



Capital Health
P L A N



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QUALITY IMPROVEMENT PROGRAM DESCRIPTION

2010

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**CAPITAL HEALTH PLAN
QUALITY IMPROVEMENT PROGRAM DESCRIPTION**

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APPENDIX A: QI STRATEGIC WORKPLAN 2010

CHP QUALITY IMPROVEMENT PROGRAM DESCRIPTION 2010

INTRODUCTION

The purpose of Capital Health Plan (CHP) is to provide the people in Leon and surrounding counties with high quality, affordable health care that: 1) focuses on delivery of evidence-based medical care under the direction of primary care physicians in an effective, timely and cost-effective manner 2) emphasizes low administrative costs and ethical business practices 3) is proactive and innovative in its quest to continually improve the health of the community. CHP incorporates this Quality Improvement (QI) Program as an integral part of its operation.

The Health Plan, a not for profit corporation, was incorporated in 1978. The first members were enrolled in 1982. The Plan serves the service area of Leon and the surrounding counties of Jefferson, Wakulla, and Gadsden. Membership as of December 1, 2009 is 112,949 of whom 9,595 are in a Medicare product. The most recent demographic information from the 2009 NCQA CAHPS Member Satisfaction survey indicates that 81.1% of the CHP Commercial population is Caucasian, 16.1% is African American, 2.6% is Asian, 1.1% is Native Hawaiian or other Pacific Islander, 2.1% is American Indian or Alaska Native and 1.6% are in the Other category. There are 2.1% members of Hispanic or Latino ethnicity. There is not a significant non-English speaking population within the network of Commercial members (99.6% of members speak English as their main language at home). The Commercial population is 63.4% female and 37.6% male. The demographics of the Medicare population are similar to the Commercial statistics: 84% of the members are white, 16% black, 1% Asian and 2% American or Alaskan Native. The Medicare population is 63% female, and 37% male. There are 2% members of Hispanic or Latino ethnicity in the Medicare population.

There are currently 501 practitioners in the CHP network; 127 primary care physicians (PCPs) and 309 specialists. The PCPs include 81 family physicians, 24 pediatricians, and 22 internal medicine physicians. CHP employs 22 PCPs, 1 cardiologist and 2 radiologists. Tallahassee Memorial Hospital (TMH) also employs 20 PCPs; 9 in the Family Practice Residency program and 10 are in small practices that operate primarily in rural areas. The remaining PCPs practice in affiliated small group practices (1 - 10 practitioners). CHP's behavioral health (BH) network includes 9 psychiatrists, and 56 counselors. In accordance with State of Florida law, patients have direct access to podiatrists, chiropractors, dermatologists, and gynecologists for well women care.

SCOPE

Capital Health Plan provides comprehensive health benefit coverage through an integrated health care delivery system to federal and Florida state government employees, large and small commercial employers, non-group enrollees, and Medicare Advantage/Part D (MAPD) beneficiaries.

CHP provides inpatient hospital services through three primary hospitals. Seven outpatient facilities provide home health, DME and hospice services; four skilled nursing facilities provided extended long care services. Seven outpatient facilities provide rehab and orthotic services, and the network has ten outpatient surgical facilities. Behavioral health services are primarily provided by two inpatient facilities, and individual psychiatrists, psychologists and counselors.

The following health plan activities are included in the scope of Capital Health Plan's quality improvement program:

- ◆ Clinical/service quality
- ◆ Patient safety/risk management
- ◆ Behavioral health services
- ◆ Physician and hospital quality
- ◆ Pharmacy management and medication safety
- ◆ Credentialing and re-credentialing
- ◆ Utilization management
- ◆ Access and availability to healthcare services
- ◆ Culturally and Linguistically Appropriate Services Program
- ◆ Continuity and coordination of care
- ◆ Chronic care improvement program
- ◆ Complex case management
- ◆ Disease management and health management programs
- ◆ Member connections
- ◆ Delegation monitoring and oversight
- ◆ Member rights and responsibilities
- ◆ Privacy and confidentiality

QUALITY IMPROVEMENT PROGRAM OBJECTIVES

CHP strives to continually improve health care services by pursuing the Institute of Healthcare Improvement's 'Triple Aim;' improving the experience of care, improving the health of populations, and reducing per capita costs of health care.

Quality improvement initiatives that support The Triple Aim will include integration of health care systems of care, redesign of primary care services and structures, population health management and improvements to financial management systems. CHP's staff practices will continue to develop a primary care 'medical home' model to ensure that health care services are safe, patient-centered, timely, effective and efficient. Measurement systems and improvement initiatives will be implemented to continually improve culturally and linguistically appropriate services, ensuring that the health care delivered is equitable for all patients.

