Capital Health PLAN℠

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Medicare Medical Quality Improvement Program Description

2018

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CAPITAL HEALTH PLAN
MEDICARE QUALITY IMPROVEMENT PROGRAM DESCRIPTION

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INTRODUCTION

The purpose of Capital Health Plan (CHP) is to provide people in Leon and surrounding counties (a seven county area of northern Florida) 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, Gadsden, Calhoun, Liberty and Franklin. The Medicare membership as of December 1, 2017 is 20,475. The most recent demographic information from the 2017 NCQA CAHPS Member Satisfaction Survey indicates that 74.6% of the CHP Medicare population is Caucasian, 21.3% is African American, 1.6% is Asian, and 0.2% is Native Hawaiian or other Pacific Islander. 4% of members are of Hispanic/Latino ethnicity.

There are currently 573 practitioners in the CHP network; 166 are primary care physicians (PCPs) and 407 are physician specialists. The PCPs include 95 family physicians, 25 pediatricians, and 46 internal medicine physicians. CHP employs 22 PCPs, 1 radiologist, 5 Urgent Care physicians and 8 optometrists. Tallahassee Memorial Hospital also employs 38 PCPs; 11 in the Family Practice Residency Program, 11 in the Internal Medicine Residency Program and 16 are in small practices that operate primarily in rural areas. The remaining PCPs practice in affiliated small groups practices (1-10 practitioners). In accordance with State of Florida law, patients have direct access to podiatrists, chiropractors, dermatologists, and gynecologists for well woman care.

SCOPE

Capital Health Plan provides comprehensive Medicare Advantage Part C and D services through retiree and individual Medicare Advantage Part D (MAPD) plans and an integrated health care delivery system for Medicare beneficiaries.

CHP provides inpatient hospital services through 3 primary hospitals. 10 outpatient facilities provide home health and hospice services; 11 skilled nursing facilities provide extended care/rehabilitation services. 11 outpatient facilities provide rehabilitation therapy and durable medical equipment services, and the network has 10 outpatient surgical facilities and 5 dialysis centers.

The following health plan activities are included in the scope of CHP's Medicare QI program:

- Clinical/service quality
- Patient safety/risk management
- Physician and hospital quality
- Pharmacy management and medication safety
- Credentialing and recredentialing
- Utilization management
- Access and availability to healthcare services
- Culturally and linguistically appropriate services
- Continuity and coordination of care
- Chronic care improvement program
- Complex case management
- Disease management and health management programs
- Wellness program and activities
- 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. These improvement activities are consistent with the National Strategy for Quality Improvement in Health Care in the Report to the United States Congress in March, 2011.

Quality improvement initiatives that support The Triple Aim and the National QI Strategy 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:

- Medicare CMS star rating of 5.0
- Medicare NCQA rating of 5.0
- Medicare NCQA Excellent accreditation rating
- 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 AIMS[1]:

- Better Care
- Healthy People/ Healthy Communities
- Affordable Care

NATIONAL PRIORITIES[2]:

- 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 and 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 measures that demonstrate national leadership (rating of 5.0).
- Evaluate and prioritize clinical measures based on the overall value to members.
- 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 network.
- Implement interventions to decrease rates of hospital readmissions within 30 days.
- Improve the health status of members through preventive/wellness activities, disease management, case management and a chronic care improvement program for members with complex conditions.
- Coordinate clinical care to ensure seamless delivery of healthcare services across the network.
- Create incentives which align goals of the health plan, practitioners and health plan staff.

[1] Source of National Aims: Report to the U.S. Congress, National Strategy for Quality Improvement in Health Care, March 2011

[2] Source of National Priorities: National Priorities Partnership convened by the National Quality Forum, November 2008

MEMBER/PRACTITIONER SATISFACTION

- Achieve and maintain scores for CAHPS Rating of Health Plan measure that exceeds the 90th national percentile.
- Achieve scores on CAHPS member satisfaction survey questions that demonstrate national leadership (rating of 5.0).
- Evaluate and prioritize survey measures based on the overall value to members.
- 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.
- Provide a superior level of access to urgent care, primary care, eye care, infusion services and other network services.
- Continually improve member access to health services, with particular emphasis on vulnerable populations (ex. CHP's Center for Chronic Care).
- 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.
- Maintain compliance with the Affordable Care Act, Section 1557 (took effect in 2016).

