AHARO Clinical Quality Committee Work Plan - July 2017 to December 2018

	Activity	Steps to Achieve	Progress	Participating Member
1	Develop a Data Exchange between AHARO and Health Plan (Payer)	• Finalize Data Agreement for exchanging data between AHARO and Payer with the following objectives: o Improve quality of care measures o Improve shared accountable care measures o Improve HEDIS and Star performance measures o Improve access to care o Improve patient experience from both Provider and Plan o Improve patient care management and coordination o Incorporate SDOH into overall patient risk and care management o Improve high risk and highest cost utilizers o Improve the member enrollment and attribution process • The following categories of data should be captured and exchanged between AHARO and Plan: Patient demographics, clinical, utilization, cost, external facilities ADT feeds, social determinants, health outcome, patient experience data, and measures for specific identified populations. • Identify underlying data sources: o For AHARO Members, typically EPM, EHR, EDR, pharmacy, and ancillary services information systems data, e.g. RIS, LIS. o For Payers, typically member/enrollment, claims, risk pool financial data. • Develop specific timeline for data exchange. • Develop common platform (with the MSO)		☐ Bay Clinic ☐ Hamakua ☐ Waianae ☐ Waimanalo

		for warehousing and exchanging data between AHARO and Payer. • Develop Data Governance to ensure protection and authorization of data access by category of data, staff role and/or other acceptable criteria for both AHAHRO and Payer. • Ensure Data Agreement includes requirements for both AHARO and Plan as outlined in this section, specific deliverables, and performance timeline. • Negotiate and sign Final Data Agreement.		
2	Implement ADT Feeds Interface	• Develop ADT feeds directly with hospitals • In order for CHC care coordinators to effectively follow up inpatient and emergency treatment with the appropriate primary care, timely and accurate ADT feeds are required. The following steps are aimed at improving the quality of ADT data sent to CHCs: o Develop daily ADT feeds from health plans o Validate ADT feeds between hospitals and health plans o Consider and implement interface with HHIE or other health information exchanges. • Integrate ADT feeds with EHR to allow clinical staff access to hospital transition information as part of patients' chart.		☐ Bay Clinic ☐ Hamakua ☐ Waianae ☐ Waimanalo
3	Rollout Population Management analytics tools	• Leverage common data platform (with the MSO) as a Population Management system to implement the following data analytics features: o Gap analysis o Quality measures reporting o Patient visit planning (huddle) reports o Provider performance dashboards		☐ Bay Clinic ☐ Hamakua ☐ Waianae ☐ Waimanalo
4	Improve Access to Care	• Improve Access to care as defined by		☐ Bay Clinic ☐ Hamakua

		HEDIS Access/Availability of Care Measures, which could include: o Adults' Access to Preventive/ Ambulatory Health Services o Children's and Adolescents' Access to Primary Care Practitioners o Annual Dental Visit for Pediatric patients o Prenatal and Postpartum Care o Call Answer Timeliness • Step to Achieve: o Develop dashboards to track performance o Monitor 3rd Next Available appointments by clinic/provider/specialty group o Monitor No show rates by clinic/provider/specialty group o Measure improvement over baseline in selected measures as defined by HEDIS o Create a hotline to assist with transitions in care and discharge coordination where hospitals can call and reach one of our staff members.		☐ Waianae ☐ Waimanalo
5	Risk Pool Management	• Collaborate with various health plans to identify key drivers of health care costs and develop a plan to reduce them. Key drivers of preventable costs include:: **Managing inpatient care transitions –** Ensure outpatient follow-up within 7 days of hospital discharge for patients with non-obstetric; non-surgical and non-behavioral health primary diagnoses. • Receive daily Hospital and ED Admission/Discharge and Transfer (ADT) feeds from the majority of local hospitals. **Decreasing low acuity hospital Emergency Department (ED) usag**e-		☐ Bay Clinic ☐ Hamakua ☐ Waianae ☐ Waimanalo