VISION OF QUALITY FOR CAPITAL HEALTH PLAN

CHP will maintain a reputation as a local, state and national leader in quality of care and service through:

- ◆ Industry-leading benchmark performance on clinical outcome measures
- ◆ Industry-leading member satisfaction
- ◆ Excellent accreditation rating
- ◆ Very low (<2%) voluntary disenrollment

QUALITY IMPROVEMENT PROGRAM STRATEGIC GOALS

NATIONAL PRIORITIES: *

- ◆ Engage patients and families in managing their health and making decisions about their care.
- ◆ Improve the health of the population.
- ◆ Improve the safety and reliability of America's healthcare system.
- ◆ Ensure that patients receive well coordinated care within and across healthcare organizations, settings & levels of care.
- ◆ Ensure appropriate and compassionate care for patients with life-limiting illnesses.
- ◆ Eliminate overuse while ensuring the delivery of appropriate care.

CLINICAL CARE

- ◆ Achieve scores on HEDIS clinical indicators (including behavioral health) that demonstrate national leadership (are the best performance nationally).
- ◆ Achieve and maintain "Top Ten" for Commercial, and "Top Five" ranking for Medicare in the US News and World Report's "Best Health Plans in America" based on HEDIS measures.
- ◆ Maintain a dialogue with the best "delivery system" health plans in the country.
- ◆ Provide community leadership in access, satisfaction, clinical outcomes, the care of chronically ill and efficiency through the 'Medical Home' model provided by staff practices (PCPs, Urgent Care and selected specialists).
- ◆ Promote evidence-based clinical practice within the medical and behavioral health networks.
- ◆ Implement interventions to decrease rates of 30 day readmission rates to inpatient hospitals to 9%.
- ◆ Implement interventions to move back surgery rates to the 50th national percentile.
- ◆ Assess and implement procedures necessary to meet requirements for the new Mental Health Parity and Addiction Act.
- ◆ Improve the health status of members through preventive/wellness activities, disease management programs, a case management and a chronic care improvement program.
- ◆ Coordinate clinical care to ensure seamless delivery of healthcare services across the medical and behavioral health networks.
- ◆ Create incentives which align goals of the health plan, practitioners and health plan staff.

* Source of National Priorities: National Priorities Partnership convened by the National Quality Forum, November 2008.

MEMBER/PRACTITIONER SATISFACTION

- ◆ Achieve and maintain “Top Ten” for Commercial, and “Top Five” ranking for Medicare in the US News and World Report’s “Best Health Plans in America” based on CAHPS member satisfaction measures. -
- ◆ Conduct member satisfaction survey for individual staff primary care physician practices.
- ◆ Achieve member satisfaction results for CHP ‘Medical Home’ practitioners that are superior to affiliate network practitioners.
- ◆ Maintain optimal practitioner satisfaction by targeting issues identified through practitioner satisfaction surveys.

ACCESS AND AVAILABILITY TO CARE AND SERVICES

- ◆ Maintain affordability of CHP’s products.
- ◆ Establish community leadership in access to urgent care, primary care, mammography, behavioral health and other network services.
- ◆ Continually improve member access to medical and behavioral health services, with particular emphasis on vulnerable populations.
- ◆ Strive to meet member expectations by achieving access and availability targets.

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

- ◆ Evaluate the needs and availability of language services within the network; implement interventions when improvement opportunities are identified.
- ◆ Measure and analyze clinical quality measures in the Medicare population stratified by race/ethnicity to identify opportunities to reduce health care disparities; implement interventions when appropriate.
- ◆ Evaluate the cultural competence of CHP’s front-line staff and network practitioners; provide support and training as needed.
- ◆ Implement procedural changes necessary to meet NCQA standards for Culturally and Linguistically Appropriate Services (CLAS).

PATIENT SAFETY

- ◆ Monitor and implement interventions to improve performance on HEDIS patient safety measures.
- ◆ Monitor and address adverse events, medication errors, adverse drug events and quality of care issues through incident reporting, analysis and interventions.
- ◆ Provide members with access to provider and practitioner patient safety information.