PATIENT SAFETY

- Monitor and implement interventions to improve performance on HEDIS and CMS star rating 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.
- Conduct reporting of patient safety data according to applicable state and federal regulations.
- Implement interventions to ensure safety at CHP facilities through the CHP Safety Committee.

QUALITY IMPROVEMENT/ ACCREDITATION

- Maintain a Medicare CMS 5.0 Star Rating.
- Maintain an NCQA Medicare rating of 5.0.
- Maintain NCQA Medicare "Excellent" Accreditation.
- Maintain compliance with state and federal regulations related to quality improvement.
- Implement and maintain an annual QI project in compliance with CMS's Quality Improvement Project (QIP) requirements.
- Implement interventions to improve 2016 priority measures; identified in the 2016 Medicare QI Workplan as measures with scores less than 5 stars. Maintain current ongoing interventions for measures scored at 5 stars.
- Integrate quality improvement processes throughout Capital Health Plan and its healthcare delivery system, striving to integrate quality improvement at every level of the organization.
- Integrate procedures for monitoring and ensuring compliance with NCQA 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.
- Integrate enrollee feedback into the design of the QI program through analysis of member satisfaction and complaint data.
- Expand and standardize quality measurement and reporting capabilities through the network.
- Develop the capability to conduct a virtual on-site NCQA survey.
- Develop the capability to submit HEDIS data electronically (new ECDS measures).
- Develop procedures to provide timely and accurate HEDIS member and physician level data for interventions.

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 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 Associate 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.
- Medication Management Committee: monitors compliance with Medicare Part D requirements, coordinates pharmacy QI activities and safe medication practices, and provides oversight for delegated procedures, including the formulary.
- The Pharmacy Quality Continuous Improvement Committee: reviews pharmacy data and information about medication quality-related events that occur within CHP health centers.
- Credentials Committee: reviews practitioner/provider information during initial credentialing and re-credentialing; makes approval decisions, or recommendations for adverse decisions related to network participation.
- 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 and/or providers that have not been approved by an Associate Medical Director**.** The checklist that the committee reviews outlines compliance with each credentialing or re-credentialing requirement.
  - The committee reviews and evaluates information and discusses issues of concern before making a decision. The committee makes approval decisions related to initial credentialing and recredentialing. The committee may make a recommendation to the CHP Senior Management Team for an adverse decision related to network participation. In this case, the Senior Management Team would make a final decision.

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.
- A primary care physician from the Physician Group of Capital Health Plan chairs the Quality Improvement Committee, and participates on the Medication Management Committee. An Associate Medical Director chairs the Credentials Committee, and works together with the CMO to integrate and implement QI activities collaboratively with 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 Vice President is responsible for communicating QI activities to CHP's members through newsletters, member handbooks and other informational program materials. This Senior Vice-President provides oversight over benefit development/maintenance procedures, and develops member educational programs.
- 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 for the administration of the HEDIS and CAHPS national performance measurement programs. 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:

- Medicare Star Rating scores
- Capital Health Plan's Strategic Plan
- Recommendations from the previous year's QI Program Evaluation
- HEDIS data analyzed at the health plan level, and stratified by staff vs. affiliates, individual physicians, and race/ethnicity.
- CAHPS member satisfaction data analyzed at the health plan level, stratified by staff vs. affiliates, and race/ethnicity.
- Medication therapy management measures
- Individual physician level performance measures (National Quality Forum measures)
- Hospital clinical quality and safety measures
- Practitioner satisfaction and quality review data
- Customer complaint and grievance data
- Analysis of clinical data, health risks, claims ,demographic, race/ethnicity and language data
- Feedback from external customers
- Analysis of HEDIS/CAHPS data
- Performance data from quality indicators or accreditation/regulatory surveys
- Clinical and service improvement activities, including Medicare Quality Improvement Projects (QIPs)
- Care coordination and hospital readmission data and indicators
- Risk management and patient safety data
- Disease management and chronic care improvement program indicators
- Wellness and health promotion indicators
- Confidentiality/HIPAA indicators
- Performance levels established by NCQA and federal and state governmental agencies

CARE FOR MEMBERS WITH COMPLEX HEALTH NEEDS

The CHP Case Management Program works with members with complex health needs to arrange and coordinate care and services. Members identified for the program include those with multiple chronic conditions, physical or developmental disabilities, and members with severe mental illnesses. Case managers assess their needs, and provide interventions up to and including complex case management.

