Group Health

2014 – 2016 Quality Plan and Program Description

2016 Update

(Pending) Approval Schedule

Quality Oversight Team (QOT): January 29, 2016
Executive Leadership Team (ELT): February 23, 2016
Quality Committee of the Board (QCOB): February 23, 2016
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2016 GROUP HEALTH QUALITY PLAN

Introduction

Group Health Cooperative enjoys a rich history of accomplishments in quality improvement. We have been pioneers in evidence-based medicine, in the use of information technology to improve health care, in applying research to clinical practice, and in defining the ideal model for care delivery for patients with chronic disease. We continue to lead our improvement work on the basis of evidence-based medicine. We do this by leveraging information technology to improve the patient care process and experience and applying research to clinical practice. This assists us in defining the ideal model for care delivery for the range of patient health status, from wellness to chronic disease management.

As highlighted in the 2015 Quality Program Evaluation, Group Health continued its position as one of the best and most innovative health care organizations in the geographic area served by Group Health as well as across the country. This was demonstrated by retaining our accreditation for NCQA, retaining the top rating on quality care measures in the Washington Health Alliance, and continuing to receive a high score of 4.5 in Medicare’s Star rating, remaining in the top twenty percent of Health Plans in the country. With the passage of health care reform legislation in 2010, our integrated approach has demonstrated our ability to deploy innovative solutions that create better health while challenging us to accelerate our work to drive lower medical expense trends.

In 2015, we continued to adopt a disciplined examination of our costs with a focus on making care processes efficient and effective. While our 2015 quality performance rankings for activity in 2014 remained excellent, we did experience a decline from the year before and have had steady but not improved performance in 2015 based on monthly HEDIS clinical performance data. Our service satisfaction as measured by monthly Press Ganey reporting in our owned and operated Delivery System has been an area of continued focus this past year with improvement through September but not yet sustained over time.

We believe that we lost some discipline and focus in our reliable application of care processes that drive quality improvement. This is primarily due to a focus on cost containment strategies across the Enterprise, resulting in staff reductions combined with a restructure of leadership within the Group Practice, leading to the majority of operational positions with new leaders in those roles. We have assessed performance and prioritized key tactics until year end to sustain performance. Despite the challenges of the ever-changing health care environment, we continue to remain confident of our ability to meet these coming challenges. We believe that all Group Health members will continue to experience and increasingly be delighted with our focused efforts to provide care that is safe, high quality, and easy to access.

Vision for Quality

Our vision for quality is predicated on our continued belief that Group Health’s approach to care delivery means better clinical outcomes for our members at an affordable price. Our integrated approach to care delivery and financing continues to distinguish us from other health care providers and health plans in this changing market with an opportunity to leverage these advantages.
While our medical group remains central to our ability to provide quality care and service at a lower cost within our owned and operated Delivery System, we must continue work to ensure a future that provides high quality care for our members regardless of where they receive it. Increasingly, employer purchasers and members are demanding demonstrated value via more effective solutions for managing health, wellness and chronic conditions. Our future means that all our members will consistently say that Group Health provides:

- The best care, information, expert advice, and support
- Outstanding service every time
- Value that exceeds needs and expectations

We believe in using the best available scientific evidence in our decision-making, tools, and practices. We believe in the importance of providing consistent care in our processes, reducing unwarranted variation and building reliable clinical information systems to support care delivery. We believe that care ought to be patient centered, providing timely, expert information to patients that allows them to make better care decisions.

We also believe that a productive relationship between physician, practice team, and patient is key to better health care outcomes, safer care, and a better care experience for the patient. These beliefs are the key components of the Planned Care Model (Wagner, et. al., MacColl Institute for Healthcare Innovation), Group Health’s model for care delivery that guides the implementation of our vision for quality. We know that when the key components of the model are supported by leaders and organized around a patient-centered, integrated system of care, we will achieve health outcomes that out-perform our competitors.

The GHC quality vision is aligned with the Triple Aim which is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. The premise of the Triple Aim is to simultaneously pursue three dimensions (which are called the Triple Aim)

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

Group Health is uniquely positioned to achieve our quality vision thanks to the excellence of our providers, our ability to efficiently and effectively organize care around patient populations, and our use of technology to support personalized care.

**Patient Centered Care**

Patient centered care is a singular strategy that reliably provides our patients opportunities to address their wellness and chronic care needs whenever we work with them. We continue to leverage our investments in Epic, My Group Health and other clinical information systems (e.g. care management and pharmacy systems) to make the right thing the easy thing to do, with activated patients and clinicians.

The three major tactics that support this work are:

1. **Opportunistic Care**: The most efficient approach toward delivering comprehensive care is to anticipate all of a patient needs and deliver them at the time of scheduled services. We will continue to build and strengthen point of service tools, including those for patients, with information that allows
clinical teams the ability to address needed preventive and scheduled chronic care services for the patient at the time of the visit. Our goal is that the majority of our patients finish their visit with us with all their clinical needs having been recognized.

2. **Patient Activation and Outreach:** We will continue to invest in improving and developing tools to activate patients to act to improve their health through reminder systems (birthday and gap letters, IVR, My Group Health reminders) and our health assessment tool that identify all of the opportunities to improve both preventive and chronic illness care. We will continue to support opportunities for patient self management including methods for participating in behavior change to improve self management of chronic conditions (e.g., health coaching and Living Well With Chronic Conditions workshops) and use of specific tools for shared decision making for preference based care interventions.

3. **Feedback:** Performance improves only when metrics are well defined and available for ongoing visual inspection. We will continue to improve the completeness and timeliness of performance reporting, including the use of tools that support patient-centered rather than disease oriented performance. We will continue to evolve the incentive system in primary care and as appropriate Specialty, across the Enterprise to support clinical and service excellence by moving away from an emphasis on productivity towards service and clinical quality outcomes among provider panels and clinic populations.

**Reliability: Characteristics of Effective Quality Improvement**

The Committee on the Quality of Health Care in America has identified six characteristics of quality improvement that need to be present to effectively address key areas where America’s health care system functions at sub-optimal levels. Group Health will continue to apply these characteristics while working to create and sustain a culture of reliability where all care processes are performed as intended consistently over time. The characteristics essential for an effective quality program include:

- **Safe:** Preventing injury to patients.
- **Effective:** Providing services that are based in scientific evidence.
- **Patient centered:** Providing care that is respectful and responsive to the patient preferences, needs, and values and ensures that patient values guide all clinical decisions.
- **Timely:** Reducing waits and sometimes harmful delays for those who receive care and for those who give care.
- **Efficient:** Avoiding waste, including waste of equipment, supplies, processes, ideas and energy.
- **Equitable:** Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status

A culture of reliability, when developed and sustained, means that systems and processes are performed as intended consistently over time. When that happens, we provide safe care with no harm, evidence based care that is clinically excellent, patient centered care that is most satisfying and efficient and effective care that contributes to our affordability.
Reflections Regarding Achievement of 2015 Quality Goals

Target: Achieve 90th percentile performance in HEDIS for six targeted populations

The method we have utilized to monitor progress towards achievement of our organizational clinical quality targets has been to monitor progress for six prioritized populations across the Enterprise. This year, we set a target of 90th percentile for measures associated with six population groups including diabetes, heart disease, a management of depression and asthma, immunizations and cancer screening. To date, we are NOT on track to achieve this target.