QUALITY IMPROVEMENT/ ACCREDITATION

- ◆ Maintain NCQA “Excellent” Accreditation, including Medicare Advantage (MA) ‘deemed’ standards.
- ◆ Maintain compliance with state and federal regulations related to quality improvement.
- ◆ Implement a minimum of one new QI project annually for the MA population that meets all CMS requirements.
- ◆ Integrate quality improvement processes throughout Capital Health Plan and its healthcare delivery system (including behavioral health), striving to integrate quality improvement at every level of the organization.
- ◆ Integrate procedures for monitoring and ensuring compliance with NCQA and MA deemed standards to departments that provide the specified services. Maintain overall oversight monitoring procedures to ensure that CHP achieves the highest accreditation scores possible that will contribute to optimal national rankings.
- ◆ Allocate and distribute resources necessary to support QI initiatives.
- ◆ Set performance targets based on the best performance nationally (when available)
- ◆ Expand and standardize quality measurement and reporting capabilities through the medical and behavioral health networks.

ACCOUNTABILITY OF THE GOVERNING BODY

The Capital Health Plan Board of Directors maintains the ultimate accountability for the QI program. The Healthcare Delivery Committee, a sub-committee of the Board, provides direct oversight to the QI program through quarterly review of program activities. This Board committee reports directly to the Board of Directors on a quarterly basis.

ACCOUNTABILITY OF QUALITY COMMITTEES

The Board of Directors and Health Delivery Committee have delegated the direct responsibility and authority for QI Program oversight to the Plan's Quality Improvement Management Team (QIMT). The Quality Improvement Management Team consists of key CHP senior managers, including the Chief Medical Officer and Medical Director. QIMT relies on the following committees to oversee specific aspects of the QI program:

- ◆ Quality Improvement Committee (QIC): coordinates, provides oversight to clinical improvement activities.
- ◆ Pharmacy Committee: monitors compliance with Medicare Part D requirements, coordinates pharmacy QI activities and safe medication administration practices, and provides oversight for the formulary and delegated procedures.
- ◆ The Pharmacy Continuous Quality Improvement Committee: reviews pharmacy data and information about medication quality-related events that occur within CHP health centers.
- ◆ Credentials Committee: makes decisions to credential and re-credential practitioners/providers when requests do not meet 100% of CHP's criteria.
- ◆ Compliance Committee: provides oversight for CHP's Compliance and HIPAA programs.

QUALITY COMMITTEES: MEETING/DECISION-MAKING PROCEDURES

- ◆ Quality committees meet according to their planned schedule unless the chairperson cancels or reschedules a meeting, or the committee does not have a quorum for a specific meeting.
- ◆ A quorum for a meeting is met when the minimum of 50% of the committee members are present.
- ◆ Quality committees document the outcome of their meetings through meeting minutes. Committee members are offered the opportunity to review and suggest revisions to meeting minutes. The chairperson of each committee signs final meeting minutes to attest to committee acceptance of the minutes. All committee documentation is marked "confidential records for quality and/or peer review".
- ◆ Decision-making procedures:
 - ◆ Each committee defines which members are eligible to vote. Each eligible committee member is entitled to one vote per decision.
 - ◆ Decisions are made by majority vote.
- ◆ Credentials Committee - decision-making procedures:
 - ◆ Each committee member reviews a checklist for practitioners that have not been approved by the Medical Director. The checklist that the committee reviews outlines compliance with each credentialing or re-credentialing requirement.
 - ◆ The committee discusses issues of concern and areas of non-compliance before making a decision. The committee may request additional information to be submitted before a final decision is made. In this case, the Medical Director provides each committee member the credentialing information for practitioners/providers with issues of concern for discussion and credentialing determinations.

ACCOUNTABILITY OF KEY CHP MANAGERS

- ◆ The Chief Executive Officer (CEO) has the ultimate responsibility for the overall coordination and direction of the QI program. The CEO's active participation in QIMT ensures that the Plan's service and clinical improvement initiatives receive appropriate integration and linkage to CHP's strategic planning and budgeting processes, including allocation of financial and human resources for QI initiatives.
- ◆ The CHP Board of Directors and CEO have designated the CHP Chief Medical Officer (CMO) as the chief physician responsible for the QI program. The CMO works to integrate and implement QI activities collaboratively with network practitioners and providers.
- ◆ The CMO chairs the Quality Improvement Committee. The Medical Director chairs the Pharmacy Committee, and provides oversight in the Credentials Committee. The Medical Director works together with the CMO to integrate and implement QI activities collaboratively with network practitioners.
- ◆ The Senior Vice-President of Clinical Operations and Quality Improvement is an active member of QIMT, and is responsible for assuring that quality outcomes support the strategic initiatives of the Plan. The Senior Vice-President is responsible for reporting QI activities to the Board of Directors and providing feedback to the QIMT and QIC committees.
- ◆ The Senior Vice-President of Marketing and Administrative Services participates as a member of QIMT. The Senior Vice-President is responsible for communicating quality improvement activities to CHP's members through newsletters, member handbooks and other informational program materials. This Senior Vice-President also manages the Medicare programs, benefit development/maintenance procedures, and develops member educational programs.