CHP's Center for Chronic Care provides a comprehensive teamwork approach to the medical care of members with chronic and complex conditions. The Center's physicians and staff work with members to support the physical, social and emotional aspects of chronic illness to achieve optimal clinical outcomes.

CONTINUITY/COORDINATION OF CARE

CHP 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 that require further investigation. 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 recredentialing decisions.

USE OF EXTERNAL CONSULTANTS

CHP utilizes external board certified physician consultants to review and evaluate potential quality of care issues.

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).
- Credentialing of practitioners for telemedicine services is delegated to Online Care Network II P.C.
- Web-based pharmacy claims and benefits information, Medicare formulary development/maintenance and pharmacy utilization management criteria are delegated to Prime Therapeutics, a pharmacy benefit management organization.
- CHP plans to delegate radiation oncology in 2018 to AIM Specialty Health. AIM is certified by NCQA in Utilization Management.
- CHP provides member experience and/or clinical performance data as part of delegation agreements, if requested by the delegate. CHP provides a report with trended data results that are specific to the performance of the delegate.

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

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

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 effectiveness of CHP's quality improvement program is evaluated by annual evaluations for Commercial and Medicare clinical and service performance measures, and evaluations for topics that include access, availability, continuity and utilization measures. The summary of effectiveness includes adequacy of QI program resources, QI committee structure, and practitioner participation and leadership involvement in the program. The health plan's achievements are identified through this process. The need to restructure or change the QI program for the following year is addressed. The Quality Improvement Management Team and the CHP Board of Directors approve these evaluations on an annual basis.

CHP Quality Committees

Committee	Objectives	Membership
Quality Improvement Management Team (QIMT) Meets minimum of 10 times per year.	• Review and approve the Medicare QI and Utilization Management program documents on an annual basis (program descriptions, work plans and program evaluations). • Assess and ensure progress toward annual Medicare 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. • Provide guidance and feedback to committees reporting to QIMT.	• CEO • Vice-Presidents • Chief Medical Officer • Medical Director
Quality Improvement Committee (QIC) Meets minimum of 4 times per year.	• Review Medicare QI program documents (program descriptions, work plans, program evaluations and quarterly reports) on an annual basis. • Review and approve Disease Management, Chronic Care Improvement and Case Management Program Descriptions and reports on at least an annual basis. • Review and evaluate quality of care issues related to individual practitioners/providers. The committee identifies and monitors corrective action plans; they may refer cases to CHP's Senior Management Team for a potential adverse event related to network participation. • Prioritize, select and monitor clinical quality initiatives, including 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).	• Chief Medical Officer • Medical Director • Practicing Network Physicians • Psychiatrist • Senior VP, Clinical Operations, QI • Director, QI • Director, Care Coordination • Compliance Officer • CHP Staff
Medicare Star Rating Committee Meets minimum of 6 times per year.	• Review and distribute to the organization CMS updates and information related to the Star Rating Program. • Coordinate with designated accountable managers to plan and track progress of QI initiatives. • Monitor and promote continual improvement in the areas of clinical quality, member satisfaction, customer service, drug pricing and patient safety included in CMS's Star Rating program. • Review and track internal performance on potential star rating measures on an ongoing basis as data becomes available. • Communicate star rating priorities to staff and departments responsible for star ratings. • Meet routinely to discuss issues related to existing star measures, track measure performance as data becomes available, and review regulatory updates.	• QI Director • Medicare Sales Manager • Health Promotions Director • Financial Analyst/Medical Admin

