2024 Quality Improvement Program Summary

This summary highlights all of the initiatives (new and continuing) proposed for 2024, along with a brief description. For full details, including initiative specifics and changes in organization structure, please see the *2024 QIP Description.* New initiatives may be added to address opportunities identified in the finalized 2023 QIP Evaluation.

Wellness and Prevention

Core Programs: Initial and Annual Health Appraisals, ChildrenFirst™ Program, Well Child and Immunization Passport, Birthday Cards, Colorectal Cancer Screening (The FITCHEK program)

2024 Initiatives:

1. COVID-19 Vaccine Distribution and Communication: Support dissemination of COVID-19 vaccines/boosters.
2. Prenatal and Postpartum Rewards Program: Expansion of ChildrenFirst™ reward program for pre and post natal visits.
3. Individual & Family Plans Quality Improvement Strategy (QIS): Leverage the pay for performance incentive for primary care providers serving Individual & Family Plan members.
4. Integrated Managed Care (IMC) PIP– Reducing Breast Cancer Screening Disparities: Performance Improvement Project focused on partnering with CHCs to improve equitable access to breast cancer screenings.
5. Member Portal Gap-in-Care Visibility: Reminders included in the Member Center linked to educational resources and references to scheduling an appointment.
6. Pregnancy Identification Reports: Monthly report to CHCs to help identify pregnant members and support timely outreach for prenatal care.
6. Comprehensive In-Home Screening Strategy: Expand in-home testing capabilities, including HbA1c tests.
7. Member Communication and Outreach (mPulse): Comprehensive outreach program targeting gaps in care.
8. Customer Service System Gap-in-Care Visibility: Customer Service prioritized maximizing inbound engagement with members to identify gaps in care in real time.

NEW **Apple Health Expansion for Undocumented Immigrants:** Expansion of Medicaid program to include undocumented immigrants.
NEW **Prospective Medical Record Review Program:** Identifies areas for improvement and ensures that medical records are accurate and complete.

Behavioral Health

Core Programs: Mental Health Integration Program (MHIP), WISe Quality Oversight, Behavioral Health Care Management, Antidepressant Medication Management Initial Prescription Start Date (IPSD) Reporting

2024 Initiatives:

1. Youth Suicide Prevention Work: Collaborative effort between community, schools, BH professionals, families and allied organizations to provide training and support to adults who come in contact with suicidal youth to create a network of support**.**
2. Penetration Measure Gap-in-Care Visibility for Customer Service: Customer Service providing support to the Concierge Team to help families navigate the Behavioral Health Provider System.
3. Washington Integrated Care Assessment Implementation: Statewide process to assess the level of bidirectional clinical integration within behavioral health and primary care outpatient practices.
4. Follow Up for Children on ADHD Medication: Phone and text outreach to members/guardians who have just been prescribed an ADHD medication to answer any questions and promote scheduling follow-up.
5. Peer Services with Substance Use Disorder (SUD) Diagnosis (WEconnect): App-based peer support and high value incentives to support SUD recovery.
6. Collaborative Care in Pediatric Primary Care: Supporting implementation of the collaborative care model in pediatric primary care.
7. Caring Connections (formally Caring Contacts): Implement the evidence-based Caring Communications intervention for CHPW members to reduce suicide and suicide attempts.
8. Medication for Opioid Use Disorder in Primary Care: Initiative aimed at increasing MOUD within primary care provider network.
9. Expanding Access to Value-Based Arrangements: Evaluate and execute arrangements to ensure CHPW is incentivizing high quality, whole person care with key providers outside of the primary care setting
10. All Managed Care Organization (MCO) Health Equity PIP: Collaborative Performance Improvement Project to improve mental health penetration focused on youth from Black, Indigenous, and other People of Color (BIPOC) communities

NEW **All Managed Care Organization (MCO) PIP:** Collaborative Performance Improvement Project focused on the Follow-up after Hospitalization for Mental Illness (FUH) 7-day measure for 18-64 year-olds.
NEW **Provider Focus Groups to Understand Behavioral Health Access:** Facilitate behavioral health provider focus groups to review performance data and understand barriers to follow-up and treatment engagement.