ACCOUNTABILITY OF KEY CHP MANAGERS – continued:

- ◆ The Director of Quality Improvement leads and coordinates the quality improvement program, and is responsible for the day-to-day operation of the program. The Director develops data collection tools, then collects, analyzes and presents quality data to internal and external audiences to identify and monitor improvement activities. The Director provides expertise in QI tools and methods to teach and facilitate a culture of quality improvement at CHP. The Director is accountable to ensure that CHP maintains compliance with NCQA, and regulatory standards including Medicare requirements for quality improvement.
- ◆ The Compliance Officer is accountable for CHP's Compliance program. The Compliance Officer also functions as CHP's HIPAA Privacy Officer and Risk Manager (meeting State of Florida Risk Management requirements related to clinical operations). The Vice-President of Information Systems is the designated HIPAA Security Officer. The two HIPAA officials work in partnership to provide leadership and coordination for CHP's HIPAA privacy and security program.

CONFIDENTIALITY OF MEMBER INFORMATION

All quality improvement practices and activities fully comply with the requirements established by CHP's HIPAA compliance program. CHP safeguards confidential information and only makes disclosures in accordance with state and federal law, as well as industry standards and professional ethics. Therefore, all records, writings, data, reports, information, and any other material labeled as "quality improvement" are held in strictest confidence. Clinical review and information used in activities and functions of the QI Program are appropriately safeguarded by CHP staff members and committee members whose duties require knowledge of, and access to this information.

QUALITY IMPROVEMENT PERFORMANCE INDICATORS/ ACTIVITIES

A number of performance indicators and activities exist to support the goals of the QI Program. They are evaluated and prioritized annually based on:

- ◆ Recommendations from the previous year's QI Program Evaluation
- ◆ Capital Health Plan's Strategic Plan
- ◆ HEDIS data analyzed at the health plan level, staff vs. affiliates, and individual physicians. Medicare HEDIS measures are stratified by race/ethnicity.
- ◆ CAHPS member satisfaction data analyzed at the health plan level, staff vs. affiliates, and individual staff physicians. Survey data for Medicare members is stratified by race/ethnicity.
- ◆ Individual physician level performance measures (National Quality Forum measures)
- ◆ Hospital clinical quality and safety measures
- ◆ Practitioner satisfaction data
- ◆ Customer complaint and grievance data
- ◆ Analysis of clinical data, health risks, claims and demographic data
- ◆ Feedback from external customers
- ◆ Analysis of HEDIS/CAHPS data by the Alliance of Community Health Plans
- ◆ Performance data from quality indicators or accreditation/regulatory surveys
- ◆ Clinical and service improvement activities
- ◆ Risk management and patient safety data
- ◆ Confidentiality/HIPAA indicators
- ◆ Practitioner quality review data
- ◆ Utilization management data
- ◆ Pharmaceutical management data
- ◆ Performance levels established by NCQA and federal and state governmental agencies

CONTINUITY/COORDINATION OF CARE

The CHP Case Management Program coordinates services for members with complex conditions and helps them access appropriate care and resources beyond a single episode of care. The purpose of the program is to improve the delivery and management of health care services, and promote high quality cost-effective outcomes in the most appropriate setting.

CHP also monitors and analyzes data on an ongoing basis to ensure that members receive seamless, continuous and appropriate care. Specific indicators are routinely monitored that evaluate communication between medical services, and between medical and behavioral health services. The use of pharmacological medications is also routinely evaluated. Opportunities for improvement in the continuity and coordination of care are identified and addressed on an ongoing basis.

ADVERSE INCIDENTS AND QUALITY OF CARE ISSUES

The review and trending of adverse incidents (including adverse drug events and medication errors) and quality of care issues provides information on potential problems requiring further investigation by a CHP Medical Director. Investigation of individual events and trends in adverse incidents/quality of care issues are used to detect potential unsafe/ineffective treatments. Results from this activity may lead to interventions such as quality improvement activities, changes in policies, or clinical practice guidelines. Quality of care issues that are related to individual physicians are incorporated into re-credentialing decisions based on the level of severity.

USE OF EXTERNAL CONSULTANTS

CHP utilizes external physician consultants on occasion to assist the Medical Director with the evaluation of potential quality of care issues. External peer review is requested when a second opinion by a board certified physician consultant is needed in a specific clinical specialty area.

