Performance Evaluation Report

AIDS Healthcare Foundation dba AHF Healthcare Centers

July 1, 2012–June 30, 2013

Medi-Cal Managed Care Division
California Department of
Health Care Services

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HSAG HEALTH SERVICES ADVISORY GROUP

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July 1, 2012 – June 30, 2013

Purpose of Report

The Department of Health Care Services (DHCS) administers California's Medicaid program (Medi-Cal), which provides managed health care services to more than 5.6 million beneficiaries (as of June 2013)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

The Code of Federal Regulations (CFR) at 42 CFR §438.364[2] requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services provided by the states' Medicaid MCPs. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness and includes designation of one or more domains of care for each area reviewed as part of the compliance review process, each performance measure, and each quality improvement project (QIP). The report must contain an assessment of the strengths and weaknesses with respect to the quality and timeliness of, and access to health care services furnished to Medicaid recipients; provide recommendations for improvement; and assess the degree to which the MCPs addressed any previous recommendations.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on the Medi-Cal Managed Care program (MCMC). Due to the large number of contracted MCPs and evaluative text, HSAG produced an aggregate technical report and MCP-specific reports separately. The reports are issued in tandem as follows:

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs' performance through organizational structure and

[1] *Medi-Cal Managed Care Enrollment Report—June 2013*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx.

[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

- MCP-specific evaluation reports (July 1, 2012–June 30, 2013). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS's contracted MCP, AIDS Healthcare Foundation dba AHF Healthcare Centers ("AHF" or "the MCP"), for the review period July 1, 2012, through June 30, 2013. Actions taken by the MCP subsequent to June 30, 2013, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

Managed Care Plan Overview

AHF is a Medi-Cal managed care specialty plan operating in Los Angeles County and providing services primarily to members living with HIV or AIDS. Some of the MCP's members are dual eligible (i.e., covered by both Medicare and Medi-Cal).

AHF became operational with the MCMC Program in April 1995. As of June 30, 2013, the MCP had 815 MCMC members.[3]

Due to the MCP's unique membership, some of AHF's contract requirements have been modified from MCMC's full-scope MCP contracts.

[3] *Medi-Cal Managed Care Enrollment Report —June 2013*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the EQRO Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specifies that the State or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid MCP's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards. DHCS conducts this review activity through an extensive monitoring process that assesses MCPs' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers DHCS's medical performance and member rights review activities. These reviews occur independently of one another, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's compliance monitoring reviews to draw conclusions about AHF's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

For this report, HSAG reviewed the most current member rights reviews, medical performance audits, and monitoring reports available as of June 30, 2013. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS MCP contracts reflect federal and State requirements. DHCS reviews and

approves MCP processes in these areas prior to the commencement of MCP operations, during MCP expansion into new counties, upon contract renewal, and upon the MCP's changes in policies and procedures.

Medical Performance Audits and Member Rights Reviews

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical performance audits of Medi-Cal MCPs. In some instances, however, these audits were conducted solely by DHCS or DMHC. These medical performance audits assess MCPs' compliance with contract requirements and State and federal regulations. These audits were conducted for each Medi-Cal MCP approximately once every three years.

During this review period, DHCS began a transition of medical performance monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical performance audit frequency from once every three years to once each year. The second change, which occurred late in this report's review period (March 2013), was the phasing out of DHCS's biennial member rights/program integrity on-site reviews.[4] The biennial member rights/program integrity on-site reviews were replaced with an expanded continuous review process.

Under DHCS's new monitoring protocols, findings identified in annual A&I Medical Audits, DMHC Seniors and Persons with Disabilities (SPD) Enrollment Surveys, and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under these new protocols include follow-up communications and meetings with MCPs, augmented by DHCS technical assistance for MCPs to develop meaningful corrective action plans (CAPs) that address findings.

Since DHCS was transitioning to new monitoring protocols during this reporting period, HSAG reviewed the most recent monitoring reports available as of June 30, 2013. In some cases, the most recent monitoring report available was the earlier DHCS or DMHC medical audit report (once every three-years) and/or the biennial member rights/program integrity review report. For some of the MCP-specific evaluation reports, HSAG assessed the MCP using materials produced under the new monitoring protocols.

DHCS did not conduct any audits or reviews with AHF during the review period for this report. In the MCP's 2011–12 MCP-specific evaluation report, HSAG noted that the MCP had findings from the June 2010 Member Rights/Program Integrity Unit (MR/PIU) review in the areas of Member

[4] These reviews were conducted by DHCS's Medi-Cal Managed Care Member Rights & Program Integrity Unit to monitor MCP compliance with requirements under the DHCS contract, Title 42 Code of Federal Regulations, titles 22 and 28 of the California Code of Regulations, and applicable MMCD All Plan and Policy Letters pertaining to the follow areas: member grievances and appeals, prior-authorization request notifications, marketing (for non-COHS MCPs), cultural and linguistic services, and program integrity (fraud and abuse prevention and detection).

Grievances, Cultural and Linguistic Services, and Member Services. HSAG also noted in the 2011–12 report that AHF's self-reported information revealed that the MCP appeared to have addressed the findings related to Cultural and Linguistic Services. At the time AHF's 2011–12 MCP-specific evaluation report was produced, the MCP did not appear to have fully resolved the following findings from the MR/PIU review:

- The MCP did not specify the processes it will use to ensure grievance resolution letters are sent within the required 30-day time frame and report on the monitoring results to demonstrate whether the MCP is meeting the requirements.
- AHF did not provide evidence that the MCP's evidence of coverage (EOC) document includes all required information.

As part of the process for producing AHF's 2012–13 MCP-specific evaluation report, AHF was asked to document actions the MCP had taken in response to each recommendation from the 2011–12 MCP-specific evaluation report. AHF provided a description of the process the MCP implemented to ensure grievance resolution letters are sent within the required time frame and that during the reporting period 97 percent of grievance resolution letters were sent within the required time frame. The MCP's self-report also indicated that it revised the EOC to include all required information and that DMHC provided approval of the revised EOC on July 27, 2012.

Strengths

AHF appears to have fully resolved the finding in the area of Member Services from the June 2010 MR/PIU review and has made progress toward resolving the finding in the area of Member Grievances.

Opportunities for Improvement

While AHF appears to have a process in place to ensure grievance resolution letters are sent within the required time frame, the MCP has the opportunity to ensure that 100 percent of the letters are sent within the required time frame.