We did successfully launch tactical efforts to support patient and provider activation in the form of additional clinical quality tools (e.g., Epic dashboard, PCER for contracted Network) and expanded outreach capability throughout the Enterprise. However, our performance for most of 2015 based on monthly feedback has demonstrated that we have sustained about the same performance since January and are unlikely to achieve the expected targets by year end. Root cause analysis conducted by operational and quality leaders identified several factors for disappointing performance that include:

- Competing priorities including shift in focus to cost reduction strategies and a significant restructure of all operational leaders in the Group Practice at the end of 2014 and into 2015 has interfered with the ability of leaders to stay on track with several aspects of the quality work.
- Primary care was reduced by five percent with decreases in physician and support staff staffing. In addition, the role of the RN in primary care was revised with loss of dedicated time for chronic disease management, clinical pharmacists were centralized, all of which impeded the ability to provide reliable outreach and collaborative management of chronic disease.
- A large number of new leaders at several levels who are learning their roles and those of their teams has interfered with a reliable application of opportunistic care, outreach, chronic disease management and use of workflow and reporting tools.
- Inconsistent leadership rounding, variation in use of visual systems and lack of consistent use of in process and outcome metrics and a disciplined development of local action plans for improvement.

Quality and operational leaders conducted an assessment of quality performance in Q3 to understand gaps and opportunities in order to develop a focused action plan that prioritized tactics and accountabilities to ensure improvement occurred for the remainder of 2015 but more importantly, that work processes requiring staffing and re-design be prioritized to optimize performance in 2016. The action plan included re-orientation of quality work, priorities, and use of reliable workflow for all new leaders in the Group Practice, revision of visual systems and re-establishment of in process metrics, re-prioritized outreach for targeted populations, and additional Enterprise wide outreach in letters and IVR before year end. With the publication of September data, there is an indication this trend has started to change.

The enterprise quality dashboard was improved in 2015 with fewer measures and a focus on more traditional quality focus areas: Clinical Effectiveness, Service, Care Management, Patient Safety, Compliance, Documentation and Coding. There are still opportunities to identify and track metrics that directly correlate to interventions that drive improvements. The customer satisfaction metrics have more satisfactorily measured data with actionable information in the Group Practice but not yet for performance in the contracted Network. The measurement plan for clinical HEDIS metrics was changed in 2015 to include a targeted set of HEDIS metrics that are the highest priority based on clinical importance, population size and impact on affordability for specific focus. The measure set has subscales for focus and maintains 90th percentile as overall goal. A Quality Focus Report was designed that provided monthly performance data from the Enterprise to the
provider level and was popularly received and is regularly visually posted throughout ambulatory care to support monthly tracking of performance.

Where there has been consistent checking at the highest levels (Quality Oversight Team) and reliable escalation of issues where performance is below target, there have been delays in both recognizing and taking direct and sustainable action regarding clinical quality, largely for all the reasons cited above. We have improved but not been reliable in the implementation of tier 1 through tier 4 metrics especially in the Group Practice and inconsistent in following up after an issue has been escalated.

**Target: Improving the Customer Experience**

While CAHPS performance (2015 data) declined in several areas, Group Health also performs about average, not exceptional, compared to local provider groups as well as nationally. In 2014 and continuing in 2015, the Group Practice laid the groundwork for focused improvement in customer service behaviors with the implementation of a toolkit, regular reporting, analysis and consultation to local teams about suggested methods for focus and expectations for the use of key service behaviors with all patient interactions. Press Ganey was established as the vendor for monthly surveys and targets for performance for each clinic and the Group Practice overall were established for achievement by year end.

To date, service performance has slightly improved in the Group Practice since January 2015 as demonstrated by Press Ganey results. The establishment of a Safety and Service Reliability Core Team for the Group Practice continues to provide the structure, leadership and expected accountabilities to continue this success in 2016. In addition, there was a renewed focus to assess the care experience across the Enterprise and in 2015; a customer experience roadmap was designed with the identification of “four moments of truth” that has resulted in the development of a set of strategies and tactics for implementation beginning in Q4, 2015 and continuing through 2016. The four areas of implementation include seeking plan information, getting care quickly, accessing recommended tests and treatment, and dealing with claims.

**Successes in 2015:** We made progress and had some key successes in the following:

**Patient Safety**
- Promotion of a just culture through the completion of reliability training completed to over ninety percent of Group Practice leaders and staff in 2015, to lead with reliability by implementing known behaviors that result in a highly reliable organization.
- Have adopted and improved the system for identification of SSEs, accountability for action plans, integration of safety focus by transformation teams. Have continued to improve and strengthen the use of the patient safety “hot sheet” and system wide “harm report” to communicate events and follow-up to leaders to drive local and system wide improvements. This has resulted in a greater than fifty percent reduction of SSEs year to date compared to 2014. There are opportunities to identify and improve the transparency and systematic “spread” of lessons learned across the Delivery System.

**Care Management**
- Sustained performance in management of transitions and re-admissions with continued high performance in readmission rates and utilization of urgent and emergency care. Continued application of specific interventions to improve outcomes for several populations with complex, chronic conditions including end stage renal disease, congestive heart failure, and asthma.
Adoption of patient centered strategies:

- Successful implementation of standard work for use of targeted health maintenance reminders including batch ordering of “fit kits” for colon cancer screening for use by Consultative Specialty and the expansion of the new Epic dashboard for use by primary care providers to monitor their quality performance and identify specific patients for targeted outreach for a variety of clinical care gaps.
- Patient outreach was extended beyond the annual birthday letter with more use of IVR (interactive voice recognition) and targeted patient centered “gap letters” congratulating patients when care gaps are up to date and encouraging action to address overdue or coming due care gaps now. In addition, IVR was utilized by surveying all Medicare patients with the health outcomes survey questions to identify those in need of follow-up for specific issues related to mental health, physical health, physical activity and those at risk of falling. Analysis of outreach impact demonstrated that within one to six months after patients receive reminder letters compared to those who do not, patients will complete their tests up to eighty per cent of the time depending on the specific care gap.
- Sustained success of the Medicare 5 Star project team and ongoing effectiveness of interventions to improve and/or sustain performance in the part C and part D metrics demonstrated by a 4.5 Star ranking for performance year 2014.

Reducing Clinical Variation

- There was sustained performance for use of shared decision making and appropriate use of high end imaging across the Enterprise. New decision aids were introduced for maternity care and use of shared decision making videos was introduced in primary care to more proactively engage patients prior to their visit in Specialty. There was a reduction in unnecessary pap smears and the launch of a Choosing Wisely campaign with focused topics for members produced monthly. The production and launch of Resource Stewardship reports in the Group Practice establishes a foundation for improvement where there is opportunity to decrease variation.

Provider Engagement: Contracted Network

- In the contracted Network, there is evidence of gains in improvement with the more consistent use of clinical quality tools such as the Planned Care Exception Report, the application of the provider consultancy model to promote quality improvement in targeted provider groups, a number of local outreach strategies, the launch of a program to capture HEDIS data and the expansion of the quality incentive program in contracted provider groups.