DELEGATION

Capital Health Plan delegates the following functions:

- ◆ Primary source verification for Credentialing is delegated to Med Advantage, Inc., an NCQA certified CVO (credentials verification organization).
- ◆ Health information telephone service is formally delegated to Health Dialog, Inc., an NCQA certified HIP (health information products) vendor. Health Dialog also provides CHP members with Commercial health risk assessments and self-management tools.
- ◆ Formulary development/maintenance, utilization management criteria, and web-based pharmacy claims and benefit information are delegated to Caremark, a pharmacy benefit management organization.

REGULATORY AND ACCREDITING BODIES

Capital Health Plan maintains compliance with all regulatory and accrediting bodies overseeing managed care organizations. These regulatory/accrediting bodies include the following:

- ◆ National Committee for Quality Assurance (NCQA) – accreditation organization
- ◆ Centers for Medicare, Medicaid Services (CMS)
- ◆ Florida Department of Health/ Agency for Healthcare Administration (AHCA)
- ◆ Office of Insurance Regulation

Compliance with these agencies includes, but is not limited to the following:

- ◆ Participating and coordinating quality/clinical site visits and inquiries by government regulatory agencies.
- ◆ Partnering with CHP's Compliance Program to implement and monitor compliance with new and existing HIPAA regulations.
- ◆ Preparing and submitting required regulatory reports and filings in a timely manner.
- ◆ Achieving minimum performance levels or above as required.
- ◆ Preparing, implementing and monitoring improvement plans as necessary.

ANNUAL QI PLAN EVALUATION

The annual Quality Improvement and Utilization Management Program Evaluations assess the effectiveness of CHP's quality improvement program. The health plan's achievements and opportunities for improvement are identified through this process. The Quality Improvement Management Team and the CHP Board of Directors approve these evaluations on an annual basis.

CHP Quality Committees

| Committee | Objectives | Membership |
|--|---|---|
| <p style="text-align: center;">Quality Improvement Management Team (QIMT)</p> <p>Meets minimum of 10 times per year.</p> | <ul style="list-style-type: none"> • Review and approve the QI and Utilization Management program documents on an annual basis (program descriptions, work plans and program evaluations). • Assess and ensure progress toward annual QI and Utilization Management goals. • Integrate the QI Program with strategic initiatives and budgeting processes. • Monitor and promote continual improvement in member and practitioner satisfaction. • Monitor and promote continual improvement in practitioner access and availability of services. • Monitor and ensure compliance with accreditation and regulatory bodies. • Prioritize, select and provide oversight to service quality initiatives, including risk management, patient safety and language/diversity activities. • Review and approve credentialing policies and procedures on an annual basis. • Review and analyze quarterly and annual credentialing reports; provide oversight over delegated functions in credentialing. • Provide guidance and feedback to committees reporting to QIMT. • Review and approve Clinical Criteria for Utilization Management Decisions. | <ul style="list-style-type: none"> • CEO • Vice-Presidents • Chief Medical Officer • Medical Directors |
| <p style="text-align: center;">Quality Improvement Committee (QIC)</p> <p>Meets minimum of 4 times per year.</p> | <ul style="list-style-type: none"> • Review QI program documents (program descriptions, work plans, program evaluations and quarterly reports) on an annual basis. • Review and approve Disease Management and Case Management Program Descriptions and reports on at least an annual basis. • Prioritize, select and monitor clinical quality initiatives, including behavioral health and patient safety. • Provide clinical expertise, feedback and analysis for clinical performance indicators and quality activities. • Provide oversight to wellness and preventive health activities. • Review and approve clinical practice guidelines and preventive health guidelines at least every other year (according to established schedules). • Review and analyze routine reports from HIP (health information products) vendor (Health Dialog); review and provide oversight over delegated procedures. | <ul style="list-style-type: none"> • Chief Medical Officer • Medical Directors • Practicing Network Physicians • PhD Counselor • CHP Staff |