Conducting the EQRO Review

DHCS annually selects a set of performance measures for the Medi-Cal full-scope MCPs to evaluate the quality of care delivered by the contracted MCPs to Medi-Cal managed care program (MCMC) beneficiaries. DHCS consults with contracted MCPs, the EQRO, and stakeholders to determine what measures the MCPs will be required to report. The DHCS-selected measures are referred to as the External Accountability Set. DHCS requires that MCPs collect and report External Accountability Set rates, which provides a standardized method for objectively evaluating MCPs' delivery of services.

Due to the small size of specialty MCP populations, DHCS modified the performance measure requirements applied to these MCPs. Instead of requiring a specialty MCP to annually report the full list of performance measure rates as full-scope MCPs do, DHCS requires specialty MCPs to report only two performance measures. In collaboration with DHCS, a specialty MCP may select measures from the Healthcare Effectiveness Data and Information Set (HEDIS®)[5] or design a measure that is appropriate to the MCP's population. The measures put forth by the specialty MCPs are subject to approval by DHCS. Furthermore, specialty MCPs must report performance measure results specific to MCMC members.

To evaluate the accuracy of reported results, HSAG conducts validation of MCPs' performance measures as required by DHCS. Validation determines the extent to which MCPs followed specifications established by DHCS for its required performance measures when calculating rates.

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

The Centers for Medicare & Medicaid Services (CMS) requires that states conduct performance measure validation of their contracted health plans to ensure that plans calculate performance measure rates according to state specifications. CMS also requires that states assess the extent to which the plans' information systems (IS) provide accurate and complete information.

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of

[5] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.[6] This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

Performance Measure Validation

For 2013, AHF was required to report two HEDIS measures: *Controlling High Blood Pressure* and *Colorectal Cancer Screening*. Both measures fall into the quality and access domains of care.

HSAG performed an NCQA HEDIS Compliance Audit™[7] of all Medi-Cal MCPs in 2013 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2013 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased.

Performance Measure Validation Findings

The *HEDIS 2013 Compliance Audit Final Report of Findings for AIDS Healthcare Foundation* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that AHF followed the appropriate specifications to produce valid rates, and no issues of concern were identified.

Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 presents a summary of AHF's HEDIS 2013 performance measure results (based on calendar year [CY] 2012 data) compared to HEDIS 2012 performance measure results (based on CY 2011 data).

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS establishes a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specifications changes impacting comparability. Table 3.1 shows AHF's HEDIS 2013 performance compared to the DHCS-established MPLs and HPLs for the two measures AHF is required to report.

[6] The CMS EQR Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.
[7] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

DHCS based the MPLs and HPLs on the National Committee for Quality Assurance's (NCQA's) national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively.

Table 3.1—2012–13 Performance Measure Results
AHF—Los Angeles County

Performance Measure[1]	Domain of Care[2]	2012 HEDIS Rates[3]	2013 HEDIS Rates[4]	Performance Level for 2013	Performance Comparison[5]	MMCD's Minimum Performance Level	MMCD's High Performance Level (Goal)
Controlling High Blood Pressure (CBP) 18–85 years	Q,A	68.2%	62.20%	★★	↔	50.00%*	69.11%*
Colorectal Cancer Screening (COL) 50–75 years	Q,A	64.2%	63.07%	★★	↔	55.99%^	73.72%^

[1] DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA).
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011. Rates in 2012 were reported to one decimal place. To be consistent with how NCQA is reporting rates for 2013, two decimal places are used for the 2013 rates. Comparison between the 2012 and 2013 rates for the measure was calculated based on rates reported with two decimal places for both years.
[4] HEDIS 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.
[5] Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.
* The minimum performance level (MPL) and high performance level (HPL) for this measure are based on NCQA's national Medicaid 25th and 90th percentiles, respectively.
^ The MPL and HPL for this measure are based on NCQA's national commercial 25th and 90th percentiles, respectively, since no Medicaid benchmarks are available for this measure.
★ = Below-average performance relative to the national Medicaid 25th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles).
★★★ = Above-average performance relative to the national Medicaid 90th percentile.
↓ = Statistically significant decrease.
↔ = No statistically significant change.
↑ = Statistically significant increase.

Performance Measure Result Findings

AHF's performance was average for both measures. The rate for the *Controlling High Blood Pressure* measure moved from above the HPL in 2012 to below the HPL in 2013; however, the rate remained well above the MPL. AHF's 2012–13 work plan indicates that the MCP's goal for both required measures is to attain the 90th percentile by December 31, 2013. HSAG will provide an assessment of whether the MCP is successful at reaching this goal in AHF's 2013–14 MCP-specific evaluation report.

Improvement Plans

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve quality, access, and timeliness associated with the low-performing measure and positively impact the measure's rate. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the steps it will take to improve care and the measure's rate. DHCS reviews each IP for soundness of design and potential efficacy. DHCS requires MCPs to correct and resubmit any IP that fails to meet DHCS's IP standards.

Assessment of MCP's Improvement Plans

Since the rates for both of AHF's required measures were above the MPLs in 2012, the MCP was not required to submit an IP for either measure. Additionally, since the rates for both measures remained above the MPLs in 2013, AHF will not be required to submit any IPs in 2013.

Strengths

AHF continues to meet performance measure requirements, with the rates for both required measures being above the MPLs in 2013.

Opportunities for Improvement

Since AHF has not yet reached its goal of attaining NCQA's 90th percentile for both measures, the MCP could benefit from conducting a causal/barrier analysis to identify the factors preventing the rates from improving. Once the barriers are identified, the MCP can identify improvement strategies to address the priority barriers.

Conducting the EQRO Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. HSAG reviews each QIP using the CMS validation protocol[8] to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

Specialty MCPs must conduct a minimum of two QIPs; however, because specialty MCPs serve unique populations that are limited in size, DHCS does not require specialty MCPs to participate in the statewide collaborative QIP. Instead, specialty MCPs are required to design and maintain two internal QIPs with the goal to improve health care quality, access, and/or timeliness for the specialty MCP's MCMC members.

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

HSAG evaluates two aspects of MCPs' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the MCP's QIP objectives (QIP results).