2016 Quality Hypothesis to Achieve Goals

The execution of a focused Action Plan with critical tactics will achieve the 2016 quality goals. This will result in a more highly reliable organization with demonstrated improvement in the patient experience of care, including safety, service and clinical quality and will contribute towards reducing the per capital cost of health care. The hypothesis for achieving the 2016 goals includes:

- Committing to the integration of reliability as an organizing principle will result in more fully engaged leaders, providers and staff to achieve and sustain a patient safety, service and quality culture to optimize the patient experience.
- Closing the gap from current performance to the 90th percentile for cancer screening, immunizations, diabetes, heart disease, depression and asthma by increasing patient and provider activation,
opportunistically addressing the care gaps during each touch and giving timely feedback to the engaged provider and care team will result in improved clinical performance.

- If we invest in re-vitalizing the primary care medical home by refining the roles and responsibilities of the team including enhanced staffing, execute the use of consistent workflow and use of tools across operational areas, conduct reliable checking and monitoring with leadership rounding, use process and outcome metrics, then we will return to a consistent trend of improvement.

- Extending patient activation strategies and tactics across the Enterprise including our ability to evaluate effectiveness of impact to broaden use of tools and technologies to reach patients more often and in new ways will result in increased patient activation and improved outcomes.

Building upon the **lessons learned and successes from 2015**, we have sharpened our focus on the critical continued need to drive improvement within the current work while extending improvement efforts into new areas that leverage what we have learned and increase the rate of improvement. Fundamental to this work is the ability to continue to build reliable, consistent processes of care which include:

**Enhance our culture of reliability with a focus on safety first:**

- Continue to improve the accountability and culture for high reliability by building practice habits for leaders and staff, integrating reliability behaviors and tools into hiring, training and performance review and establishing goals, metrics and feedback loops.

- Implement reliability practice habits with a consistent use of patient safety transformation teams, development of patient safety coaches.

- Improve the measurement systems to maximize learning from patient safety events by improving the detection of events, optimizing cause analysis, and enhancing transparency in lessons learned.

**Improve the Customer Experience:**

- Continue the work in 2015 in the Group Practice with the implementation of a focused work plan to improve the reliability of the care experience as demonstrated by progress towards achievement of 90th percentile ranking for overall satisfaction with focused efforts on demonstration of behaviors by leaders and staff, improvements in access and all aspects of the patient visit.

- Further refine the tools and training to support Group Practice leaders in understanding performance data and focusing improvement efforts with educational curriculum, webinars and identification of “best practices” for improving the care experience.

- Collaborate with the patient safety team in the implementation of a system to capture safety occurrences and customer complaints and use as additional data source for identifying themes and targeted opportunities for improvement.

- Implement the prioritized strategies identified at an Enterprise level in the four targeted “moments of truth” areas.

**Improve the design and execution of patient centric strategies for prevention and chronic disease management by:**

- Improve and/or re-design the available Epic and Reporting tools that support patient centered strategies as well as improvements in documentation and coding to address chronic conditions.

- Improve the use and adoption of Shared Decision Making throughout the Delivery System.

- Continued deployment of patient-centered information technology tools and reminder systems to improve opportunistic care and outreach, and increase patient activation across the enterprise.
Improve the reliability of key processes that support clinical quality in the Group Practice:

- Strengthen the reliable work processes within each Region for opportunistic care and outreach, both in primary care and Specialty.
- Re-dedicate time for the team RN in primary care to implement case management and population management activities in collaboration with providers and clinical pharmacists.
- Continue the reliable use of a routine cadence and structure for leadership rounding that is patient centered with focus on safety, quality and service.
- Assure that care teams within pharmacy, lab, radiology, eye care and others reliably integrate population outreach and opportunistic reminders into workflow for targeted populations.

Improve the reliability of key processes that support clinical quality in the Contracted Network:

- Refine and further standardize the Network practice engagement model with tools, cadence, feedback and data analysis, adoption of “best practices” across provider groups.
- Evaluate and spread the use of incentives for quality performance.
- Continue to improve processes for data capture and targeted local improvement efforts with contracted provider groups.

In 2016, we will continue to monitor progress toward our goals using measures that are relevant to our customers and that can be benchmarked against other health care systems both locally and nationally. The HEDIS (Healthcare Effectiveness Data Information Set), CAHPS (Consumer Assessment of Healthcare Providers and Systems) and Medicare 5 Star quality measures are a core part of that performance measurement, target-setting, and monitoring process. Attention to the purchaser’s expectations, through eValue8, supported by the National Business Coalition on Health (NBCH), and interactions with our key purchaser groups will continue to carry Group Health forward in demonstrating its leadership in value-based purchasing.

These measures are comprehensive, covering a broad set of domains in clinical quality, care experience, and affordability. They allow us to continue to measure our progress and compare our results against other local and national health plans.

All quality improvement metrics in support of the Quality Plan goal will be monitored by the Quality Dashboard as approved by the Executive Leadership Team (ELT). The Group Health management system includes periodic reviews and adjustment processes to ensure achievement of goals and results. When planned actions are not executed or expected outcomes not achieved, countermeasures will be developed and activated.

Quality goals and progress toward those goals remain the accountability of the Quality Oversight Team and Executive Leadership Team, and ultimately, the Board of Trustees, who have delegated responsibility for oversight to the Quality Committee of the Board. The membership and accountabilities of these groups are described in the Quality Program Description.
QUALITY PROGRAM DESCRIPTION

Program Objective and Scope
A comprehensive Quality Program\(^1\) is essential to meeting organizational goals, carrying out its vision and promoting our approach to care delivery. The process for monitoring, evaluating and improving quality is designed in concert with the purpose and strategic plan of Group Health Cooperative. Two key components of the process include:

- Involvement of medical and behavioral health care professionals in the analysis of data to identify opportunities for improvement, and

- The use of data\(^2\) to assist with the delivery of high quality healthcare, ongoing monitoring and evaluation of important aspects of care and service, and continuous improvement of systems and processes.

Under the direction of the Group Health Cooperative Medical Director and GHC President/CEO, the Quality Program is designed to promote high quality, safe medical and behavioral health care, and superior service to Group Health (GH) and Group Health Options, Inc. (GHO) enrollees and other patients who receive services within Group Health in a caring, personalized manner that is respectful of member and individual member values and choices. The Group Health Medical Director and the GHC President/CEO delegate substantial responsibility for the quality program to the Medical Director for Quality and the VP of Clinical Excellence and Integration, who co-chair the Quality Oversight Team (QOT), the QI Committee for the organization. They are the designated leaders with substantial involvement in the QI program and are responsible for quality management and improvement activities. The quality assessment and improvement programs and outcomes are reviewed and approved annually by the Executive Leadership Team (ELT) and the Quality Committee of the Board (QCOB), as delegated by the GH Board of Trustees.

Group Health assumes accountability, through its Quality Program, for continuous quality improvement for all of our members for all product and plans, including Group Health Cooperative and Group Health Options Commercial and Medicare and Medicaid lines of business. Due to changes in the state’s contracting strategy for Medicaid and Basic Health, Group Health took a new approach to serving patients within these programs beginning July 1, 2012: Group Health now functions solely as a delivery system through a contract with Molina Healthcare to provide care for this population.

