/MRR provider office audits for member safety.	Ongoing					Facility Site Review (FSR), Medical Record Review (MRR) and Physical Accessibility Review (PAR) is mandated for each Health plan by DHCS. Site reviews are another way the QI Department ensures safety within the provider office environment.	Internal Quality Improvement Committee	Ongoing			Gina Battaglia /Access to Care Mgr
QI Director / QI Medical Director	QI Director / QI Medical Director	**Inter-rater Reliability (IRR) Continuation**	Ensure the monitor the consistency and accuracy of review criteria applied by all clinical reviewers - physicians and non-physicians - who are responsible for conducting clinical reviews and to act on improvement opportunities identified through this monitoring.	Ongoing						All Sub-Committees	Ongoing			S. Wakefield, RN, Sr. Dir. Quality Dr. Bhatt / Medical Director

Member Experience

Business Lead	Project Manager	Topic	Goal	Timeframe for Completion	Q1, 2020	Q2, 2020	Q3, 2020	Q4, 2020	Summary	Subcommittee	Projected Due Date	Plan Update	Date Completed	Name/Title
QI Director / QI Medical Director	Access to Care Manager	**CG-CAHPS Survey Continuation**	Ensure that survey questions align with DHCS timely access standards & meet member language needs	Ongoing					Measurement tool to assess and evaluate member's experience with health plan and affiliated providers	Access and Availability Subcommittee			Ongoing	Gina Battaglia /Access to Care Mgr
QI Director / QI Medical Director	Access to Care Manager	**Provider Satisfaction Survey Continuation**	To ensure that the survey is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities	Q4 with result analysis Q1 2020					Measurement tool to assess and evaluate provider experience with health plan services	Access and Availability Subcommittee				Gina Battaglia /Access to Care Mgr
QI Director / QI Medical Director	Access to Care Manager	**CAHPS 5.0 (Member Satisfaction Survey)Continuation**	To ensure that the survey is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities	Q3 with result analysis Q4 2020					Measurement tool to assess and evaluate members' experiences with health plan and affiliated providers	Access and Availability Subcommittee				Gina Battaglia /Access to Care Mgr
QI Director / QI Medical Director	Access to Care Manager	**After Hours Care Continuation**	To ensure that the survey is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities	Q3 with results analysis Q4 2020					Measurement tool to assess and evaluate network provider after hours, emergency, availability and response times	Access and Availability Subcommittee				Gina Battaglia /Access to Care Mgr
QI Director / QI Medical Director	Access to Care Manager	**Initial Pre-Natal Visits Continuation**	To ensure that the survey is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities	Q4 2019 with results analysis Q2 2020					Measurement tool to assess and evaluate network provider initial pre-natal appointment availability.	Access and Availability Subcommittee				Gina Battaglia /Access to Care Mgr
QI Director / QI Medical Director	Access to Care Manager	**Oncology Survey Continuation**	To ensure that the survey is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities	Q4 2019 with results analysis Q2 2020					Measurement tool to assess and evaluate network oncology provider appointment availability.	Access and Availability Subcommittee				Gina Battaglia /Access to Care Mgr
QI Director / QI Medical Director	Access to Care Manager	**PAAS (Provider Appt Availability Survey) Continuation**	To ensure that the survey is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities	Q4 2019 with results analysis Q2 2020					Measurement tool to assess and evaluate network provider urgent and non-urgent appointment availability.	Access and Availability Subcommittee				Gina Battaglia /Access to Care Mgr
QI Director / QI Medical Director	QI Director / QI Medical Director	**Annual QI Program Evaluation Continuation**	Conduct an annual written evaluation of the QI program that includes: 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network wide safe clinical practices	Q1 2020 Q2 2020 Q3 2020 Q1 2021					Ongoing	All Sub-Committees and HCQC	5/2020			S. Wakefield, RN, Sr. Dir. Quality Dr. Bhatt / Medical Director