Beginning July 1, 2012, HSAG began using a revised QIP methodology and scoring tool to validate the QIPs. HSAG updated the methodology and tool to place greater emphasis on health care outcomes by ensuring that statistically significant improvement has been achieved before it assesses for sustained improvement. Additionally, HSAG streamlined some aspects of the scoring to make the process more efficient. With greater emphasis on improving QIP outcomes, member health, functional status, and/or satisfaction will be positively affected.

[8] The CMS Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

HSAG organized, aggregated, and analyzed AHF's validated QIP data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

Quality Improvement Project Objectives

Specialty MCPs must be engaged in two QIPs at all times. However, because specialty MCPs serve unique populations that are limited in size, DHCS does not require them to participate in the statewide collaborative QIP. Instead, specialty MCPs are required to design and maintain two internal QIPs with the goal to improve health care quality, access, and/or timeliness for the specialty MCP's beneficiaries.

Table 4.1 lists AHF's QIPs, whether the QIP is clinical or nonclinical, and the domains of care (i.e., quality, access, timeliness) the QIP addresses.

Table 4.1—Quality Improvement Projects for AHF—Los Angeles County July 1, 2012, through June 30, 2013

QIP	Clinical/Nonclinical	Domains of Care
Advance Care Directives	Nonclinical	Q
CD4 and Viral Load Testing	Clinical	Q, A

AHF's *Advance Care Directives* QIP sought to increase the percentage of members with documentation of advance care planning. As defined by NCQA, advance care planning is a discussion about preferences for resuscitation, life-sustaining treatment, and end-of-life care. At the initiation of the QIP, 7.2 percent of the eligible members had an advance care directive.

AHF's *CD4 and Viral Load Testing* QIP focused on increasing CD4 and viral load testing. At the start of the QIP, 69.3 percent of eligible members had three or more CD4 tests and 68.9 percent had three or more viral load tests. AHF's project attempted to improve the testing rates by using both member and provider interventions.

Quality Improvement Project Validation Findings

Table 4.2 summarizes the QIP validation results and status across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Validation Activity
AHF—Los Angeles County
July 1, 2012, through June 30, 2013

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Internal QIPs				
Advance Care Directives	Annual Submission	93%	100%	*Met*
CD4 and Viral Load Testing	Annual Submission	85%	100%	*Met*

[1] **Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.
[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.
[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[4] **Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Validation results during the review period of July 1, 2012, through June 30, 2013, showed that AHF's annual submission of its *Advance Care Directives* QIP received an overall validation status of *Met* with 100 percent of critical elements and 93 percent of evaluation elements being met. AHF's annual submission of its *CD4 and Viral Load Testing* QIP received an overall validation status of *Met* with 100 percent of critical elements and 85 percent of evaluation elements being met.

Table 4.3 summarizes the aggregate validation results for AHF's QIPs across CMS protocol activities during the review period.

Table 4.3—Quality Improvement Project Average Rates*
AHF—Los Angeles County
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2012, through June 30, 2013

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	100%	0%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
	V: Valid Sampling Techniques (if sampling is used)	NA	NA	NA
	VI: Accurate/Complete Data Collection	100%	0%	0%
Design Total		**100%**	**0%**	**0%**
Implementation	VII: Sufficient Data Analysis and Interpretation	94%	0%	6%
	VIII: Appropriate Improvement Strategies	67%	33%	0%
Implementation Total		**86%**	**9%**	**5%**
Outcomes	IX: Real Improvement Achieved**	63%	0%	38%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total**		**63%**	**0%**	**38%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

**The stage and/or activity totals may not equal 100 percent due to rounding.

HSAG validated Activities I through IX for the *Advance Care Directives* and *CD4 and Viral Load* QIPs' annual submissions.

AHF demonstrated a strong application of the Design and Implementation stages, meeting 100 percent and 86 percent, respectively, of the requirements for all applicable evaluation elements within the two study stages for both QIPs. In the *Advance Care Directives* QIP, AHF did not indicate whether or not the MCP identified factors that affected its ability to compare measurement periods, resulting in a lower score for Activity VII. The MCP also did not indicate if the ongoing interventions were standardized processes, resulting in a lower score for Activity VIII. AHF received a lower score for Activity VIII for the *CD4 and Viral Load* QIP because the interventions did not fully address the identified barriers. Since the Remeasurement 2 rates for both study indicators were lower than the baseline rates, the MCP should either revise current interventions or implement new interventions to better address the barriers.

For the *Advance Care Directives* QIP, AHF met 100 percent of the requirements for all applicable evaluation elements for Activity IX. The *CD4 and Viral Load* QIP received a lower score for Activity IX because the rate for Study Indicator 1 had a non-statistically significant decline and the rate for Study Indicator 2 had a statistically significant decline from Remeasurement 1. Additionally, the rates for both indicators were below their respective baseline rates. Activity X was not assessed for either QIP since neither QIP could be assessed for sustained improvement, which is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

Quality Improvement Project Outcomes and Interventions

Table 4.4 summarizes QIP study indicator results and displays whether statistically significant improvement was achieved over baseline and whether sustained improvement was achieved (i.e., the statistically significant improvement was maintained or improved for at least one subsequent measurement period).

Table 4.4—Quality Improvement Project Outcomes for AHF—Los Angeles County July 1, 2012, through June 30, 2013

QIP #1—Advance Care Directives			
Study Indicator: Percentage of eligible members who have an advance directive or have had a discussion regarding advance directives with their provider			
Baseline Period 1/1/10–12/31/10	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement¥**
7.2%	25.7%*	‡	‡
QIP #2—CD4 and Viral Load Testing			
Study Indicator 1: Percentage of eligible members receiving at least three CD4 lab tests			
Baseline Period 1/1/09–12/31/09	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
69.3%	69.7%	63.8%	‡
Study Indicator 2: Percentage of eligible members receiving at least three Viral Load lab tests			
Baseline Period 1/1/09–12/31/09	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
68.9%	73.4%	65.7%**	‡

¥ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

* Statistically significant improvement over baseline (p value < 0.05).