Using the principles of population-based care for organizing our improvement activities, Group Health addresses member needs in a patient-centered manner while simultaneously acknowledging special needs of our members, in particular, our culturally and linguistically diverse members and those with complex health needs. Group Health strives to provide the same quality of care to all patients regardless of language or communication barriers and provides onsite and telephone interpretation and written translation services to ensure members and patients, regardless of language and communication barriers, receive the highest quality of care. Group Health’s complex case management program, as described in the Care Management Program Description, is designed to help members with multiple chronic conditions by providing resources and support.

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\(^1\) The scope of the Group Health Cooperative quality program includes medical and behavioral health care, service, and care management in the owned and operated facilities and the contracted network, as well as patient safety and staff effectiveness.

\(^2\) Data sources include claims, encounter data, enrollment data, complaints and inquiries, utilization management data, and HEDIS data.
to address these complex health needs. Special attention is paid to our obligations for oversight and monitoring of the Behavioral Health Care quality improvement program and for specific vulnerable populations of our membership such as those in our Medicare program.

The scope of our Quality Program includes oversight, monitoring and improvement of behavioral health care for members. The medical director for Behavioral Health Support Services (BHSS) is the designated behavioral health care practitioner most involved in the behavioral health aspects of the QI program. He is a member of the Quality Oversight Team (QOT), BHSS Leadership Team (BHSSLT) and Clinical Excellence and Integration Team, assuring accountability and ongoing engagement in the Quality Improvement Program. The BHSSLT is the organization’s committee for improving quality for behavioral health services. Key tasks for BHSSLT include setting the department’s quality agenda and providing input into organization and divisional quality plans. This oversight includes monitoring, planning, and taking actions to improve key aspects of quality including HEDIS performance, access, continuity and coordination of care, confidentiality, patient satisfaction, referral and triage functions, under/over utilization, use of new technology, and patient safety. (see BHSSLT committee description). Behavioral health representation or input is solicited for multiple quality committees to ensure these important aspects of care are considered; e.g., Patient Safety, Care Management Committee, Medical Technology Assessment Committee (MTAC), Pharmacy and Therapeutics Committee (P&T Committee), and relevant clinical practice guideline teams.

The organization, with oversight by ELT and QOT, provides a number of structures to address the monitoring and improvement work of clinical quality, service quality, patient safety, and utilization/ care management in both medical and behavioral health care provided to Group Health and Group Health Options enrollees.
Quality Improvement Planning Process
Group Health sees its commitment to improving the performance of our health care system performance as a key strategy—contributing to overall organizational success and viability. The diagram below illustrates the quality improvement planning process relies heavily on ongoing performance monitoring and assessment to identify potential organizational quality improvement priorities.

- Approval of Quality source documents.
- High level oversight of Quality program and performance.
- Advise the Board of Trustees on strategic planning and resource allocation issues related to achieving and maintaining quality goals.

- Approve the Quality Program (Quality Program Description, Plan, and Evaluation).
- Oversight of Quality program and performance (i.e., Quality A3 and dashboard measures).
- Make resource decisions for strategic priorities, including the Quality Program.
- Set the Quality Agenda (Quality Vision, Priorities, and Performance Targets).

- Inform the strategic plan re: recommended organizational Quality priorities and performance goals and targets.
- Oversee the Quality Program, including the Care Management Program and Group Health Options, to assure it meets regulatory and accreditation requirements/standards; provide regular reports to ELT.
- Identify areas without systems to support continuous improvement or gaps in performance.

- Performance monitoring and analysis of QI activities/quality performance; identify potential gaps/concerns.
- Identify improvement opportunities and plan strategies/toolkits to use.
- Coordinate with centralized quality support resources.
- Provide status reports to QOT (linked checking).
- Share best practices.

Sources for Potential Quality Improvement Activities:
- Strategic Goal Deployment (organizational priorities)
- Quality Plan/Quality Performance Measures
- Local gaps/improvement opportunities that support system wide priorities
- Legal/Regulatory Requirements and feedback regarding opportunities identified
- New Customer/Market requirements or expectations (to incorporate in quality planning)

Board of Trustees and Quality Committee of the Board

ELT (Executive Leadership Team)

QOT (Quality Oversight Team)

Group Practice Division and Health Plan Division Leadership Teams

Enterprise Quality Functions: Clinical Excellence & Integration

(*Arrows indicate opportunities for interaction)
Quality Program Implementation

Implementation of our quality program continues to emphasize lean principles and adopting consistent and reliable processes in quality improvement. Previously, we focused on outcomes alone – meeting our customer requirements for clinical quality and safety, care experience and affordability without regard to how we achieved those results. That model left us with significant limitations in our ability to accelerate sustainable improvements – while heroism produced some important gains, it was not a sustainable model for the organization, and did not spread from site to site reliably. In 2016 we will continue to augment our work to ensure that key characteristics to improve quality are present in all of our operations. The attributes of successful, sustainable quality improvement that we will monitor include:

- Identification of customer requirements and the key processes that support meeting them.
- Development of reliable work processes that are sufficient to meet all of the requirements.
- Measurement of adherence to standards (defects in standard work processes).
- Establishment of in-process and outcome metrics, and regular tracking of performance.
- Use of visual controls to make the work and gaps visible.
- Evidence that progress towards goals is checked.
- Adjustments to plan that are supported by data.
- Implementation of counter measures.

Professionals from a variety of expert groups, including medical directors, front line physicians, consultant specialists, nursing staff, quality improvement staff, operational managers and others come together as a team that works with a high level of objectivity and integrity and utilizes sophisticated quality management tools and approaches. They analyze data to identify improvement opportunities, understand and identify variation in the care and service provided to members, and establish and develop system-wide approaches to meet agreed-upon quality outcomes.

To the greatest extent possible, quality improvement efforts are encouraged and supported at the local level. Health care and administrative teams are charged with reviewing performance according to the agreed-upon measures and goals, analyzing and agreeing upon the areas that require the most improvement and designing strategies to close performance gaps. These teams are supported in performing rapid-cycle continuous improvement activities. Performance data and expert consulting resources are available to assist local teams. This local level work is directly linked with the organizational goals that are agreed upon by the Executive Leadership Team. The teams are asked to share their progress on a quarterly basis to the Quality Oversight Team and to each other so that cross-organizational learning can take place. The expected results are to provide high quality care and service that is patient-centered and supports practitioners with the tools and support needed to provide excellent care and service.

Group Health continues to focus on providing high quality and safe care and service to members while controlling costs through proven medical management strategies. This focus requires continued emphasis on ensuring that each activity of our business adds value to the delivery of care and service. Central to this effort are: the development and implementation of evidence-based guidelines, medical management strategies, and population –based care programs; support for physicians with information about their patients; centralized systems, where applicable, that provide patient-centered reminder systems; and, information systems that provide valid and reliable data for ongoing assessment and feedback.
**Evaluation of the Quality Program**

The Quality Program at GH is formally evaluated annually by the Executive Leadership Team (ELT) and the Quality Committee of the Board (QCOB), as delegated by the GH Board of Trustees. The intent of the evaluation process is to determine whether areas identified as needing improvement have been appropriately addressed, established indicators adequately assess the performance of the organization’s quality of care and service, and objectives are being effectively and efficiently accomplished. The evaluation includes an assessment of the overall effectiveness of the QI program, including progress toward influencing safe clinical practices throughout the delivery system, as well as monitoring other aspects of the program, such as practitioner availability, over and under utilization, and complaints and appeals.