| Committee | Objectives | Membership |
|---|--|--|
| <p>Compliance Committee</p> <p>Meets minimum of 4 times per year, more often as needed.</p> | <ul style="list-style-type: none"> • Review and approve policies, procedures and practices related to compliance and HIPAA regulations. • Provide oversight for CHP's compliance and HIPAA programs. | <ul style="list-style-type: none"> • Compliance Officer • Chief Medical Officer • Vice President • Managers |
| <p>Pharmacy Committee</p> <p>Meets minimum of 6 times per year, more often as needed.</p> | <ul style="list-style-type: none"> • Monitors compliance with NCQA and Medicare Advantage/Part D requirements. • Review and approve CHP's pharmacy policies and procedures on an annual basis. • Review and approve utilization and clinical criteria pertaining to medication use. • Monitor and promote continual improvement in safe medication practices, including adverse drug events. • Develop interventions to improve HEDIS measures related to medication use. • Coordinate benefit and quality issues/activities with the pharmacy benefit management company. • Review and analyze routine reports from the pharmacy benefit management company; review and provide oversight over delegated procedures and formularies. | <ul style="list-style-type: none"> • Chief Medical Officer • Medical Director • Pharmacist • Practicing Physicians • PhD Counselor • CHP Staff |
| <p>Pharmacy Continuous Quality Improvement Committee</p> <p>Meets 4 times per year.</p> | <ul style="list-style-type: none"> • Review pharmacy data and information about medication errors and quality-related events that occur within CHP medical centers. • Recommend improvement interventions as appropriate. | <ul style="list-style-type: none"> • Medical Director • Practicing Physicians • Pharmacist • Vice President • CHP Nurses |
| <p>Credentials Committee</p> <p>Meets minimum of 4 times during each calendar year, more often as needed.</p> | <ul style="list-style-type: none"> • Review and approve practitioners and providers into the CHP network based on specific credentialing/recredentialing criteria. • Review and approve credentialing criteria, policies and procedures on at least an annual basis. • Review and recommend approval of credentialing policies on an annual basis. | <ul style="list-style-type: none"> • Medical Director • Practicing Network Physicians • CHP Staff |

Appendix A: QI Strategic Work Plan - 2010

| #1 Priority Measures | 2009 Results | Target 2010 (Best in Nation 09) | Planned Improvement Projects |
|---|---------------------|--|---|
| Avoidance of Antibiotics for Adults w/ Acute Bronchitis (high # = better) | 34% C | 90.5% | Staff: Incentive for FP & IM (internal medicine) nurses. Increase utilization of EMR decision support. Staff Drs: correct diagnosis coding errors. Staff & Affiliate: send quarterly individual performance data to Drs., meet with offices to educate about the measure. |
| Monitor Patients on Long Term Meds (combo, 4 meds) * | 80% C 90% M | 93.4% | TBD |
| Alcohol -Engagement of Treatment * | 17% C 0% M | 53.4% | Work with TMH ER staff to correct diagnosis coding errors. CHP staff follows up with PCPs to request tx. |
| Antidepressant - Acute Phase Treatment * | 58% C 57% M | 89.6% | Continue PCP contacts, and telephone follow-up with members; investigate generics sold in retail pharmacies. |
| Antidepressant - Continuation Phase Treatment * | 41% C 48% M | 77.8% | Continue individual follow-up with members. |
