2023 Quality Improvement Program Summary

This summary highlights all of the initiatives (new and continuing) proposed for 2023, along with a brief description.
For full details, including initiative specifics and changes in organization structure, please see the *2023 QIP Description.* New initiatives may be added to address opportunities identified in the finalized 2022 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)

2023 Initiatives:
1.Individual & Family Plans Quality Improvement Strategy (QIS): Leverage the pay for performance incentive for primary care providers serving Individual & Family Plan members.
2.**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
3.Member Portal Gap-in-Care Visibility: Reminders included in the Member Center linked to educational resources and references to scheduling an appointment
4.All MCO Performance Improvement Project (PIP) - Well Child Work Group: required PIP focused on improving well child visit rates among infants, young children, and adolescents, with a particular focus on 3-11 year olds.
5.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: Comprehensive outreach program targeting gaps in care.
8. COVID-19 Vaccine Distribution and Communication: Support dissemination of COVID-19 vaccine.
9. Customer Service System Gap-in-Care Visibility: Customer Service prioritized maximizing inbound engagement with members to identify gaps in care in real time

NEW **Breast Cancer Screening Rewards Program:** $25 rewards for breast cancer screening
NEW **COVID-19 Vaccine Strategy Implementation:** Improve overall vaccination rates and reduce disparities

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

2023 Initiatives:
1. 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
2.Washington Integrated Care Assessment Implementation: Statewide process to assess the level of bidirectional clinical integration within behavioral health and primary care outpatient practices
3. 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
4. BHSO Adult Performance Improvement Project (PIP) - Peer Services with Substance Use Disorder (SUD) Diagnosis (WEconnect): App-based peer support and high value incentives to support SUD recovery
5. Collaborative Care in Pediatric Primary Care: Supporting implementation of the collaborative care model in pediatric primary care.
6. Caring Connections (formally Caring Contacts): Implement the evidence-based Caring Communications intervention for CHPW members to reduce suicide and suicide attempts.
7. Medication for Opioid Use Disorder in Primary Care: Initiative aimed at increasing MOUD within primary care provider network
8. Behavioral Health Data Integration Demonstration Project: Piloting access to the Clinical Integration Solution (CIS) with a behavioral health agency to enhance collaboration with primary care.
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 Performance Improvement Project: Collaborative PIP to improve mental health penetration focused on youth from Black, Indigenous, and other People of Color (BIPOC) communities

NEW **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

2023 Quality Improvement Program Summary

Appropriate Utilization

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

2023 Initiatives:
NEW **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

2023 Initiatives:
1. Chronic Condition Improvement Program (CCIP) - 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
2.Hepatitis C Treatment Engagement: Outreach to members with Hepatitis C to encourage treatment.

NEW **Supporting Dual Medicare Members with Social Drivers of Health:** Expanded zero-cost items to ensure SNP members receive additional wraparound benefits for SDOH
NEW **Papa Pals to Support Medicare Members:** Pairs members with adults for companionship, assistance, and

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 and Member Engagement Workgroups, Provider Satisfaction Survey

2022 Initiatives:
1.Member Experience Survey Redesign: Member experience survey that mirrors CAHPs to identify opportunities for improvement at the clinic, region, or population level.
2. Member Listening Post: Creates real-time feedback as member interacts with Health Plan to provide insights to responses to CAHPS questions
3. Member Experience Plan (MXP): Serves as annual roadmap of critical activities for improvement in member engagement, experience, and overall CAHPS score and Medicare Star Rating.
4. Center to Advance Consumer Partnership (CACP) Partnership: Continued partnership with CACP to improve member engagement, experience, and health equity.

NEW **Member Experience Grants for Community Health Centers:** Launch new incentive to improve member experience for CHPW members by providing funding to support capacity and infrastructure at CHCs
NEW **Improving Member Educational Materials and Support:** Enhancing members' knowledge of plan resources such as Customer Service support and understanding how to navigate CHPW resources
NEW **Member Advisory Councils:** Develop a council to support CHPW member engagement strategy
NEW **Digital Navigator Program:** Launch Link to Care WA program, which provides comprehensive digital navigation services to CHC patients across Washington State

2023 Quality Improvement Summary

Equitable Care

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

2023 Initiatives:

1. 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
2. Expanding Equity Data: Implement new process to collect, store, and use member sexual orientation and gender identity data
3.Support Access to Care for Refugee and Immigrant Families: Supporting immigrant and refugee families and addressing concerns regarding Public Charge rule.
4. Optimizing Social Determinant of Health (SDoH) Data: Assess, collect and share pertinent SDoH data to inform development of community programs and quality initiatives.
5.Advancing Health Equity Learning Collaborative: Continuing partnership with HCA and CHNW to reduce health disparities through integrated payment and health delivery reforms, including the Learning Collaborative Grant program.

NEW **NCQA's Health Equity Accreditation Survey:** Initiative to align with new Health Equity Standard
NEW **Social Drivers of Health Mapping in the CIS:** Collecting SDOH data in a way that can be aggregated, analyzed, and applied in project planning
NEW **Health Disparities Campaign:** Review disparities and prioritize initiatives based on findings

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 (Timeliness of Prenatal Care and Postpartum Care)
- Immunizations for Adolescents—HPV
- Chlamydia Screening in Women
- Colorectal Cancer Screening
- Comprehensive Diabetes Care (HbA1c Testing)
- Breast Cancer Screening
- Cervical Cancer Screening
- COVID-19 Vaccine Distribution*
- Blood Pressure Control
- Access to Preventative/Ambulatory Health Services

Behavioral Health

- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Antidepressant Medication Management
- Access to Behavioral Health Services for Children and Adolescents*
- Evidence-based practice implementation*
- Clinical Integration System (CIS) Access for Behavioral Health Providers*

Appropriate Utilization

- Avoidable ED Use*

*Indicates non-HEDIS measures

Condition Management

- Medication Adherence for Hypertension (RAS Antagonists)
- Medication Adherence for Diabetes
- Medication Adherence for Cholesterol
- Comprehensive Diabetes Care—Eye Exam
- Comprehensive Diabetes Care—HbA1c Poor Control
- Asthma Medication Ratio
- Hepatitis C Treatment Initiated*
- SNP Initial Health Risk Assessment (HRA) Completion*
- Electronic Clinical Data Access for CHCs*
- Behavioral Health Value-Based Payment Models*
- Decrease Hospitalizations for members with ESRD*

Safe Care

- Maintain all safety standards and requirements*

Member and Provider Experience:

- Getting Needed Care
- Getting Care Quickly
- Create real-time feedback loops
- Increase member retention*

Equitable Care:

- Education, Advocacy, and Resources for Immigrant Health Services*
- Education and Learning on Equity for CHNW*
- Addressing Social Determinants of Health*
- Reducing Health Disparities*