		Applies to all Health Center Medicaid patients. • Use of specialized supportive/clinical staff who will contact discharged patients to reconnect them to their medical home and/or schedule an appointment to establish with a provider. **Reducing overall rate of hospital ED usage** – Applies to all Health Center Medicaid patients. • Use of specialized supportive/clinical staff who will contact discharged patients to reconnect them to their medical home and possibly refer high utilizers to case management/care coordination. **Reducing high utilization (6 or more visits) of hospital ED services** – Applies to all Health Center Medicaid patients. **Managing a high risk cohort of patients with intensive care coordination by:** • **Addressing their gaps in care** • **Improving medication adherence** • **Managing transitions of care following hospitalizations and ED visits** • Finalize contracts with Payers. • Develop means of tracking progress in regards to the key drivers of preventable costs. • Track both clinical and financial performance quarterly.		
6	Care Coordination Interventions	Implement a Care Coordination team with the following features: **Managing inpatient care transitions and decrease Emergency Department (ED) usage:** Ensure outpatient follow-up within 7		☐ Bay Clinic ☐ Hamakua ☐ Waianae ☐ Waimanalo

		days of hospital discharge for patients with non-obstetric; non-surgical and non-behavioral health primary diagnoses. • CHC staff will connect discharged patients to reconnect them to their medical home and/or schedule an appointment to establish a provider. • Within 2-5 days of discharge, members will receive a telephone call to schedule a follow up appointment. • Patients will complete a follow up appointment within seven days of discharge. • High utilizers will be referred to case management/care coordination. **Managing a mutually agreed upon high risk cohort of patients with intensive care coordination.** • Determine level of care coordination and complete care plan. • Provide health coaching to address chronic conditions • Assess for the following: physical, cognitive & bodily systems, ADL's & IADL's, review medications & treatments, risk for falls, history of emergency department visits, available supports, medical & social history, vital signs • Address gaps in care and schedule referrals as appropriate • Complete 1147 if applicable • Improve medication adherence • Complete reassessments to address significant events occurring for the patient.		
7	Patient Engagement	• Currently the Health Plans assign patients based on geographic proximity (e.g. zip codes) to CHCs. Once the patient is assigned to the CHC, an introductory letter to the patient may currently be the only	• New measure – Pending	☐ Bay Clinic ☐ Hamakua ☐ Waianae ☐ Waimanalo

		method by which the patient is notified. Unfortunately, old or outdated patient mailing addresses (obtained from the state) may hinder the ability to the engage the patient. Additionally, patients that are ultimately contacted and scheduled for a PCP visit, may not show up or cancel without notifying the health plan. AHARO proposes developing a pilot project with the Health Plan to improve the patient assignment process and accuracy through the following activities: o A monthly report available to the CHC that provides a status update of newly assigned patients to the CHC to allow the CHC to follow up with first-time patients. This report can also include the patient's assigned service coordinator, if applicable. o CHC to initiate contact via phone/letter no more than 30 days after member assigned to CHC and attempt to schedule an appointment to establish a PCP. o A report sent monthly from the CHC to the Health Plan's UTR department that identifies patients that cannot be contacted by the CHC as well as patients unmatched in EHR or EPM utilizing existing patient matching capabilities or through Azara. Referrals can be completed in the Health Plan's documentation portal.		
8	Implement Consumer Engagement Tools	• Rollout Patient Portal organization wide with the following features: o Patient and family access to PHI (personal health information) o Patient and family ROI (Request of Information) o Secure communication between patient and provider o Patient access to medication refill		☐ Bay Clinic ☐ Hamakua ☐ Waianae ☐ Waimanalo

		requests, appointment reminders and requests, medication and allergy lists, visit summaries, and health condition educational materials • To promote Patient Portal access, research and rollout computer/kiosks and/or Wi-Fi access for patients in clinics. • Track utilization of Patient Portal, both by PCP as well as patients and measure improvement over baseline. • Develop and utilize patient satisfaction surveys. • Select areas of needed improvement as identified by patient satisfaction surveys and measure improvement over baseline.		
9	Collect data on Social Determinants of Health (SDOH)	• Utilize a standardized method of collecting SDOH data. • Develop an electronic version • Modify as necessary to be culturally sensitive • Disseminate tool amongst all patients seen • Analyze data collected to improve care		☐ Bay Clinic ☐ Hamakua ☐ Waianae ☐ Waimanalo
10	Alternative Treatment Models	• Explore EHR integrated telemedicine options, e.g. Certintell's Virtual Visit platform. Develop a pilot project with aim of decreasing unnecessary PPS visits without compromising quality while enhancing patient experience using technology. Any potential savings would be incorporated into resources for HIT/care coordination.		☐ Bay Clinic ☐ Hamakua ☐ Waianae ☐ Waimanalo