| Hypertension Treatment (<140/90) * | 71% C 66% M | 87.6% | Staff: financial incentive for FP & IM nurses. Develop an e- learning session on taking BPs. Follow-up incorporated into diabetes disease mgt. program. |
| ADHD Continuation Treatment | 41% C | 82.6% | Staff: Financial incentive for Ped. nurses. After 2 nd drug fill, CHP PA conducts a telephone visit. CHP staff contacts Dr. offices after 4 th prescription fill to recommend visit by due date. |
| Mgt. of COPD Exacerbation, Systemic Corticosteroid * | 54% C 62% M | 91.3% | CHP staff calls & sends letters to members after discharge. If medications are necessary, letters are sent to PCPs. |
| Anti-Rheumatic Drug Therapy * | 85% C 85% M | 97.6% | Contacting physicians who have diagnosed RA, and have not prescribed a DMARD. |
| Appropriate Tx for Children w/ Upper Respiratory Infection | 84% C | 99.1% | Staff: Measure is on EMR Dashboard; report added to CHP Connect. Affiliate: Meet with offices to educate about the measure. |
| Mgt. of COPD Exacerbation, Bronchodilator * | 64% C 79% M | 92.9% | CHP staff calls & sends letters to members after discharge. If medications are necessary, letters are sent to PCPs. |
| #2 Priority Measures | | | |
| Well Care Visits for Adolescents | 57% C | 79.1% | Staff: Financial incentive for FP & IM nurses. |
| ADHD - Initiation Phase Treatment | 34% C | 59.4% | Staff: financial incentive for Ped. nurses. Staff & Affiliate: CHP staff contacts physician offices to schedule follow-up appointments within 30 days. |
| Chlamydia Screening (combined ages) | 65% C | 81.8% | Staff: added to EMR Dashboard in fall, 2009. Plan to add Chlamydia report to Adolescent well child reports, so PCPs can see if test is needed during a well child exam. |
| Well Child Visits (3-6YO) | 79% C | 97% | Staff: financial incentive for Ped. nurses. |
| Alcohol - Initiation of Treatment * | 46% C 41% M | 69.9% | Work with TMH ER staff to correct diagnosis coding errors. CHP staff follows up with PCPs to request tx. |
| Cervical Cancer Screening | 88% C | 94.4% | Continue member information included in mammography member letters. |
| Childhood Immunization - Combo. 2 | 89% | 97.6% | Staff: financial incentive for Peds. nurses. Assess vaccine schedule & current letter for gaps. |
| Well Child Visits (6 in first 15 mo.) | 85% C | 100% | Staff: financial incentive for Ped. nurses. |
| 7-Day Follow-up after Hosp. * | 85% C | 97.6% | Current interventions through TMBC will continue. |
| LDL Screening – (cardiovascular conditions) * | 91% C 97% M | 98.1% | Continue to identify and follow up with this population. |
| Strep Test for Children w/ Pharyngitis, on antibiotics | 83% C | 95.2% | Staff: Measure is on EMR Dashboard |
| Access to Care (7-11YO) | 93% C | 98.7% | Plan to implement a financial incentive for Pediatricians in 2010. |
| Asthma Appropriate Meds – ages 18-56 | 92% C | 98.8% | Health Promotions staff to develop plan for asthma management program. |
| Diabetic LDL < 100 * | 55% C 68% M | 76.4% | Staff: financial incentive for FP & IM nurses. Report posted on CHP Connect on a monthly basis for PCPS beginning 10-09. Follow-up incorporated into diabetes disease management program. |
| #3 Priority Measures | | | |
| Asthma Appropriate Meds – ages 10-17 | 94% C | 100% | Health Promotions staff to develop plan for asthma management program. |
| Postpartum Care | 88% C | 99.0% | Increase use of Category 2 codes; automate data collection on claims. |
| Breast Cancer Screening * (42-69 YO) | 82% C 86% M | 85.1% | Continue monthly mailings to MDs & members. Address fears of radiation through member letters. |