2024 Quality Improvement Program Summary

Appropriate Utilization

Core Programs: Utilization Management, Nurse Advice Line, Medical Alumni Volunteer Expert Network (MAVEN)

2024 Initiatives:
1. Expanding the Use of Telehealth to Manage Chronic Conditions: Improve timely access to care and effective chronic condition management through collaborative partnership to provide reviews via telehealth.

Condition Management

Core Programs: Care Management, Health Homes, Maternal Child Health Program, In-Home Health Risk Assessment, Pay for Performance (P4P), Provider Quality Improvement Support, Quit for Life, ScreenRx Medication Adherence Program, Value-Based Care, Supporting Star Medication Adherence, Electronic Data Access

2024 Initiatives:
1. Supporting Dual Medicare Members with Social Drivers of Health: Expanded zero-cost items to ensure SNP members receive additional wraparound benefits for SDOH.
2. Papa Pals to Support Medicare Members: Pairs members with adults for companionship, assistance, and support to reduce social isolation.
3. Supporting Members with End-Stage Renal Disease (ESRD): Collaborative partnership between Care Management and Population Analytics to identify members with ESRD Diagnosis and launch outreach campaign.
4. Hepatitis C Treatment Engagement: Outreach to members with Hepatitis C to encourage treatment.

NEW **Integrated Managed Care (IMC) PIP– Reducing Diabetes Disparities:** Performance Improvement Project focused on improving diabetes management, specifically focusing on Glycemic Status Assessment for Patients with Diabetes (GSD) HEDIS Measure.
NEW **Chronic Condition Improvement Program – Diabetes Management Program:** Support members in self-management of diabetes mellitus type 1 and type 2 and pre-diabetes.
NEW **Embedding Pharmacists in Community Health Centers to Support Adherence:** Embed clinical pharmacists in CHC pharmacies to support Medicare medication adherence.

Safe Care

Core programs: Clinical Practice Guidelines; Medication Prescription Safety: Drug Utilization Reviews, Medication Therapy Management (Medicare), and the Personal Medication Coach (Medicaid); Monitor Clinical Quality Concerns, Patient Review and Coordination Program, Medicare Opioid Overutilization Program (MOOP)

Member and Provider Experience

Core Programs: Crossroads Patient Satisfaction Survey, Health Maps, Provider Satisfaction Survey

2024 Initiatives:
1. Improving Member Educational Materials and Support: Enhancing members' knowledge of plan resources through educational resources, expectation-setting, and other opportunities identified in SQIC.
2. Member Advisory Councils: Regionally-based councils which are representative of the populations served by CHPW. Councils will provide input into CHPW's quality, population health, and member engagement strategies.
3. Digital Navigator Program: Launch Link to Care WA program, which provides comprehensive digital navigation services to CHC patients across Washington State.
4. CAHPS Awareness Campaign: Targeted communication strategy focused on CHPW staff, providers, and members.
5. Medicare Stars Training Module: Training module focused on importance of Stars and the impact of CAHPS.
6. Stars Administrative Dashboard: Dashboard developed by MA Quality Committee to report progress on Part C and D administrative measures.
7. Medicare Stars Workgroup: Focused on identifying opportunities for improving CHPW's Medicare Star Rating.
8. SQIC Member Experience Improvement Workgroup: Focused on addressing identified opportunities for service recovery and improving member experience.

NEW **Equity Transformation Incentive Program:** 3-year roadmap to create a performance-based incentive program to reduce health disparities.