Committee	Objectives	Membership
Compliance Committee Meets minimum of 4 times per year, more often as needed.	• Review and approve policies, procedures and practices related to compliance and HIPAA regulations. • Provide oversight for CHP's compliance and HIPAA programs.	• Compliance Officer • Chief Executive Officer • Chief Medical Officer • Senior Vice Presidents • Controller • Directors
CHP Safety Committee Meets minimum of 4 times per year, more often as needed.	♦ Review and approve policies, procedures and practices related to the safety within CHP facilities. ♦ Provide oversight for the implementation of safety procedures. ♦ Review incident reports regarding safety issues and recommend/approve solutions.	♦ IT Security Administrator ♦ Sr. Vice President ♦ Facilities Manager ♦ Nursing Director ♦ CHP Clinical Staff
Medication Management Committee Meets minimum of 6 times per year, more often as needed.	• Monitor compliance with NCQA accreditation and Medicare Advantage/Part D requirements. • Monitor Part D Star Rating performance measures; identifies and provides oversight over improvement interventions. • Review and approve pharmacy policies and procedures on an annual basis. • Review and approve delegate policies, procedures and formulary on an annual basis. • Review and adopt utilization and clinical criteria pertaining to medication use. • Monitor and promote continual improvement in safe medication practices. • Develop interventions to improve performance measures related to medication use. • Collaborate with the pharmacy benefit management company (PBM) to resolve benefit and quality issues. • Review and analyze routine reports from the PBM; review and provide oversight over delegated functions.	• Chief Medical Officer • Medical Director • Pharmacist • Practicing Physicians • Psychiatrist • CHP Staff
Pharmacy Continuous Quality Improvement Committee Meets 4 times per year.	• Review pharmacy data and information about medication errors and quality-related events that occur within CHP medical centers. • Recommend improvement interventions as appropriate.	• Medical Director • Practicing Physicians • Pharmacist • Vice President • CHP Nurses
Credentials Committee Meets minimum of 4 times during each calendar year, more often as needed.	• Review and approve practitioners and providers into the CHP network based on specific credentialing/recredentialing criteria. • Review and make recommendations for adverse decisions to the Senior Management Team. • Review and approve credentialing criteria, policies and procedures on at least an annual basis. • Review and approve delegate policies and procedures on an annual basis. • Review and analyze quarterly and annual credentialing reports; provide oversight over delegated functions in credentialing.	• Medical Director • Practicing Network Physicians • Supervisor, Network Services

APPENDIX A: Medicare NCQA 2018 QI Work Plan

	#1 Priority Measures	2017 Results	2017 Natl %	Planned Improvement Projects/Comments
1	*Non-recommended PSA Screening (HEDIS admin: low score is better)	44%	10th	2016 results: 49%. Added to Accreditation for 2018. Measure is on the CMS display page; expected to be included in 2019 star ratings. Improvement in this measure benefits accreditation and Medicare NCQA rating. CHP has removed screening from routine testing template.
2	*Pharmacotherapy Mgmt of COPD: Bronchodilator (HEDIS admin)	77%	25th	2016 results: 84%. Change in technical specifications for HEDIS 2017. CMS display measure. Improvement benefits accreditation, and Commercial & Medicare NCQA ratings. HP staff reviews diagnoses. If COPD is not the primary diagnosis, staff works with TMH staff to restack the claims. If COPD is the primary diagnosis, HP staff calls patients not filling prescriptions to assess reasons.
3	*Pharmacotherapy Mgmt of COPD: Corticosteroids (HEDIS admin)	68%	25th	2016 results: 75%. Change in technical specifications for HEDIS 2017. CMS display measure. Interventions same as above.
4	*Annual Flu Vaccine (CAHPS)	72%	25th	2016 results: 80%. Improvement in this measure benefits NCQA Commercial and Medicare ratings, accreditation, and CMS star ratings. Plan to hold Flu clinics for members of staff practices in 2018.
5	Reducing the Risk of Falling (HOS)	55%	25th	2016 results: 56%. Change in technical specifications for HEDIS 2017. Continue distributing information to members visiting staff PCPs. An indicator has been added to the EHR. Improvement benefits Medicare NCQA rating, accreditation and CMS star ratings.
6	*Statin Adherence (80%) with Cardiac Disease (HEDIS admin)	81%	50th	2016 results: 77%. Added to Accreditation and the NCQA ratings for 2018. NCQA Commercial priority topic, and a Star rating priority for 2018. Prime PBM: continue outreach to prescribers through the Guided Health Program. Gap reports are available.
7	*Statin Therapy for Patients with Diabetes (HEDIS admin)	83%	75th	2016 result: 73%. Added to Accreditation and the NCQA ratings for 2018. NCQA Commercial priority topic, and a Star rating priority for 2018. Prime PBM: continue outreach to prescribers through the Guided Health Program. Gap reports are available.
8	*Osteoporosis Mgt. in Women who had a Fracture (HEDIS admin)	44%	50th	2016 results: 48%. Population is monitored by CHP Radiology staff; follow up to schedule appts. Repeat contacts with members until success. Work on code corrections if appropriate. Improvement in measure benefits accreditation, NCQA MC ratings & CMS star ratings.
9	*Plan All Cause Readmissions (HEDIS admin: low score is better)	10.4%	50th	2016 results: 9.9% CMS weight: 3 points. Change in technical specifications for HEDIS 2017. Measure added to the NCQA ratings for 2018. TPCA practices monitor hospital discharges, and schedule PCP visits within 7 days.
10	*Persistence of Beta Blocker Tx (HEDIS admin)	93%	50th	2016 results: 97%. CMS display measure. HP staff monitors fill history for members in population. If not filling, contact is made with member urging them to continue taking their medications.
11	*Breast Cancer Screening (HEDIS admin)	81%	75th	2016 results: 83%. HEDIS 2018: diagnostic screenings are included in the measure; added digital breast tomosynthesis. Continue to monitor and contact members to schedule appointments. Improvement in this measure benefits Commercial & Medicare NCQA ratings, accreditation and CMS star ratings.