** A statistically significant difference between the measurement period and prior measurement period (p value < 0.05).

‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

Advance Care Directives QIP

The *Advance Care Directives* QIP goal for Remeasurement 1 was that 25 percent of the eligible members would have evidence of advance care planning or having had a discussion with their provider regarding advance care planning. At the first remeasurement period, AHF achieved its goal, with 25.7 percent of eligible members having evidence of advance care planning. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following observations:

- AHF conducted a brainstorming session to identify barriers and produced a revised fishbone analysis that included previously-identified barriers and new barriers that arose since implementation of the QIP. Analysis also included a SWOT (Strengths/Weaknesses/Opportunities/Threats) diagram that helped the MCP identify best opportunities and future threats. Interventions were selected based on their feasibility and level of importance toward improving the indicator's rate.
- The MCP indicated that all planned interventions were implemented successfully, with the exception of the provider report cards. Limited resources prevented the information technology department from being able to develop the provider report cards by the target date; however, AHF established September 2012 as the new target date. The MCP will provide information about the implementation of this intervention in the next annual submission, which will be August 2013.
- AHF did not indicate whether or not the MCP identified factors that affected its ability to compare measurement periods. The MCP should reference the QIP Completion Instructions to ensure that all documentation requirements for each activity have been addressed prior to submission to avoid incomplete documentation of the various elements.
- AHF indicated that several of its interventions were ongoing and described how the MCP monitors the interventions for efficacy in impacting the rate; however, the MCP did not indicate whether or not these ongoing interventions were standardized processes.
- The QIP study indicator achieved statistically significant improvement over baseline in Remeasurement 1. The reported improvement was consistent with the planned and implemented interventions.

CD4 and Viral Load Testing QIP

AHF set the project objective for the *CD4 and Viral Load Testing* QIP as a 5 percent increase annually. From baseline to the first remeasurement period, neither study indicator achieved statistically significant improvement over baseline. From Remeasurement 1 to Remeasurement 2, the rates for both study indicators declined, with the decline for Study Indicator 2 being statistically significant. A review of the MCP's QIP Summary Form and QIP Validation Tool revealed the following observations:

- AHF completed a new casual/barrier analysis and used improvement strategies related to the causes/barriers identified through data analysis and a quality improvement process; however, the implemented interventions were not successful. The MCP should revisit the causal/barrier analysis process to determine if the barriers affecting the outcomes need to be re-prioritized.
- The measurement period timelines documented by AHF in the QIP Summary Form are inconsistent. The MCP should ensure that timelines are consistent throughout the QIP Summary Form.
- Although AHF expected that its documented interventions would likely produce long-term effects, the latest reported rates were lower than the baseline rates. The MCP should revise current interventions, or implement new interventions, that are organization-wide initiatives aimed at improving performance.
- AHF documented the use of a standardized report to enable continuous monitoring of Viral Load/CD-4 testing. The MCP documented that the report enabled AHF's Quality Team to monitor the interventions and improvement in rates; however, the report may not necessarily monitor the success of the individual interventions implemented by AHF.
- AHF did not describe in the QIP Summary Form how the MCP monitors individual interventions to determine if the interventions are successful or the problem-solving techniques used to identify the reasons interventions are not positively impacting the outcomes. The MCP should regularly monitor interventions and employ problem-solving techniques to determine why implemented interventions are not having a positive impact on the outcomes and document these processes in the QIP Summary Form.

Strengths

AHF demonstrated an excellent application of the Design stage, meeting 100 percent of the requirements for all applicable evaluation elements for this stage for both QIPs.

For the *Advance Care Directives* QIP, AHF was able to improve care for its members by increasing the number of AHF Medi-Cal members with documented advance care directives. The QIP interventions resulted in significantly more members having documented advance care directives in Remeasurement 1 when compared to baseline.

Opportunities for Improvement

AHF has the opportunity to ensure that all required documentation is included in the QIP Summary Form. The MCP should refer to the QIP Completion Instructions prior to submitting the QIP to ensure completeness of the data. For its *CD4 and Viral Load Testing* QIP, the MCP should assess if barriers need to be re-prioritized, existing interventions need to be revised, or new

interventions need to be implemented. Additionally, the MCP should implement organization-wide initiatives aimed at improving performance. Finally, the MCP should ensure that it has processes in place to monitor interventions and determine why implemented interventions are not having a positive impact on the outcomes and that it documents these processes in the QIP Summary Form.

Conducting the EQRO Review

In addition to conducting mandatory federal activities, DHCS periodically assesses the perceptions and experiences of MCMC beneficiaries as part of its process for evaluating the quality of health care services. For full-scope MCPs, DHCS contracted with HSAG to administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[9] survey. Specialty MCPs are required to administer their own annual consumer satisfaction survey to evaluate Medi-Cal member satisfaction regarding care and services provided by the MCPs.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG reviewed AHF's member satisfaction survey description, survey results, and AHF's analysis.

AHF contracted with Decision Support Systems, LP (DSS), to conduct a CAHPS survey in 2013. DSS assessed the same areas for AIDS Healthcare Foundation that were assessed by HSAG for the full-scope MCPs and also assessed *Health Promotion and Education* and *Coordination of Care*. The overall results of the survey showed that members were satisfied with the services being provided by the MCP. DSS identified the following items as most important in driving the overall MCP rating:

- Prescription plan (got needed prescriptions, prescription plan overall)
- Private home care provider (PHCP) nurse (satisfied with help from nurse, satisfied with treatment plan)
- How well doctors communicate (shows respect, spends time, clearly explains, listens carefully)
- Overall ratings (personal doctor, specialist)
- Customer service (gave information needed, treated with courtesy/respect)
- Getting care quickly (urgent care, got care within 24 hours)

[9] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Strengths

Results from AHF's CAHPS survey showed that members were satisfied with the health care services being provided by the MCP.

Opportunities for Improvement

Of the 14 items identified as most important in driving the MCP's member satisfaction rating, the following items were identified as ones with the most opportunity for improvement:

- PHCP nurse (satisfied with help from nurse, satisfied with treatment plan)
- How well doctors communicate (shows respect)
- Customer service (gave information needed, treated with courtesy/respect)
- Getting care quickly (urgent care, got care within 24 hours)

Conducting the Review

Accurate and complete encounter data are critical to the success of managed care programs. The completeness and accuracy of these data are essential in DHCS's overall management and oversight of its Medi-Cal MCPs. In order to examine the extent to which encounters submitted to DHCS by MCPs are complete and accurate, DHCS contracted with HSAG to conduct an encounter data validation (EDV) study.

Methodology

During the reporting period, HSAG evaluated two aspects of the encounter data for each MCP. First, HSAG evaluated the information systems and processes of each MCP. Secondly, HSAG performed a comparative analysis between the encounter data housed in the DHCS data warehouse and the encounter data submitted to HSAG from each MCP's data processing system.