* Required measure for Medicare Advantage

Appendix A: QI Strategic Work Plan - 2010

| #3 Priority Measures | 2009 Results | Target 2010 (Best in Nation 09) | Planned Improvement Projects |
|---|-----------------------|--|---|
| Cardiac LDL < 100 | 73% C 79% M | 80.1% | Plan to increase use of Lisinopril & aspirin for these members. |
| Diabetic HbA1c Testing * | 91% C 96% M | 98.0% | Diabetic report posted monthly on CHP Connect for PCPS beginning 10-09. Follow-up incorporated into diabetes disease management program. |
| Diabetic BP Control (<130/80) * | 45% C 49% M | 55.3% | Diabetic clinical report posted on CHP Connect on a monthly basis for PCPS beginning 10-09. Health Promotions staff responsible for diabetic disease management in 2010, planning mailings. |
| Beta Blocker – Cont. Tx* | 94% C | 95.9% | Continue individual follow-up with members. |
| Diabetic LDL Screening * | 92% C 96% M | 96.9% | Diabetic clinical report posted on CHP Connect on a monthly basis for PCPs as of 10-09. Follow-up incorporated into diabetes disease management program. |
| Diabetic BP Control (<140/90) * | 77% C 76% M | 85.4% | Diabetic clinical report posted on CHP Connect on a monthly basis for PCPs beginning 10-09. |
| Prenatal Care Visits | 97% C | 99.6% | Increase use of Category 2 codes; automate data collection on claims. |
| Diabetic Kidney Monitoring * | 92% C 93% M | 94.2% | Diabetic clinical report posted on CHP Connect on a monthly basis for PCPs beginning 10-09. Follow-up incorporated into diabetes DM program. |
| Diabetic HbA1c Control (≤9) * | 84% C 90% M | 88.7% | Staff: financial incentive for FP & IM nurses (<8.0). NOTE: HEDIS HbA1c poor control measure – inverted results presented. Follow-up incorporated into diabetes disease management program. |
| Colorectal Cancer Screening * | 78% C 90% M | 78.7% | Current screening procedures & follow-up will continue; added to EMR dashboard in 10/09. |
| Diabetic Retinal Eye Exams * | 83% C 89% M | 90.8% | Staff: financial incentive for Eye Care staff. Continue individual follow-up with members. Develop EMR pop-up. |
| Asthma Appropriate Meds – ages 5-9 | 99% C | 100% | Health Promotions staff to develop plan for asthma management program. |
| Spirometry Testing for COPD * | 84% C 82% M | 84% (CHP) | Appropriate members contacted & scheduled for services. |
| Use of High Risk Meds in Elderly * (1 Rx) (low # = better) (MA 2009 QI Project) | 33% M | | Continue letters to physicians semi-annually of Medicare patients 65+ on high risk meds (CMS QIO project). |
| Potentially Harmful Drug-Disease Interactions in the Elderly * (M) (low # = better) | 30% M | | Investigate potential interventions. |
| Use of Imaging Studies for Low Back Pain | 78% C | 86.5% | Reward Gold Card status to physicians with a trend in authorization approvals (eliminates pre-auth. requirement) |
| Glaucoma Screening for Older Adults * (MA 2010 QI Project) | 80% M | | Staff: financial incentive for Eye Care staff. Continue individual follow-up with members. Plan to conduct screening in affiliate offices in 2010. |
| Adult BMI Assessment * | 55% C 64% M | N.A. | Staff: increase annual height measurements. |
| BMI Assessment (age 3-17) | 49% C | N.A. | Staff: increase annual height measurements. |
| Nutrition Counseling (age 3-17) | 61% C | N.A. | EMR decision support |
| Physical Activity Counseling (age 3-17) | 52% C | N.A. | EMR decision support |
| Relative Resource Use – Diabetes (C&M) * | Med: 1.01 Rx: 0.99 | 1.0 | Continue diabetes interventions. Will be publicly reported in 2010. |
| Relative Resource Use – Asthma (C) | Med: 0.87 Rx: 0.97 | 1.0 | Continue asthma interventions. Will be publicly reported in 2010. |
| Relative Resource Use – Acute Low Back Pain (C) | Med: 0.99 Rx: 1.02 | 1.0 | Reward Gold Card status to physicians with a trend in authorization approvals (eliminates pre-auth. requirement) |
| Relative Resource Use – Cardiac Conditions (C&M) | Med: 0.93 Rx: 1.04 | 1.0 | |
| Relative Resource Use – COPD (C&M) | Med: 0.99 Rx: 1.09 | 1.0 | Continue COPD interventions. |
| Relative Resource Use – Hypertension (C&M) | Med: 1.01 Rx: 1.07 | 1.0 | Continue hypertension interventions. |
| Osteoporosis Mgmt. (M) * | 54% M | | Staff: financial incentive for Radiology staff. Continue individual follow-up. Investigate issue of incorrect telephone numbers; address fears of radiation in reminder letters. |
| Adult Access to Preventive Care Age 65+ * | 98% M | 100% | |
| Flu Shots Older Adults * (M) (CAHPS - % yes) | 81% M | 86% | |

* Required measure for Medicare Advantage

Appendix A: QI Strategic Work Plan - 2010

| #3 Priority Measures | 2009 Results | Target 2010 (Best in Nation 09) | Planned Improvement Projects |
|---|---------------------|--|---|
| Flu Shots Adults Ages 50-64 (CAHPS – % yes) | 54% C | 71% | |
| Pneumonia Vaccines for Older Adults * (M) (CAHPS - % yes) | 84 %M | | |
| Advise Smokers to Quit * (CAHPS - % yes) | 74% C 76% M | 89% | Counsel COPD patients about smoking during spirometry visits. |
| Call Answer Timeliness * | 90% C 85% M | 99.7% | |
| Call Abandonment * | 3% C 3% M | 0.3% | |
| Getting Care Quickly (CAHPS - usually/always) | 87% C 76% M | 94% | |
| Getting Needed Care (CAHPS - usually/always) | 89% C 95% M | 94% | |
| Customer Service (CAHPS - usually/always) | 90% C 98% M | 97% | |
| Claims Processing (CAHPS - usually/always) | 95% | 97% | |
| Doctors Communicate Well (CAHPS- usually/always) | 94% C 95% M | 97% | |
| Shared Decision Making (CAHPS – % yes) | 58% C | 71% | New composite measure reported in 2009. |
| Rating of Health Plan (CAHPS: 9-10) | 62% C 79% M | 84% | |
| Rating of Health Care (CAHPS: 9-10) | 56% C 64% M | 72% | |
| Rating of Personal Doctor (CAHPS: 9-10) | 69% C 77% M | 81% | |
| Rating of Specialist (CAHPS: 9-10) | 67% C 73% M | 82% | |

Approved: 12/22/2009

* Required measure for Medicare Advantage