2024 Quality Improvement Summary

Equitable Care

Core Programs: Culturally and Linguistically Appropriate Service (CLAS) Standards, CLAS Learning Series, Health Equity Accreditation, Language and Communication Services, Social Drivers of Health Resource Network (Unite Us), NCQA's Health Equity Accreditation

2024 Initiatives:

1. Health Disparities Campaign: Review disparities and prioritize initiatives based on findings.
2. Social Drivers of Health Mapping in the CIS: Collecting SDOH data in a way that can be aggregated, analyzed, and applied in project planning.
3. Promoting Organizational Diversity, Equity, and Inclusion: Ongoing work to create a culture of DEI through the Equity Council and various internal programs focused on driving equity.
4. Expanding Equity Data: Implement new process to collect, store, and use member sexual orientation and gender identity data.
5.Support Access to Care for Refugee and Immigrant Families: Supporting immigrant and refugee families and addressing concerns regarding Public Charge rule.
6. Optimizing Social Determinant of Health (SDoH) Data: Assess, collect and share pertinent SDoH data to inform development of community programs and quality initiatives.

NEW **Equity Transformation Incentive Program:** Performance-based incentive program to drive meaningful reductions in health disparities. Transformation of the Equity Learning Collaborative Program.

Measures of Focus for New and Continuing Initiative Goals

Note: This is not inclusive of all measures tracked in the QIP.

Wellness & Prevention

- Well-Child Visits in the First 30 Months of Life
- Child and Adolescent Well-Care Visits (ages 3-21)
- Childhood Immunization Status Combo 10
- Prenatal and Postpartum Care
- Immunizations for Adolescents—HPV
- Chlamydia Screening in Women
- Colorectal Cancer Screening
- Breast Cancer Screening
- Cervical Cancer Screening
- COVID-19 Vaccine Distribution*
- Controlling High Blood Pressure
- Hemoglobin A1c Control for Patients With Diabetes - HbA1c Poor Control / Glycemic Status Assessment for Patients With Diabetes (GSD)
- Access to Preventative/Ambulatory Health Services
- Antidepressant Medication Management
- Plan All-Cause Readmissions
- Osteoporosis Mgmt in Women with a Fracture
- Primary Care Engagement for AH Expansion*

Behavioral Health

- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Antidepressant Medication Management
- Follow-Up Care for Children Prescribed ADHD Med.
- Follow-Up after Hospitalization for Mental Illness
- Follow-Up after ED Visit for Mental Illness
- Follow-Up after ED Visit for Substance Use
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Pharmacotherapy for Opioid Use Disorder
- Mental Health Service Rate*
- Substance Use Disorder Treatment Rate*
- Incorporate WA-ICA Recommendations*
- Increase Recovery Capital for Members with SUDs*
- Improve Access to BH Services via CoCM*
- Caring Connections Engagement*
- BH VBP Arrangement Development*

Appropriate Utilization

- Condition Documentation and Annual Visits*

Condition Management

- Hemoglobin A1c Control for Patients With Diabetes - HbA1c Poor Control / Glycemic Status Assessment for Patients With Diabetes (GSD)
- Hepatitis C Treatment Initiated*
- Decrease Hospitalizations for members with ESRD*
- Improve Engagement in Condition Management*
- Reduce Loneliness and Improve Outcomes*
- Medication Adherence for Diabetes, Hypertension, and Cholesterol
- Increased CM engagement for members with pre-diabetes and diabetes*

Safe Care

- Maintain all safety standards and requirements*

Member and Provider Experience:

- Getting Needed Care
- Getting Care Quickly
- Rating of Health Plan
- Expansion of member advisory councils*
- Expand Digital Navigation*
- Enhance Member Education Materials*
- Track Star Admin Measures*
- Provide Oversight of Star Measures*
- Educate Staff on Importance of Star Rating*

Equitable Care:

- Transition to Equity Incentive Program*
- Release Health Disparities Report*
- Ensure Accurate Mapping of SDOH EMR Data*
- Create Culture of Equity*
- Education, Advocacy, and Resources for Immigrant Health Services*
- Education and Learning on Equity for CHNW*
- Expand Collection and Use of SDOH Data*
- Meet Members SDOH Needs*

*Indicates non-HEDIS measures