**Confidentiality**

Respect and recognition of the sensitivity of quality assessment and improvement information is of primary importance. Quality assessment information is available only to duly authorized personnel. Some quality assessment information is considered confidential and is protected from discovery/disclosure based on local, state, and federal statutes. Group Health operates a State of Washington Department of Health approved Coordinated Quality Improvement Program (RCW 43.70.510). This voluntary program provides protection of certain information and documents created through quality assessment and improvement efforts.
**Quality Program Structure and Accountability**

The overall organizational structure is depicted in Attachment 1. Attachments 2-5 represent the organization’s quality structures.

The Clinical Excellence & Integration Division provides oversight for the enterprise Quality function by supporting processes, practices, and improvements. Quality is one of the four focus areas of Group Health’s Business Plan and is led by the Executive Medical Director of Health Plan Services Administration who is the Quality pacesetter. The Quality pacesetter sets the tempo for Quality as a business strategy and engages managers and staff in meeting the targets established. The Quality pacesetter is responsible for removing barriers that stand in the way of continuous improvement, breaking down silos between functions, resolving conflicts, representing customers, and ensuring that Group Health is making progress toward goals.

The delivery system is accountable for quality improvement. Two divisions represent the delivery system: the Group Practice Division and the Health Plan Division. The Group Practice Division encompasses the majority of Group Health’s owned and operated clinical services. These include a hospital, 25 primary care medical centers, 6 specialty care units, 7 behavioral health clinics, and numerous other clinical sites providing vision, speech, hearing, and retail services. The Health Plan Division has oversight of all contracted network care and many care management functions.

The following serves as a description of the various committee and leadership structures at GH which are designed to promote and support excellent quality of care and service.

The following committees and groups **provide oversight** of the quality improvement work throughout GH:

<table>
<thead>
<tr>
<th>COMMITTEE OR GROUP DESCRIPTION</th>
<th>COMPOSITION OF GROUP</th>
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</thead>
</table>
| **Quality Committee of the Board** *(QCOB meets at least 4 times per year)* | • The Quality Committee shall be comprised of no less than three (3), nor more than five (5) members of the Board of Trustees. Currently there are 5 members serving on the Quality Committee.  
• Group Health Management Representatives (non-voting members of QCOB; attend as requested by QCOB) |

**Purpose:** The Quality Committee of the Group Health Cooperative Board of Trustees is established by action of the Board of Trustees for the primary purpose of acting on behalf of the Board in overseeing implementation of Group Health’s Quality Plan and Program, and monitoring the organization’s performance to ensure goals and standards established for the delivery of care and services to Group Health members and patients are met.

**Functions:**
- Review and approve the Group Health Cooperative Quality Plan and Program Description and the annual Quality Program Evaluation.
- Review and accept the annual professional liability report and make recommendations regarding the functioning of the system to increase the rate of improvement.
- Annually review and approve the Group Health Central Hospital Quality Management Plan and Patient Safety and Quality of Care report.
- Perform the functions of the governing body of Central Hospital, under the delegated authority of the Board of Trustees. Specific duties to include: 1) Review and approve necessary amendments to the Hospital Bylaws biennially; and 2) Receive periodic reports on hospital issues and review and accept Hospital Medical Executive Committee minutes.
### Quality Committee of the Board (con’t)

- Perform the functions of the governing body of Group Health Cooperative-owned ambulatory surgery centers, under the delegated authority of the Board of Trustees.
- Oversee and review the activities of the credentialing and privileging processes for practitioners and providers, specifically:
  1. Receive and accept an annual report on the credentialing and privileging process.
  2. Receive quarterly reports on credentialing and privileging trends, exceptions, and policy changes.
- Approve the Family Medicine Residency Program Annual Review.
- Monitor defined performance measures to gauge success in achieving and maintaining targeted standards of quality care and service.
- Monitor patient, member, and employee satisfaction with Group Health’s care delivery system, the health plan, and business operations.
- Ensure that management has identified and is taking corrective or improvement actions to address performance deficiencies.
- Review Board policies within the scope of the delegation to the committee and recommend the adoption or amendment of such policies to the Board.
- Regularly report to the Board regarding the execution of the committee’s duties and responsibilities.
- Assess the performance of the Quality Committee on at least an annual basis and determine and implement improvements to the functioning of the Quality committee.

### Executive Leadership Team (ELT—meets weekly)

**Purpose:** Sets organizational strategy and provides senior leadership oversight to organizational performance and improvement activities.

ELT is responsible for overseeing the development and implementation of a system-wide quality agenda that supports achievement of the organization’s strategies, and for monitoring performance and progress of the quality program.

Group Health Options, Inc. (GHO) delegates to Group Health Cooperative responsibility for its quality program, including the responsibility for overseeing the implementation and monitoring the performance of its quality program. Group Health Cooperative performs that delegated responsibility through the work of the Executive Leadership Team and Quality Oversight Team and is accountable to GHO executive management for assuring the quality program meets all the necessary requirements as outlined in the GHO-GHC delegation agreements.

**Functions:**
- Set the quality agenda (quality vision, priorities, and performance targets) and approve the GH Quality Plan and Program Description.
Executive Leadership Team (con’t)

- Make recommendations to the Quality Committee of the Board regarding:
  a. resource allocation for strategic performance improvement support;
  b. annual assessment of the success of the quality program;
  c. approval of quality indicators for regular review by the Quality Committee; and
  d. sponsorship of the Quality Plan.

Quality Oversight Team (QOT – meets quarterly)

**Purpose:** QOT is charged by ELT to serve as the QI Committee for the organization. QOT evaluates and monitors organization-wide efforts designed to improve the value of the health care delivered to Group Health patients, considering issues of safety, clinical excellence, care experience and affordability.

The charge of the group is to oversee goals established by ELT for quality performance and support the care delivery system in attaining those goals. The delivery system is responsible for the outcomes, with operating divisions deciding local tactics to meet their goals. The Enterprise Quality department informs decisions for improving quality, providing expertise in population management strategies, quality improvement, improving patient safety, supplying timely measurement, and leveraging our informatics infrastructure to support local teams.

QOT will provide regular reports to ELT regarding the oversight and evaluation activities conducted by QOT at ELT direction, and regarding any recommendations for the quality agenda.