In the first EDV activity, HSAG conducted a desk review of the MCPs' information systems and encounter data processing and submission. HSAG obtained the HEDIS Record of Administration, Data Management, and Processes (Roadmap)[10] completed by the MCPs during their NCQA HEDIS Compliance Audit™. In addition to using information from the Roadmap, HSAG prepared a supplemental questionnaire that focused on how the MCPs prepare their data files for submission to the DHCS data warehouse.

Concurrent with the review of the MCP information systems and processes, HSAG used the administrative records (claims/encounters) in each MCP's claims processing system to evaluate the extent to which the encounters submitted to DHCS were complete and accurate. HSAG evaluated the encounters submitted to DHCS with a date of service between July 1, 2010, and June 30, 2011, and submitted to DHCS on or before October 31, 2012, for the following four types of encounters:

- Medical/Outpatient
- Hospital/Inpatient
- Pharmacy
- Long-Term Care

[10] The Roadmap is a tool used by MCPs to communicate information to the HEDIS auditor about the MCPs' systems for collecting and processing data for HEDIS.

All encounters submitted to HSAG by the MCPs underwent a preliminary file review. The preliminary file review determined whether any potential data issues identified in the data files would warrant a resubmission. The comparative analyses evaluated the extent to which specified key data elements in DHCS's data warehouse are matched with the MCP's files in the following categories:

- Record Completeness
- Element-Level Completeness
- Element-Level Accuracy

The *Medi-Cal Managed Care Technical Report, July 1, 2012–June 30, 2013,* provides an overview of the objectives and methodology for conducting the EQRO review.

AHF's 2012–13 MCP-Specific Encounter Data Validation Study Report contains the detailed findings and recommendations from the EDV study. A brief summary of the findings and opportunities for improvement is included below.

Encounter Data Validation Findings

Review of Encounter Systems and Processes

The information provided in AHF's Roadmap and supplemental questionnaire demonstrated that the MCP has procedures in place for the creation, validation, correction, and ongoing monitoring of encounter data. AHF's error rate is generally between 1 and 3 percent of the total claims submitted to DHCS. The MCP has an internal control program that ensures claims are adjudicated accurately and processed for timely payment.

Record Completeness

Overall, AHF had record omission and record surplus rates of 10 percent or less, indicating relatively complete data when comparing DHCS's data and the encounter data extracted from AHF's data system for this study. AHF's rates were better than all statewide rates, except for one. The record omission rate of 9.6 percent for the Medical/Outpatient claim type was worse than the statewide record omission rate of 4.1 percent. The record omission for the Medical/Outpatient claim type was mainly due to the records with dates of service in July 2010 and August 2010. For the records included in the data AHF submitted to HSAG but not in the DHCS data, more than 85 percent had beginning dates of service in July 2010 and August 2010.

Data Element Completeness

AHF had element omission and element surplus rates of 0.0 percent for all of the key data elements in the Pharmacy claim type. The Medical/Outpatient claim type also had high data element completeness with low element omission rates for all key data elements except the element omission rate of 12.4 percent for the *Referring/Prescribing/Admitting Provider Number*. Overall, AHF rates met or exceeded the respective statewide rates for the majority of the element omission rates and for all of the element surplus rates. The *Referring/Prescribing/Admitting Provider Number* was the only data element that performed below the statewide element omission rate.

Data Element Accuracy

AHF had 100.0 percent data element accuracy for most of the key data elements. The *Billing/Reporting Provider Number* for the Medical/Outpatient claim type was the only data element with a substantially lower element accuracy rate of 52.4 percent, which fell below the statewide rate by 38 percentage points. This discrepancy appeared to be due to different types of provider numbers, with nearly 90 percent of the difference due to two billing/reporting provider numbers in DHCS's data and one billing/reporting provider number in the data AHF submitted to HSAG. Although the *Rendering Provider Number* and *Provider Specialty* had minor inaccuracies between the matched records, both of the element accuracy rates exceeded the respective statewide rates.

The Pharmacy claim type had an all-element accuracy of 100.0 percent and exceeded the statewide rate by more than 20 percentage points. However, the Medical/Outpatient claim type had an all-element accuracy rate of only 40.7 percent, falling below the statewide all-element accuracy rate by 23.3 percentage points.

Recommendations

Based on its review, HSAG recommends the following:

- AHF should investigate why the Medical/Outpatient records from some months (i.e., July 2010 and August 2010) were missing from the DHCS data warehouse and create strategies to ensure all records are submitted to DHCS.
- Although the record surplus rate for the Pharmacy claim type performed better than the statewide rate, there is room for improvement. HSAG noted that more than 80 percent of the additional Pharmacy records in the DHCS data had dates of service in the first half of January 2011 and the second half of June 2011. AHF should investigate the reason(s) and apply appropriate quality control procedures to avoid similar issues with future data submissions.
- Although the file from the DHCS data warehouse did not contain any *Referring/Prescribing/*Admitting *Provider Number* information, AHF provided the provider numbers

to HSAG for approximately 12 percent of the Medical/Outpatient records. However, the majority of the *Referring/Prescribing/Admitting Provider Number* provided in the data AHF submitted to HSAG had the same value as the respective *Rendering Provider Number*. AHF should investigate whether more values for the data element *Referring/Prescribing/Admitting Provider Number* can be submitted to DHCS.

- AHF should investigate the low element accuracy rate for the data element *Billing/Reporting Provider Number* and take actions to improve the accuracy for this data element.
- For the matched Medical/Outpatient records, 88.4 percent were missing values for the data element *Rendering Provider Number*. This element absence rate was relatively high compared to the statewide rate. AHF should investigate whether more values for the data element *Rendering Provider Number* can be submitted to DHCS.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Although HSAG uses a standardized scoring process to evaluate each full-scope Medi-Cal MCP's performance measure rates and QIP performance in the areas of quality, access, and timeliness domains of care, HSAG does not use this scoring process for specialty MCPs due to the small size of the specialty MCPs' populations. To determine the degree to which specialty MCPs provide quality, accessible, and timely care to beneficiaries, HSAG assesses each specialty MCP's performance related to medical performance and MR/PIU reviews (as applicable), performance measure rates, QIP validation, QIP outcomes, member satisfaction surveys, and the accuracy and completeness of the MCP's encounter data.

Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.[11]

DHCS uses the results of performance measures and QIPs to assess care delivered to beneficiaries by an MCP in areas such as preventive screenings and well-care visits, management of chronic disease, and appropriate treatment for acute conditions, all of which are likely to improve health outcomes. In addition, DHCS monitors aspects of an MCP's operational structure that support the delivery of quality care, such as the adoption of practice guidelines, a quality assessment and performance improvement program, and health information systems. DHCS also uses the results of member satisfaction surveys to assess beneficiaries' satisfaction with the quality of the health care they receive from the MCPs.

HSAG reviewed the quality documents AHF submitted as part of the process for producing this MCP-specific evaluation report. The MCP's quality improvement program structure supports the

[11] This definition of quality is included in Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocols Introduction: An Introduction to the External Quality Review (EQR) Protocols*, Version 1.0, September 2012. The definition is in the context of Medicaid/Children's Health Insurance Program MCOs, and was adapted from the IOM definition of quality. The CMS Protocols can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

provision of quality care to the MCP's members and includes continuous quality improvement goals and processes.

Both of the MCP's required performance measures, *Controlling High Blood Pressure* and *Colorectal Cancer Screening*, fall into the quality domain of care. The rates for both measures were above the MPLs in 2013.

Both of the MCP's QIPs fall into the quality domain of care. The *Advance Care Directives* QIP was successful at significantly increasing the number of AHF Medi-Cal members with documented care directives, which positively impacts the quality of care for these members. The *CD4 and Viral Load* QIP has not been successful in ensuring members receive at least three CD4 and Viral Load tests.

HSAG's review of AHF's CAHPS survey results found that members appear to be satisfied with the quality of care being provided by the MCP.

Overall, AHF showed average performance related to the quality domain of care based on the MCP's 2013 performance measure rates (which reflect 2012 measurement data), QIP validation results, and CAHPS results.

Access

The access domain of care relates to an MCP's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries. DHCS has contract requirements for MCPs to ensure access to and the availability of services to their MCMC members and uses monitoring processes, including audits, to assess an MCP's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services. DHCS uses medical performance reviews, Medi-Cal Managed Care Division reviews, performance measures, QIP outcomes, and member satisfaction survey results to evaluate access to care.

When reviewing the quality documents AHF submitted as part of the process for producing this MCP-specific evaluation report, HSAG found activities and goals with a focus on ensuring members' access to needed care.

AHF fully resolved the finding in the area of Member Services from the June 2010 MR/PIU review, ensuring that all required information is included in the MCP's EOC document.

Both of the MCP's required performance measures, *Controlling High Blood Pressure* and *Colorectal Cancer Screening*, fall into the access domain of care. The rates for both measures were above the MPLs in 2013.

The *CD4 and Viral Load* QIP falls into the access domain of care. As indicated above, this QIP has not been successful at ensuring members receive at least three CD4 and Viral Load tests.

HSAG's review of AHF's CAHPS survey results found that members appear to be satisfied with their level of access to needed health care services.

Overall, AHF showed average performance related to the access domain of care based on the MCP's 2013 performance measure rates (which reflect 2012 measurement data), QIP validation results, and CAHPS results.

Timeliness

The timeliness domain of care relates to an MCP's ability to make timely utilization decisions based on the clinical urgency of the situation, to minimize any disruptions to care, and to provide a health care service quickly after a need is identified.

DHCS has contract requirements for MCPs to ensure timeliness of care and uses monitoring processes, including audits and reviews, to assess MCPs' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures that assess if a health care service is provided within a recommended period of time after a need is identified are used to assess if MCPs are ensuring timeliness of care. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

AHF's description of its quality improvement program provides details about the MCP's activities related to enrollee rights, grievances, and utilization management, which all impact the timeliness of care delivered to members.

AHF's self-report indicates that the MCP has a process in place to ensure grievance resolution letters are sent within the required time frame and that during the reporting period, 97 percent of grievance resolution letters (35/36) were sent within the required time frame. While 97 percent is an improvement over the 94 percent observed during the June 2010 MR/PIU review, it does not meet the State's requirement that 100 percent of grievance resolution letters must be sent within the required time frame.

HSAG's review of AHF's CAHPS survey results found that members appear to be satisfied with the time it takes to receive health care services.

Overall, AHF showed average performance related to the timeliness domain of care based on the MR/PIU review results and the MCP's CAHPS results.

Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2011–12 MCP-specific evaluation report. AHF's self-reported responses are included in Appendix A.

Recommendations

Based on the overall assessment of AHF in the areas of quality, timeliness, and accessibility of care, HSAG recommends the following to the MCP:

- Ensure that 100 percent of grievance resolution letters are sent within the required time frame.
- Since AHF has not yet reached its goal to attain NCQA's 90th percentile for the *Controlling High Blood Pressure* and *Colorectal Cancer Screening* measures, consider conducting a causal/barrier analysis to identify the factors preventing the rates for these measures from improving. Once the barriers are identified, the MCP can identify improvement strategies to address the priority barriers.
- To improve performance related to QIPs:
  - Refer to the QIP Completion Instructions prior to submitting QIPs to ensure that all required documentation is included in the QIP Summary Form.
  - For its *CD4 and Viral Load Testing* QIP:
    - Assess if barriers need to be re-prioritized, existing interventions need to be revised, or new interventions need to be implemented.
    - Implement organization-wide initiatives aimed at improving performance.
    - Ensure that the MCP has processes in place to monitor interventions and determine why implemented interventions are not having a positive impact on the outcomes and that it documents these processes in the QIP Summary Form.
- Review the detailed CAHPS results report from DSS, and develop strategies to address the priority areas of:
  - PHCP nurse (satisfied with help from nurse, satisfied with treatment plan)
  - How well doctors communicate (shows respect)
  - Customer service (gave information needed, treated with courtesy/respect)
  - Getting care quickly (urgent care, got care within 24 hours)
- Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies to address the recommendations to ensure accurate and complete encounter data.

In the next annual review, HSAG will evaluate AHF's progress with these recommendations along with its continued successes.