APPENDIX A: Medicare NCQA 2018 QI Work Plan

	#1 Priority Measures	2017 Results	2017 Natl %	Planned Improvement Projects/Comments
12	*Potentially Harmful Drug-Disease Interactions in Elderly (HEDIS admin: low score is better)	39.5%	25th	2016 results: 39%. Change in technical specifications for HEDIS 2017. CMS display measure. Prime edits are in place to identify potential issues. Improvement benefits accreditation, Medicare NCQA ratings and future CMS star ratings.
13	*Getting Appointments and Care Quickly (CAHPS)	78%	25th	2016 results: 75%. Work with new staff physicians to implement flexible scheduling in 2018. Develop article for first quarter 2018 Healthline; on-hold message. Measure is a Star Rating priority topic for 2018.
14	Transitions of Care Measure (4 HEDIS hybrid measures)	NA	NA	Measures will be implemented for HEDIS 2018; are expected to be included in the 2019 star ratings at a weight of 3 per measure. Notification of Inpatient Admission Receipt of Discharge Information Patient Engagement after Inpatient Discharge (30 days) Medication Reconciliation Post Discharge New measures are a priority for the CCD department in 2018. CHP Reception staff will follow up on PCP visits after hospitalizations.
15	Follow-up after ED Visit for Mental Illness (HEDIS admin)	NA	NA	Baseline data to be collected in 2018; includes telehealth visits. Measure is expected to be included in future NCQA and CMS star ratings. Network News article distributed in 2017. Measure is an MJO for CCD and Nursing staff.
16	Follow-up after ED Visit for Alcohol and other Drug Dependence (HEDIS admin)	NA	NA	Baseline data to be collected in 2018; includes telehealth visits. Measure is expected to be included in future NCQA and CMS star ratings. Network News article distributed in 2017. Measure is an MJO for Nursing staff.
17	Follow-up after ED Visit for People with High Risk Multiple Chronic Conditions (HEDIS admin)	NA	NA	New measure for HEDIS 2018.
18	Use of Opioids at High Dosage (3 HEDIS admin measures)	NA	NA	New measure implemented for HEDIS 2018 (3 measures). The measure is expected to be included in future NCQA rating, and will be included on the CMS display page in 2019. Prime PBM Guided Health Program sends letters to physicians. Edits are in place for the total daily dose of MSO4.
19	Use of Opioids from Multiple Providers (3 HEDIS admin measures)	NA	NA	New measures (3) implemented for HEDIS 2018. The measure is expected to be included in future NCQA rating, and will be included on the CMS display page in 2019. Same interventions as above.
20	Utilization of PHQ to Monitor Depression in Adolescents/Adults (HEDIS ECDS)	NA	NA	New voluntary ECDS (electronic clinical data systems) measure implemented in 2016. CHP can only submit data from our staff practice EHR at the current time. Plan to evaluate current use of PHQ9 tool within the staff practices.
21	Depression Remission/ Response (HEDIS ECDS)	NA	NA	New ECDS measure implemented in 2017. Investigate current use of PHQ9 tool in staff practices.
22	Alcohol Screening & Follow-up (HEDIS ECDS)	NA	NA	New ECDS measures (2 measures) implemented for HEDIS 2018. Measures are expected to be added to the CMS display page in 2020.
23	Pneumococcal Vaccines for Older Adults (HEDIS ECDS)	NA	NA	New ECDS measure implemented for HEDIS 2018. % adults 65 years and older who received recommended series of pneumococcal vaccines (PCV13 and PPSV23).