**Functions:**
- Oversee the broad integrity of the Quality Program for the enterprise.
- Incorporate GHO and other lines of business into the GHC oversight model.
- Recommend goals and targets to ELT.
- Recommend quality improvement priorities.
- Define and communicate standards, metrics, and targets for assessing performance.
- Require regular reporting of performance, including quantitative and qualitative analysis.
- Analyze and evaluate the results of QI activities.
- Identify systemic themes and barriers, and assign needed actions and ensure follow-up as appropriate.
- Assess and leverage relational aspects of quality (clinical, safety, service/access, clinical risk documentation and coding, and care management) to ensure both balance and opportunity.
- Escalate issues that require ELT action.
The following committees **report through** the Quality Oversight Team (QOT) and/or ELT:

<table>
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<tr>
<th>COMMITTEE OR GROUP DESCRIPTION</th>
<th>COMPOSITION OF GROUP</th>
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</table>
| **Professional Liability Committee** *(meets monthly)* | • Assistant General Counsel, Litigation  
• Director of Risk Management  
• Three GHP physicians, with at least one family practice physician  
• GHC Medical Director, or Designee  
• Representation of medical centers in Spokane and/or Puget Sound region  
Exec. Director, Nursing Operations, or Designee |

**Purpose:** The Professional Liability Committee has responsibility for reviewing medical and legal issues that result in certain professional liability claims and litigation against Group Health Cooperative. The Committee authorizes settlements and reviews system issues for quality improvement opportunities.

**Functions:**
- Analyze professional liability claims and litigation database to identify risk and develop counter measures to system issues.
- Authorize professional liability settlement amounts up to $250,000 and recommend settlements in excess of $250,000.
- Recommend system changes to improve the quality and safety of care provided.
- Review and monitor the Peer Support Consultant Program.

| **Provider Support Committee** *(meets semi-annually)* | Medical Director for Patient Safety  
• Risk Management Staff  
• Representation of physicians from the Group Practice Division |

**Purpose:** To support quality patient care by ensuring that providers are emotionally supported when a patient is harmed by care.

**Functions:**
- Provide consultation on adverse events with individual providers.
- Ensure alignment with Group Health policy for communication of adverse events.
- Promote the spread of patient safety improvement by sharing lessons learned.

| **Credentialing and Privileging Committees** *(C&PCs – meets at least 10 times annually)* | Western Washington Credentialing & Privileging Committee  
Eastern WA/N. Idaho Credentialing Committee  
*(See Attachment #4 for complete membership)* |

**Purpose:** To select, evaluate, and monitor the practitioners and providers (healthcare delivery organizations) who care for GH enrollees.

**Functions:**
- Establish standards/criteria regarding qualifications for GH providers and practitioners.
- Approve/deny the credentials of practitioners and make recommendations to the Quality Committee regarding appointments, reappointments, privileging, and re-privileging within the GH delivery system.
- Provide oversight of delegated credentialing activities.
- Provide oversight of ongoing monitoring of practitioner or provider sanctions, complaints, and adverse events.
- Approve credentialing/privileging policies and procedures.
### COMMITTEE OR GROUP DESCRIPTION

#### Care Management Oversight Team *(CMOT – meets quarterly)*

**Purpose:** The Care Management Oversight Team (CMOT) is delegated by Group Health’s Quality Oversight Team (QOT) to oversee the statewide Care Management program. CMOT specifically:

- Acts as the approval body for organizational care management work plans and policies, including UM policies for denials and appeals, Medical Technology and Assessment Committee (MTAC), and Pharmacy & Therapeutics Committee (P&T).
- Develops the Care Management Program Description and Annual Work Plan.
- Conducts an annual evaluation of the Care Management Work Plan in meeting organizational goals and objectives.
- Monitors the operational status of care management activities across the organization to ensure a cross-functional, integrated approach to delivering high-quality care to members.
- Oversees and monitors compliance with regulatory and accrediting bodies.

**Functions:**
CMOT’s scope is primarily related to improvement and monitoring work, including:
- Approval body for organizational care management work plans, such as case management, pharmacy, etc.
- Oversight and approval of systems and programs to ensure compliance with regulatory and accrediting bodies such as NCQA, CMS, etc.

#### Medication Safety Committee *(MSC - meets quarterly)*

**Purpose:** To support quality patient care by using a systems-oriented approach in evaluating and promoting the safety of the medication use process.

**Functions:**
- Help build and foster a safety culture within the organization.
- Improve and maintain an effective medication unusual occurrence reporting system.
- Review and prioritize the level of patient risk based on trends identified in the Unusual Occurrence data, Institute of Safe Medication Practice (ISMP), and other external sources.
- Make recommendations towards medication safety improvement efforts with both internal and contracted delivery system leaders.
- Provide expert consultation as it relates to medication safety concerns.
- Review, approve and monitor the Medication Safety work plan.
- Ensure alignment with regulatory compliance as it relates to Medication Safety.

### COMPOSITION OF GROUP

**Core Membership includes:**
- Exec. Medical Director, Health Plan Division (or Designee), chair
- Chief Medical Officer
- Director, Review Service
- Exec. Director, Care Management
- Director, Continuing Care, or Designee
- Medical Director, Behavioral Health Services
- Medical Director, Care Management
- Manager, Quality Improvement
- Additional representatives may attend on an ad hoc basis

**Physician, Medication Safety (co-chair)**
- Manager, Medication Safety (co-chair)
- Medical Center Pharmacy Manager(s)
- Clinical Pharmacist Representative(s)
- Director, Pharmacy Operations
- CDIT Pharmacist
- Manager, Nursing Operations
- Patient Safety Officer
- Manager, AMB Pharmacy Contact Center
- Manager, Specialty Pharmacy Services
- Manager, Hospital Services
- Consultant Sub-group from Clinical and Operational areas as determined
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<tr>
<th>COMMITTEE OR GROUP DESCRIPTION</th>
<th>COMPOSITION OF GROUP</th>
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</table>
| **Clinical Information Systems Safety Committee** *(CISSC – meets monthly to quarterly)* | • Chief Medical Information Officer, sponsor  
• Medical Director of Clinical Informatics, co-chair  
• Care Delivery IT Executive Director, co-chair  
• Medical Director for Patient Safety  
• Patient Safety Officer  
• Medication Safety Manager  
• Care Delivery IT Clinical Director  
• Pharmacy Informatics representative  
• Nursing Operations, CIS Manager  
• Clinical Departmental Systems Manager  
• Laboratory and Interdepartmental Systems representative  
• Epic Clinical Manager  
Consultant members from technical, clinical and operational areas as needed |
| **Purpose:** To develop and implement a comprehensive organizational clinical systems patient safety program under the leadership of the Chief Medical Information Officer (CMIO).  
**Functions:**  
• Assess and prioritize patient safety risks through monitoring and analysis of:  
  a. Unusual Occurrences  
  b. ERT incidences  
  c. Epic patient safety alerts and concerns  
  d. Liaison activities with Medication Safety and Lab committees.  
• Make recommendations and coordinate improvement activities in clinical systems.  
• Identify and evaluate opportunities for proactive system developments to improve patient safety in clinical systems.  
• Build and foster a culture of patient safety within the teams that support clinical systems. |  
| **Guideline Oversight Group** *(meets once per month)* | • Medical Director, Clinical Improvement  
• Medical Director, Preventive Care  
• Medical Director, Clinical Knowledge Development and Support  
• Assistant Medical Director, Preventive Care  
• Director, Clinical Improvement and Prevention (RN)  
• Manager, Clinical Knowledge Development and Support  
• Coordinator, Clinical Guideline Development  
• Clinical Epidemiologists  
• Supervisor, Clinical Publications |
| **Purpose:** Oversee the development and updating of clinical guidelines to ensure high quality products, efficient use of GHC/GHP resources and timeliness of project completion. Act as a liaison between guideline teams and the Quality Oversight Team (QOT).  
**GOG members represent the organization and provide area-specific expertise in the development and approval of clinical guidelines. Examples include the U.S. Preventative Services Task Force, Medical Technology Assessment Committee, Pharmacy & Therapeutics, Preventive Care, Pediatrics, Primary Care, patient information, research, Health Profile, and Epic.**  
**Functions:**  
• Evaluate requests for new guidelines and prioritize based on clinical, business, and customer service factors.  
• Oversee creation of processes related to clinical guidelines, such as system for deciding whether to adopt or adapt material from outside source or develop product internally.  
• Review changes to guideline recommendations and anticipate organizational issues or concerns and help determine implementation and communication strategies.  
• Consult with Medical Director, Clinical Knowledge Development and Support to:  
  ➢ Ensure that the updated process proceeds according to plans regarding scope (e.g. which questions to ask, which gaps are worth closing, what topics to include/exclude) |
**COMMITTEE OR GROUP DESCRIPTION**  