Appendix A. MCP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

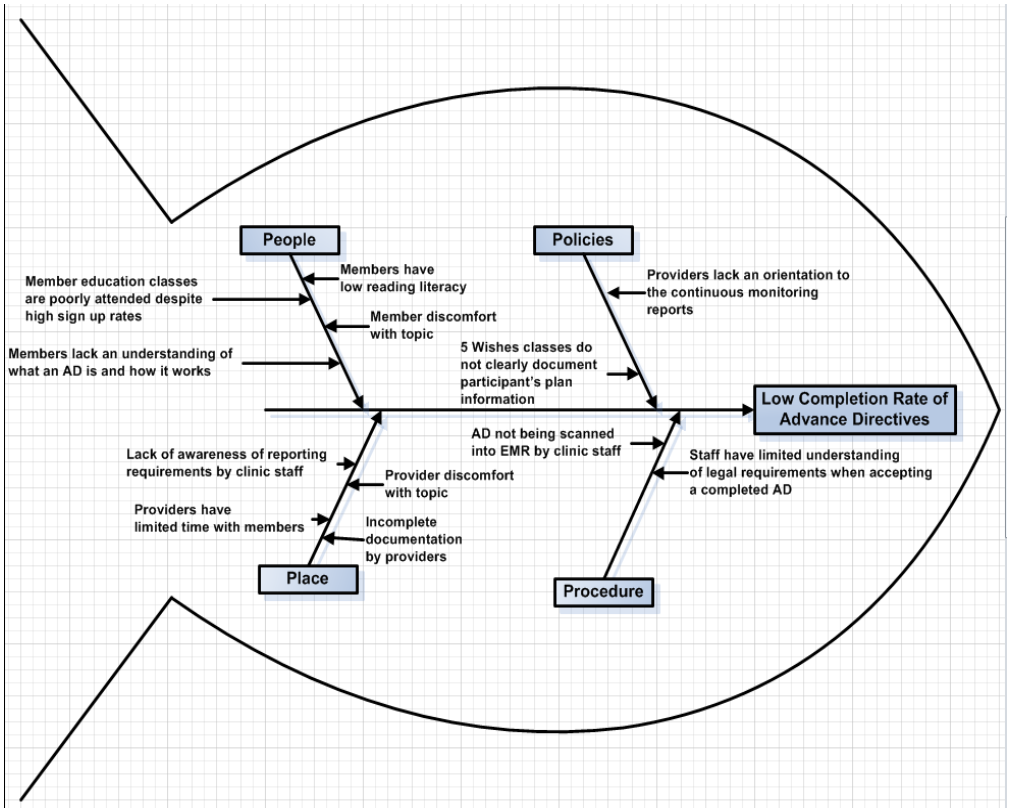
for AIDS Healthcare Foundation

The table below provides external quality review recommendations from the July 1, 2011, through June 30, 2012, Performance Evaluation Report, along with AHF's self-reported actions taken through June 30, 2013, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

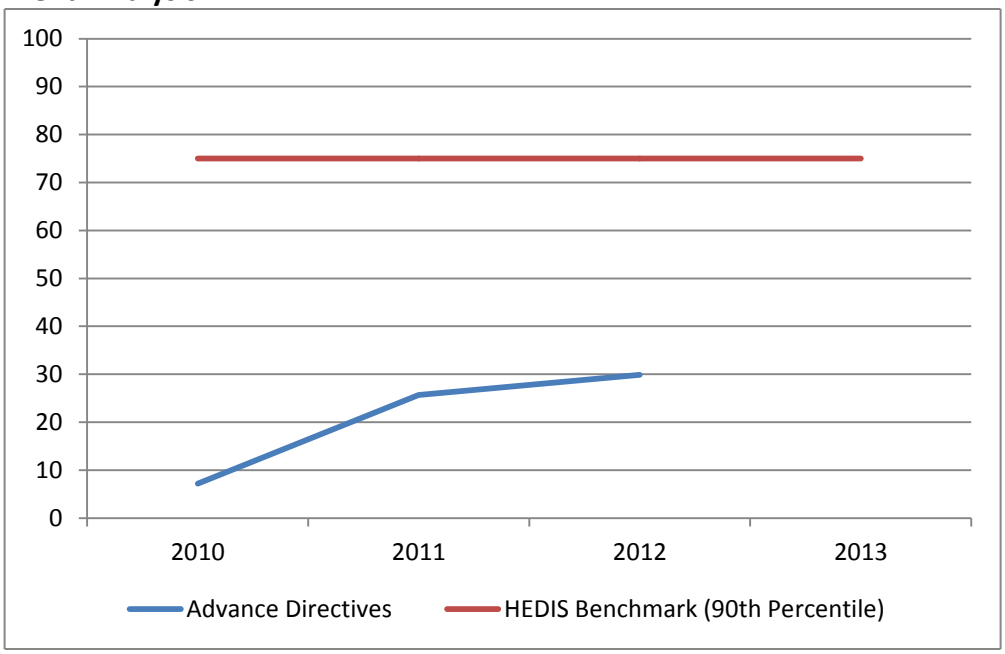
Table A.1—AHF's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2011–June 30, 2012 Performance Evaluation Report

2011–12 External Quality Review Recommendation	AHF's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
1. Specify the processes the plan will use to ensure resolution letters are sent within the required time frame and report on the monitoring results to demonstrate whether AHF is meeting the requirements.	Upon receipt of a new grievance, the project coordinator reviews the Investigation Case Form to verify the receipt date for the grievance and adds the date that the resolution letter is due. This information is calculated using a formula in the Grievance Log. The coordinator confirms that the due date is calculating correctly based on the receipt date. Timeliness results for grievances are monitored weekly at the Medical Administration meeting. In the action period, 97 percent (35/36) of grievance resolution letters were sent within the time frame requirements.
2. Revise the plan's evidence of coverage document to include all required information.	EOC/DF (Membership Guide) revised for the Knox-Keene application that complies with DMHC regulations. DMHC approved this document. The Notice of Approval was signed July 27, 2012.
3. Implement a data collection process to freeze data used to create annual HEDIS rates so they can be recreated.	In November 2012, AHF contracted with an NCQA-Certified software vendor, Innoapp, to accept and process AHF's HEDIS data. The data collection procedure requires a data file to be submitted to Innoapp at specified times during the HEDIS timeline. Upon receipt of the data file, Innoapp produces the rates based on the data received and data are frozen so HEDIS rates can be recreated.

