2019 Quality Improvement Work Plan

Initiatives

Quality of Care

Business Lead	Project Manager	Topic	Goal	Timeframe for Completion	Q1, 2019	Q2, 2019	Summary	Subcommittee
QI Director / QI Medical Director	Clinical Quality Manager	**HEDIS Rates MY 2018**	Increase the HEDIS AQFS rate by 1% 2019-2020 season	January 2020	Working closely with the quality analytics team, the QI Team will focus on P4P Incentivized measures; these measures include: - HEDIS: CIS, CAP, WCC, AMR, CCS, CDC, CBP, MPM - Other: Opioid Education, IHA, ED Visits / 1000, Pharmacy Generics Utilization	7/2019 Final HEDIS results 74% Prep for 2019-2020 HEDIS season with new MCAS and MPL for certain measures ≥ 50%.	The HEDIS season runs throughout the year; in Q1/Q2, the emphasis is on record retrieval / abstraction / overreads. The entire year focuses on QI initiative and projects that will impact future years rates and positively and clinically impact members.	Internal Quality Improvement Committee
QI Director / QI Medical Director	Clinical Quality Manager	**HEDIS Retrieval and Overreads**	Alongside the analytics team, provide HEDIS support related to medical record retrieval, abstraction, and overreads.	May 2020	Continue weekly meetings; schedule and participate in medical records retrieval training, abstraction training, overread training, IT training Ongoing record retrieval has begun; AAH staff - including those from QI - have been retrieving records initally from CHCN. Project is on track. Overreads will begin soon after abstraction is completed.	7/1/2019 Medical record retrieval and abstraction completed with 96% accurracy. Training for medical record review and abstraction for 2019-2020 to begin Q4 2019	In conjuntion 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
QI Director / QI Medical Director	QI Director / QI Medical Director	**Pay For Performance (P4P)**	Incentives providers to improve care through P4P measures	January 2020	Distribute P4P measures / brochure to direct providers (via PR) and delegates Work closely with AHS to encourage IHA completion rates Phone conversations with delegates requesting conversation and also directs with question / enquiries	7/2019 Distribute P4P measures / brochure to direct providers (via PR) and delegates Work closely with all network providers including delegates on required IHA/SHA completion rates Provider education includes new MCAS with new MPL ≥ for some measures. New P4P measurses selected	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
QI Director / QI Medical Director	Clinical Quality Manager	**QIP #1: Monitoring Members on Persistent Medications PIP**	Improve rate of annual lab testing for members on persistent medication, as defined by HEDIS, assigned to Tiburcio Vasquez clinics Hayward and Union City from 84.19% to 87.85%	December 2019	In order to isolate the effects of the pharmacy internvetion, Tiburcio Vasquez will no longer text members re: lab testing. Pharmacy is gathering billing contacts for involved pharmacies in order to finalize reimbursement work flow. Once work flow is finalized, pharmacies will receive education regarding project and soft stop can be implemented.		This project works with members assigned to Tubercio Vasquez and encourages members on diuretics / ACE-I / ARBs to obtain annual blood screening.	Internal Quality Improvement Committee
QI Director / QI Medical Director	Clinical Quality Manager	**QIP #2: Improve Adolescent Access to Care PIP**	In compliance with 5 module PIP structure, pilot an intervention to increase the rate of primary care visits among 12-19 year olds assigned to Mowry 1, Mowry 2 and Liberty clinics in the CHCN network from 86.1% to 90%.	September 201 9	Module 4 update submitted and approved by the state detailing implementation of the intervention. Tri-City is reporting monthly and Data Analytics has developed a tool for AAH to validate teen visits. Anticipated approval for outreach letter shortly at which time, all members remaining in the gap will receive targeted mailer.		This is a DHCS Mandated PIP. It will follow the 5 DHCS required modules. This project works with members assigned to Mowry 1, Mowry 2 and Liberty clinics to encourage children to access their pediatricians for care.	Internal Quality Improvement Committee
QI Director / QI Medical Director	Clinical Quality Manager	**QIP #3: Improve A1C Testing in AAM**	In compliance with 5 module PIP structure, pilot an intervention to increase the rate of African American men with daibetes assigned to Highland Outpatient Clinic receiving HbA1c testing from 65.6% to 79%.	September 201 9	AHS has experience staff shortages that have complicated the implementation of POCT. Leadership are evaluating the viability of POCT at this time. AAH is prepared to do telephone outreach in the event that POCT is not possible.		This project targets African American men with DM assigned to Highland Outpatient Clinic to undergo HbA1c testing annually.	Internal Quality Improvement Committee
QI Director / QI Medical Director	Clinical Quality Manager	**QIP #5: Tdap Completion Rates**	Working with DPH, improve Tdap immunization rates identiified clinics	January 2020	Establish target sites with >30 deliveries and tdap rates < 80%; letter from DPH and AAH to be drafted; meeting between HGH, DPH, and AAH		In conjuntion 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
QI Director / QI Medical Director	QI Director / QI Medical Director	**PDSA Cycle**	Ensure that all divisions within HCS utilize the PDSA cycle and the adopted reporting template to evaluate their processes	December 2019 / Ongoing	Work with divisions in the HCS team to properly utilize reporting template		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; sub-committees are encourage to assist in completion of the report -- especially that of the next steps.	All Sub-Committees
QI Director / QI Medical Director	CMDM Manager	**HRA/HIF-MET**	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.	August 2019	Plans for ongoing improvement: 1) Develop internal capability to perform IVR calls; 2) Develop standardized work flow 3) Automate entry of completed forms into TruCare		The volume of HRAs required outside vendors to maitain standards set out in the APL and for turnaround times. Quality improvement opportunities were identified and QI and UM continue to work together to streamline both HRA and HIF/MET processes.	Utilization Management Subcommittee