**Guideline Oversight Group (con’t)**

- Identify key proposed or potential updates to the guideline given new evidence prior to the meeting.
- Anticipate, identify, and attempt to resolve any areas of ambiguity or controversy by the conclusion of the Evidence Review meeting.

- Review and provide final approval of completed projects submitted by guideline teams to ensure high quality of products and consistency of key recommendations with the evidence.
- Oversee preparation of materials on guideline projects to be reviewed by QOT.

**Behavioral Health Support Services Leadership Team (BHSSLT - meets 2 – 3 times per month)**

**Purpose:** Provides senior leadership oversight for behavioral health (BH) care across the GH delivery system and is responsible for all business and quality improvement functions. As the department’s approving quality body, is responsible for orchestrating the department’s quality agenda to support organizational strategies, implementing the quality program, monitoring performance, and making changes as needed.

**Tasks:**

- Set the department’s quality agenda and provide input into organization and divisional quality plans.
- Monitor, plan and support actions to improve:
  - HEDIS performance on BH measures
  - Patient experience of BH care
  - Access to care
  - Coordination of care
  - Patient Safety
- Ensure compliance with accreditation and regulatory standards for Behavioral Health (e.g., NCQA, State, Medicare).
- Oversee BHS systems and infrastructure (e.g., referral and triage functions, new technology).
- Oversee training and professional development for staff.
- Liaison with other departments in the organization to connect departmental efforts with organizational work (e.g., patient confidentiality, unusual occurrence monitoring).
- Oversee utilization management functions for BHSS.
- Quality of Care reviews are delegated to the Quality of Care Review Committee who report findings through the Unusual Occurrences reporting system. This committee meets monthly and results are reported twice a year to the BHSS LT.

<table>
<thead>
<tr>
<th>COMPOSITION OF GROUP</th>
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<tbody>
<tr>
<td>• Medical &amp; Operations Director, Behavioral Health Support Services</td>
</tr>
<tr>
<td>• Manager, Care Management</td>
</tr>
<tr>
<td>• Assistant Director of Professional Services</td>
</tr>
<tr>
<td>• Chief, Chemical Dependency &amp; Consultative Psychiatry</td>
</tr>
<tr>
<td>• Consultant, Specialty Services</td>
</tr>
<tr>
<td>• Manager, Social Work and Consultant Integrated Services</td>
</tr>
<tr>
<td>• Assistant Medical Director, Specialty Services</td>
</tr>
<tr>
<td>• Assistant Medical Director, Health Plan Operations</td>
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</table>

The following **groups provide support for and promote communication and execution of quality improvement opportunities and initiatives throughout GHC:**


<table>
<thead>
<tr>
<th><strong>Committee or Group Description</strong></th>
<th><strong>Composition of Group</strong></th>
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<tr>
<td><strong>Division Leadership Teams</strong> <em>(meets at least monthly to quarterly)</em></td>
<td>Varies by site, includes key physician and administrative leadership through the following structures:</td>
</tr>
</tbody>
</table>
| **Purpose:** Provide division-specific and/or function-specific organizational direction and oversight for quality improvement initiatives. Facilitate and provide direct support for the quality improvement initiatives based on directions derived from the strategic plan A3 deployment, the Quality Committee of the Board and/or the QOT. | • Group Practice Division Leadership Team *(Attachment #1, 2)*  
• Health Plan Division Leadership Team *(Attachment #1, 3)* |
| **Tasks:** | |
| • Monitor the quality indicators [process measures/standards] and identify and present trends to the attention of QOT when they cross pre-established thresholds, or otherwise warrant attention or action by ELT or the Quality Committee. | |
| • Identify opportunities for improvement and provide direction regarding which issues to target for intervention. | |
| • Review and approve policies that impact quality. | |
| • Approve, support/guide performance improvement teams. | |
| • Recognize and celebrate performance improvement efforts. | |
| **Enterprise Quality Functions: Clinical Excellence and Integration** | • See Attachment 5 |
| **Purpose:** To support executive leaders in driving process, practice and quality/service improvements across the enterprise while ensuring that initiatives are integrated and coordinated in order to fully leverage our integrated system. | |
| **Tasks:** | |
| • Assist with the planning and development of strategies for safety, service and clinical quality improvement. | |
| • Support implementation of quality improvement strategies and initiatives. | |
| • Provide internal expertise through the application of Lean tools to meet strategic, service line, and local improvement needs. | |
| • Provide quality improvement support in the delivery systems. | |
| • Support the care management strategy development and implementation. | |
| • Support clinical guideline development and implementation. | |
| • Provide organizational health information and education. | |
| • Provide training and consultation for service and practice improvement strategies. | |
| • Support the implementation and management of the Group Health Options quality program. | |
**GH Quality Assessment and Improvement Accountability Structure**

The key feature of Group Health’s quality assessment and improvement process is the ability to view sub-optimal quality from a broad, systems perspective. We believe that most quality problems are the result of poorly designed systems and processes. An essential activity that is built in to the quality assessment process is to “drill down” to determine whether an individual provider’s apparent problem may be related to an underlying system issue. Performance measures and reporting of progress against targeted measures is widely available to all Group Health staff through the internal web site Connection.

Group Health conveys quality information to those who are accountable for assessing and improving care in one of two forms:

1. **In the aggregate form.** This information is used for population or geographic area assessments and identification of system problems.
2. **In the practitioner-specific form.** This information is used for credentialing and performance evaluation.

The structure diagrams on the following pages describe linkages among responsible groups. These linkages are the communication conduits for performance information. Attachment 6 describes the data sources and analytical resources that support the quality program.
ATTACHMENT 1

GHC Quality Assessment and Improvement Structure

- Board of Trustees
- Quality Committee of the Board
- Executive Leadership Team
- Quality Oversight Team

Professional Liability Committee
- Provider Support Committee

Credentialing & Privileging Committees

*Behavioral Health Support Services Leadership Team
- Quality of Care Review Cmte.