<table>
<tr><th>2011–12 External Quality Review Recommendation</th><th>AHF's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation</th></tr>
<tr><td>4. Assess the processes that are working to assist members in controlling their blood pressure and ensure the processes are being implemented plan-wide.</td><td>AHF identified the following interventions that contribute to appropriate blood pressure control. The activities are as follows:
1. Member Newsletter (December 12, 2012): article "High Blood Pressure" in the Winter 2012 Positive Outlook distributed to all plan members. Available in English and Spanish.
2. Health Care Center Education (June 2013): new media created for the Health Care Center video monitors, which was approved by Medical Administration. Implementation for media messaging for control and monitoring of hypertension is underway.
3. Quit for Life (April 2013): AHF implemented the Quit For Life Program that is sponsored by the American Cancer Society and Alere Wellbeing. It is offered to any plan member who wishes to quit using tobacco products. The program is directly promoted to members (program notices and telephone calls) and providers (medical staff meetings, direct e-mail and newsletter).</td></tr>
<tr><td>5. Identify the strategies that are resulting in appropriate colorectal cancer screening so the plan can duplicate the strategies across all providers.</td><td>AHF identified the following interventions that contribute to appropriate colorectal cancer screenings. Each is standardized across the organization and listed below.
1. Newsletters (ongoing): Each member newsletter, Positive Outlook, contains a reminder for Colorectal Cancer screening. Every provider newsletter, Positive Practice, colon cancer is included in the standing section on the Screenings/Vaccinations.
2. Sharing HEDIS performance results with providers (6/7/13, 7/5/13): Colorectal Cancer Screening results were presented to AHF providers.
3. Provider reports (ongoing project): Added customized reports from the HEDIS software vendor to track HEDIS measures at the provider and member level.</td></tr>
<tr><td>6. Provide documentation of the QIP barrier analysis, providing the data and the rationale for how the barriers are prioritized.</td><td>AHF used three main sources of data when conducting its barrier analysis of Advance Directive rates.
<table>
<tr><th>Data Source</th><th>Key Findings</th></tr>
<tr><td>Chart Review</td><td>A sample of charts was reviewed to track progress of advance directive discussions and completed forms.
Priority Barrier Identified: Clinic staff does not scan completed advance directive forms into the Electronic Medical Record.</td></tr>
<tr><td>Frequency Counts from 5 Wishes Classes</td><td>Frequency counts of attendees were collected at each 5 Wishes session.
Priority Barrier Identified: 15 percent of attendees were Positive Healthcare (PHC) members.</td></tr>
<tr><td>Qualitative Key Informant Interviews</td><td>The SWOT and Fishbone analyses were developed from discussions with relevant staff to highlight clinic-level barriers.
Priority Barrier Identified: Provider and member discomfort with advance directive topic.</td></tr>
</table></td></tr>
</table>

2011–12 External Quality Review Recommendation	AHF's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	Below are the three components of AHF's barrier analysis: Fishbone Diagram, SWOT Analysis, and a Trend Analysis. **Fishbone Diagram** 

<table>
<tr><th>2011–12 External Quality Review Recommendation</th><th>AHF's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation</th></tr>
<tr><td></td><td>
SWOT Analysis
<table>
<tr><td><u>Strengths</u>
Bimonthly Five Wishes classes (offered in English and Spanish)
Formal communications among administration and providers on performance goals and results
EMR captures advance directive (AD) discussions and completed forms
Providers dedicated to improving performance of AD completion
Ongoing AD provider monitoring reports available</td><td><u>Weaknesses</u>
Staff have limited understanding of legal requirements when accepting a completed AD
Providers lack an orientation to the continuous monitoring reports
AD not being scanned into EMR by clinic staff
Physicians have a limited amount of time with patients during visits and a competing list of issues to cover
Some providers have low advance directive completion and discussion rates</td></tr>
<tr><td><u>Opportunities</u>
Imbed Care Managers/Nurses into the AD process to target PHC members during home visits
Create a one-page handout to improve provider participation in AD discussions
Display messages about AD on waiting room monitors to reinforce AD discussions
Address provider discomfort around advance directives</td><td><u>Threats</u>
Member education classes have limited attendance despite high sign-up rates
Interventions reach highly engaged members only
Attitudes, beliefs, and discomfort that prevent members and providers from discussing/completing advance directives are difficult to change</td></tr>
</table>
</td></tr>
</table>

2011–12 External Quality Review Recommendation	AHF's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation
	Trend Analysis 

<table>
<tr><th>2011–12 External Quality Review Recommendation</th><th>AHF's Self-Reported Actions Taken through June 30, 2013, that Address the External Quality Review Recommendation</th></tr>
<tr><td>7. Document how QIP interventions address high-priority barriers.</td><td>During this QIP cycle for the Advance Directive (AD) QIP, barriers were analyzed and those related to provider or member completion of AD were considered high-priority and targeted for intervention. Below is a partial list of interventions for the improving rates of Advance Care Directives QIP for high priority barriers.
<table>
<tr><th>Intervention</th><th>Barrier</th></tr>
<tr><td>Incentives (February 2013): Incentive of $10 gas card or grocery card for attendance at Five Wishes class.</td><td>Poor class attendance at Five Wishes classes</td></tr>
<tr><td>Provider Report Card</td><td>• Lack of awareness of reporting requirements
• Incomplete documentation of advance directives in EMR
• No audit report to capture advance directive rates</td></tr>
<tr><td>Member Newsletter (August 13, 2012): Annual article in Positive Outlook discussing importance of completing an advance directive and available resources to assist members in completing one.
Spanish Five Wishes Class (March 8, 2013; June 7, 2013): Spanish-speaking facilitator trained and available to teach class on routine basis. Two classes held during reporting period.</td><td>• Discomfort discussing topic
• Limited knowledge of what an advance directive is and how it works</td></tr>
</table></td></tr>
<tr><td>8. Document the method that will be used to evaluate each QIP intervention and provide the results of the interventions' evaluations for each measurement period.</td><td>For this measurement cycle, a plan is included for future evaluation of each intervention using both process and outcome measures. For example, one intervention for the Advance Directive QIP is an advance directives prompt in the EMR targeting health care providers. The future plan of evaluation for this intervention utilizes the following indicators.
• # of discussions/education prompts completed in the measurement period
• Quarterly analysis of the Provider Compliance Report
QIP activities and results for the measurement periods are reviewed on an at least quarterly basis and reported to the Quality Management Committee.</td></tr>
</table>