APPENDIX A: Medicare NCQA 2018 QI Work Plan

	#2 Priority Measures	2017 Results	2017 Natl %	Planned Improvement Projects/Comments
24	*Comp Diabetes - BP Control (<140/90) (HEDIS hybrid)	74%	50th	2016 results: 75%. CMS weight: 3 points. Improvement in this measure benefits Commercial & Medicare ratings, and accreditation. Same interventions as above.
25	*Controlling High Blood Pressure (HEDIS hybrid)	83.5%	75th	2016 results: 81.5%. Change in technical specifications for HEDIS 2017. CHP staff nurses will recheck BPs, and repeat visits will be scheduled when results are out of control. Gap reports are available. Improvement in this measure benefits NCQA Comm. & Medicare ratings, accreditation and CMS star ratings.
26	*Diabetes Care Eye Exam (HEDIS hybrid)	82%	75th	2016 results: 80.5%. Change in technical specifications for HEDIS 2017. Continue individual member follow-up, and providing mobile services with new retinal camera in 2018. Improvement benefits Commercial & Medicare NCQA ratings, accreditation, and CMS star ratings (included in QI composite).
27	*Coordination of Care Composite (CAHPS)	86%	25th	2016 results: 85%. 6 new HEDIS measures implemented. Plan to eliminate current CAHPS composite measure for the star ratings in the future; thus will not be a priority improvement initiative.
28	*Getting Needed Care (CAHPS: 8-10)	85%	50th	2016 results: 85%. Develop article for first quarter 2018 Healthline; on-hold message.
29	*High Risk Medications in Elderly (HEDIS admin: 1 rx; low score is better)	13.6%	50th	2016 results: 12.8%. Change in technical specifications for HEDIS 2017. Prime PBM: sends notifications to prescribers when high risk medications are ordered; program will continue in 2018. The Prime formulary does not include majority of high risk meds. Health Promotions (HP) staff mails out educational materials to members who fill a sleep aid or anti-anxiety medication for the first time.
30	*Antidepressant Med Mgmt – Acute Phase Treatment (HEDIS admin)	78%	75th	2016 results: 81%. Change in technical specifications for HEDIS 2017. Added telehealth visits for HEDIS 2018. Measure is on the CMS display page. Continue correct coding initiatives for members with major depression.
31	*Follow-up After Hosp. for Mental Illness – 7 Day (HEDIS admin)	56%	90th	2016 results: 66%. Change in technical specifications for HEDIS 2017. HEDIS 2018: Added telehealth visits; excluded visits on the day of discharge. Measure is on the CMS display page (30 day follow-up).
32	*Diabetes Care Blood Sugar Controlled (HbA1C <8) (HEDIS hybrid)	77%	90th	2016 results: 81%. Change in technical specifications for HEDIS 2017. Evaluate repeating intervention of sending lab slips to members who have not had a HbA1c test done during the measurement year.
33	*Rating of Specialist (CAHPS: % 8-10)	90%	NA	2016 results: 88%. NCQA ratings use scores of % 9-10.
34	*Advising Smokers to Quit (CAHPS)	86%	NA	2016 results: 86%. Interventions are being implemented at TPCA for this measure. Improvement benefits accreditation, and NCQA Medicare ratings.
35	*Pneumonia Vaccine (CAHPS)	83%	NA	2016 results: 82%. Improvement benefits NCQA Medicare rating, accreditation and future CMS star ratings. Measure is on the CMS display page.