Quality of Service

Business Lead	Project Manager	Topic	Goal	Timeframe for Completion	Q1, 2019	Q2, 2019	Summary	Subcommittee
QI Director / QI Medical Director	Clinical Quality Manager	**QIP #4: IHA**	To properly capture IHA completion rates, validate IHA completion, and promote IHA education	August 2019	IHA Audit Report to HCQC on 1/17; CAP to be mailed to 19 providers before 2/1/19 FSR IHA Report to IQIC 2/27/19; ensure that 32 CAPs that have been sent regarding FSR IHA have been closed		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
QI Director / QI Medical Director	Access Manager	**Telephone Practices**	Ensure timely access via telephone using annual and quarterly monitoring surveys. Incidents of non-compliance are trended, continued non-compliance is communicated, repeat non-compliance is CAP'd. Goal: less than 3% of telephone calls not returned.	Ongoing	Adopt standard for office call wait time (to be discussed at HCQC 1/17/19). Subsequently, providers will be notified, provider manual will be updated, and secret shopper survey will be undertaken. Internal Survey to be performed Present internal survey results to A&A committee		Telephone practices are monitored through traige and screening (Advice Nurse Line) and returned phone call times. Telephone access is monitored through secret shopper calls quarterly. Annually, after hours access is monitored through an After Hours Survey. This survey monitors after hours emergency instruction messaging as well as after hours telephone access.	Access and Availability Subcommittee

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Initiatives

Safety

Business Lead	Project Manager	Topic	Goal	Timeframe for Completion	Q1, 2019	Q2, 2019	Summary	Subcommittee
QI Director / QI Medical Director	Clinical Quality Manager	**QIP #6: Opioid / SUD**	Develop an opioid / SUD continuum of care that supports: 1. Prevention 2. Intervention and Treatment 3. Recovery Support	December 2019 / Ongoing	Additional data analysis re: mortality data (from county), bup / narcan carve out data (from state), membership data (from PerformRx) Closely monitor data, grievances, provider practices, member usage, ED Data Continue monthly review of opioid focused cases with pharmacy team HR 6 Opioid Legislation Overview Focused provider outreach and letter Member letters to be drafted		Develop an opioid / SUD continuum of care that supports: 1. Prevention 2. Intervention and Treatment 3. Recovery Support	Internal Quality Improvement Committee
QI Director / QI Medical Director	Clinical Quality Manager	**Potential Quality Issues (PQIs)**	Review all PQIs for trends and incidence of quality of care (QOC) with appropriate reporting software.	December 2019 / Ongoing	Phase 1 of PQI App has begun; as of 1/3, all cases that are entered in the G&A app Bugs have been identified and will be fixed; phase 1 permits data entry. Phases 2 and 3 that permits a more robust reporting system will be underway		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
QI Director / QI Medical Director	Access Manager	**Facility Site Review (FSR)**	Develop a strategy to ensure back up staff to complete FSR tasks	December 2019 / Ongoing	A FTE Master Trainer has been hired; work is ongoing for the 2018 and 2019 year. Master Trainer will work closely with recently trained RN to ensure backup.		Facility Site Review (FSR), Medical Record Review (MRR) and Physical Accessibility Review (PAR) is mandated for each Health plan by DHCS. Corrective Action Plans are required depending on the site FSR and MRR scores. Site reviews are another way the QI Department ensures safety within the provider office environment.	Internal Quality Improvement Committee
QI Director / QI Medical Director	QI Director / QI Medical Director	**Inter-rater Reliability (IRR)**	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.	December 2019 / Ongoing	Work with divisions in the HCS team to properly compete an IRR in 2019		The IRR process aims to ensure the monitor the consistency and accuracy of review criteria applied by all clinical reviewers. QI oversees the IRR process, ensures that QI 133 is followed, and provides support in whatever manner the respective division requires.	All Sub-Committees

Member Experience

Business Lead	Project Manager	Topic	Goal	Timeframe for Completion	Q1, 2019	Q2, 2019	Summary	Subcommittee
QI Director / QI Medical Director	Access Manager	**CG-CAHPS Survey**	To ensure that the CG-CAHPS survey is effective, direct, and actionable while maintain the avaiability of benchmarking metrics.	Q3 with results analysis Q4 2019	Ensure that questions align with timely access standard Work with vendor to ensure translation and publication of CG-CAHPS survey The survey will evaluate non-urgent appts (<10 business days), urgent appt availability, in-office wait times (<60 minutes), call return time (<1 day), time to answer call (<10 minutes), and lanugage services		Measurement tool to assess and evaluate member's experience with health plan and affilliated providers	Access and Availability Subcommittee
QI Director / QI Medical Director	Access Manager	**Provider Satisfaction Survey**	To ensure that survey is effective, direct, and actionable while maintain the avaiability of benchmarking metrics.	Q3 with results analysis Q4 2019	Interdepartmental collaboration and evaluation of survey results.		Measurement tool to assess and evaluate provider experience with health plan services	Access and Availability Subcommittee
QI Director / QI Medical Director	Access Manager	**After Hours Care**	To ensure that survey is effective, direct, and actionable while maintain the avaiability of benchmarking metrics.	Q3 with results analysis Q4 2019	Ensure that questions align with After Hours standards		Measurement tool to assess and evaluate network provider after hours, emergency, availability and response times	Access and Availability Subcommittee
QI Director / QI Medical Director	QI Director / QI Medical Director	**Annual QI Program Evaluation**	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 networkwide safe clinical practices	Q2 2019 Q3 2019 Q4 2019 Q1 2020	Conduct and document performanc evaluation quarterly, with trend and qualitative and quantitave analysis, for identified opportunities for improvement.		Ongoing	All Sub-Committees and HCQC