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	#3 Priority Measures	2017 Results	2017 Natl %	Planned Improvement Projects/Comments
36	*Rating of PCP (CAHPS: 8-10)	93%	NA	2016 results: 92%. NCQA ratings: use scores of % 9-10.
37	*Rating of Health Care Quality (CAHPS 8-10; CMS CAHPS 9-10)	88%	90th	2016 results: 88%
38	*Initiation of Alcohol or Other Drug Treatment (HEDIS admin)	75%	95th	2016 results: 69%. Change in technical specifications for HEDIS 2017; results cannot be trended with HEDIS 2018. Added telehealth visits for HEDIS 2018. Measure added to Accreditation for Medicare. CMS display measure. HP staff will continue a correct coding initiative. Charts are reviewed for appropriateness of diagnosis. Outreach to diagnosing provider to code the visit correctly if member is not experiencing an acute crisis.
39	*Colorectal Cancer Screening (HEDIS hybrid)	88%	95th	2016 results: 88%. Change in technical specifications for HEDIS 2017. Continue current screening procedures & follow-up.
40	Osteoporosis Testing (HOS)	86%	95th	2016 results: 89%. Change in technical specifications for HEDIS 2017. Measure added to the NCQA ratings for 2018. Measure is on the CMS display page. Monitor population and intervene to schedule appointments as necessary.
41	Customer Service (CAHPS)	94%	95th	2016 results: 91%. Measure added to the NCQA ratings for 2018. CHP reception and Member Services staff survey members if their questions have been answered.
42	*Rating of Health Plan (CAHPS: 8-10)	93%	95th	2016 results: 92%
	Measures not Included in NCQA 2018 Ratings	**2017 Results**	**2017 Natl %**	**Planned Improvement Projects/Comments**
43	Diabetes Care Kidney Monitoring (HEDIS hybrid)	97%	90th	2016 results: 98%. Measure removed from Accreditation and the NCQA ratings for 2018. Gap reports are available.
44	Adult BMI Assessment (HEDIS hybrid)	98%	90th	2016 results: 98%. Measure removed from Accreditation and the NCQA ratings for 2018.
45	Rheumatic Arthritis Management (HEDIS admin)	87%	90th	2016 results: 88%. Change in technical specifications for HEDIS 2017. HP staff contacts physicians regarding correct coding of members with diagnosis of RA.
46	*Antidepressant Medication Management 6 months (HEDIS admin)	74%	95th	2016 results: 61%. Change in technical specifications for HEDIS 2017. Added telehealth visits for HEDIS 2018. Measure is on the CMS display page.
47	*Engagement of Alcohol and Other Drug Treatment (HEDIS admin)	9%	95th	2016 results: 1%. Change in technical specifications for HEDIS 2017; results cannot be trended with HEDIS 2018. HEDIS 2018: Added telehealth visits; increased treatment timeframe from 30 to 34 days. Measure is on the CMS display page.
48	Medication Reconciliation Post Discharge (HEDIS hybrid)	82%	95th	2016 results: 76%. Change in technical specifications for HEDIS 2017. HP staff notifies PCPs of daily member hospital discharges. CHP staff practices monitor discharges and intervene when appropriate.

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	Measures not Included in NCQA 2018 Ratings	2017 Results	2017 Natl %	Planned Improvement Projects/Comments
49	Hospitalization for Potentially Preventable Complications (HEDIS admin)	1.09	NA	Measure is on the CMS display page; is expected to be included in the 2019 star ratings.
50	Healthcare Infection Rate: Central lines (HEDIS admin)	0.8843	NA	New Medicare measure for HEDIS 2017.
51	Healthcare Infection Rate: Urinary tract catheters (HEDIS admin)	0.0648	NA	New Medicare measure for HEDIS 2017.
52	Healthcare Infection Rate: MRSA infections (HEDIS admin)	0.9258	NA	New Medicare measure for HEDIS 2017.
53	Healthcare Infection Rate: C difficile infections (HEDIS admin)	0.6983	NA	New Medicare measure for HEDIS 2017.

* Measure is included in the Medicare 2018 accreditation score.

Color Coding to Prioritize Initiatives for 2018:

Gold Star Initiatives: top priority QI initiatives for 2018.
Begin initiatives to address new measures.
Continue current initiatives that are in place, or plan new intervention for 2018.

Report date: 1/22/2018 C. Glush

QIMT review: 1/25/2018
Approval by Board of Directors: 3/14/2018