*Care Management Oversight Team
- Medical Policy Cmte. (MPC)
- Medical Technology Assessment Cmte. (MTAC)
- Pharmacy & Therapeutics Cmte. (P&T)
- *Care Planning and Improvement Committees (CPICs)

Group Practice Division Leadership Team
- Medication Safety Committee
- CIS Safety Committee
- Quality of Care Case Review
- Primary Care/Behavioral Health Support Services Leadership Team

Health Plan Division Leadership Team
- Network Performance Management Leadership Team

Legend:
- GHC Division
- *also has links to Divisional Leadership Teams
ATTACHMENT 3
Health Plan Division Performance Management System

**Care Management Quality Oversight Structure**

**LOAD**
- Prioritizing enterprise work
- Setting strategies
- Monitoring performance outcomes
- Contracting oversight
- Strategic positioning in service delivery markets

**ORGANIZE AND DESIGN**
- Determine feasibility of new initiatives
- Determine disposition of new initiatives
- Develop tactics, strategies, and designs to close performance gaps
- Eliminate redundant improvement efforts
- Request analytics

**DEPLOY AND IMPROVE**
- Run Operations
- Operationalize improvement initiatives
- Drive ongoing improvement
- Strategic input to design teams/CDOG

**QOT**
- Set Quality Agenda
- Prioritization of quality initiatives

**QCOB**
- Establish Metrics for Care Delivery System
- Cost, Quality, Access, Member/Pt. Satisfaction, Business Alignment, Purchaser Satisfaction

**Care Management Oversight Team**
- Annual organizational monitoring
- Includes regulatory oversight, monitoring of ongoing operational programs throughout system, and identification of new opportunities

**MEDICAL POLICY COMMITTEE**
- Assures consistent and uniform set of medical policies
- Assures and maintains balance between medical policy, medical efficacy and market/environment
- Considers new technologies
- Maintains, reviews and creates medical necessity policy to use in making coverage decisions

**MEDICAL TECHNOLOGY ASSESSMENT COMMITTEE**
- Assesses the evidence for new and existing technologies and provides the assessment outcomes to MPC

**PHARMACY & THERAPEUTICS COMMITTEE**
- Identifies the most cost-effective pharmaceutical treatment and recommends changes to the formulary and prior auth criteria
- Evaluates use of new pharmaceuticals or new application of existing pharmaceuticals

**HEALTH PLAN OPERATIONS TEAM**
- Unify health plan operation oversight and provide a forum for timely decision-making on issues that involve or impact health plan operations

**Case Management/Population Management**
- CMLF
- Care Management Leadership Forum

**Gold Carding & Delegation Committee**
- GCDC
- Case Management/Population Management
## ATTACHMENT 4
### Credentialing Committees Membership

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<tr>
<th>Member</th>
<th>Specialty</th>
<th>Status</th>
<th>Member</th>
<th>Specialty</th>
<th>Status</th>
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<tbody>
<tr>
<td>Eastern Washington</td>
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<td>Quality Committee Oversight</td>
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<td></td>
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<td></td>
<td>of Credentialing &amp; Privileging:</td>
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<tr>
<td>Pope, Brad, MD, chair</td>
<td>Family Practice</td>
<td>GHP</td>
<td>Katie Bell</td>
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<td>Dimer, Jane, MD, back-up</td>
<td>Obstetrics/Gynecology</td>
<td>GHP</td>
<td>Harry Harrison, MD</td>
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<td>Bergum, Mary, MD</td>
<td>Family Practice</td>
<td>Contracted</td>
<td>Dorothy Ruzicki, RN</td>
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<tr>
<td>Pakkianathan, Stephen, MD</td>
<td>Obstetrics/Gynecology</td>
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<td>Judy Schurke</td>
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<tr>
<td>Taylor, Tona</td>
<td>Director, Credentialing</td>
<td>Staff</td>
<td>Hugh Straley, MD</td>
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<td>Obstetrics &amp; Gynecology</td>
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<td>Radiology</td>
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<td>Urgent Care</td>
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<td>Orthopedic Surgery, Chief of TSC</td>
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<td></td>
<td>Gastroenterology</td>
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<td>Urology</td>
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<td>GHP</td>
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<td>Chief Medical Officer, Review of Network providers</td>
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<td>Optometry</td>
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<tr>
<td></td>
<td>Supervisor, Credentialing</td>
<td>Staff</td>
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<tr>
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ATTACHMENT 5:
Enterprise Quality Function: Clinical Excellence & Integration
ATTACHMENT 6
Quality Resources at Group Health Cooperative

Quality Improvement Activity Resources
The resources that Group Health devotes to the Quality Improvement Program and specific quality improvement activities are broad and include staff (employees and consultant staff), data sources, and analytical resources such as statistical expertise and programs. Evaluation of adequate quality resources is determined through evidence that the organization is completing quality improvement activities in a competent and timely manner. This is done through the annual Quality Program Evaluation, as well as ongoing monitoring of performance and progress on the quality workplan by the Quality Oversight Team (QOT) throughout the year.

Oversight for Enterprise Quality is provided by a Vice President and a Medical Director for Quality, and a total of six medical directors, one in each of the following areas: Informatics, Clinical Improvement, Preventive Care, Clinical Knowledge Support, Continuing Medical Education, and Senior Services. The Preventive Care Department also has an Associate Medical Director and an Assistant Medical Director.

Staff (around 100 positions), including about 40 in the Clinical Improvement and Prevention department, dedicated to quality improvement activities are present in the following areas:
- Patient Safety
- Clinical Knowledge Support
- Continuing Medical Education
- Clinical Improvement and Prevention
- Quality Performance Review
- Consulting Services
- Credentialing
- Member Appeals
- Clinical Review Unit
- Member Quality of Care Grievances
- Behavioral Health Services
- Care Management
- Pharmacy Administration

In addition, external consultant staff arrangements are made as needed.

Data Sources
Group Health uses a number of different sources and systems to collect data and generate results for quality indicators, including the following:
- Premier membership and billing system – enrollment data
- Premier claims system – data for institutional and professional services received inside and outside Group Health clinics
- Enterprise Master Files (EMF) – additional consumer and practitioner demographics
- EPIC clinical information system – clinical data from the electronic medical record
• EPIC practice management suite – encounter, appointment, admit/discharge/transfer, and billing information for inpatient and outpatient services received at Group Health facilities on or after 11/1/2009
• LastWord – encounter, appointment, admit/discharge/transfer, and billing information for inpatient and outpatient services received at Group Health facilities prior to 11/1/2009
• Coop Rx – internal pharmacy claims system
• MedImpact – external pharmacy claims system
• Laboratory Information System (LIS) – internal laboratory services and results
• PAML – selected external laboratory services and results for some members treated in Spokane area Group Health clinics
• CareTracker prior to 4/1/2014/Jiva after 4/1/2014 – care coordination tracking tool
• eWatson – customer relationship management tracking system (including complaint and appeals data)
• Press Ganey (vendor based patient satisfaction) – results from Press Ganey’s survey of patient satisfaction
• Cancer Screening Exclusions – Supplemental source of data, identifying members with valid exclusions from selected screening procedures
• Washington State Immunization Information System – Supplemental source of immunization data

Enterprise Data Warehouse (EDW) developers create programs to extract the data used to produce results for key clinical, utilization, and service quality indicators.

Data Warehouse and Reporting Resources
Group Health maintains a data warehouse repository usable by staff across the organization for analysis and reporting. Part of that maintenance requires pulling data from original source systems such as claims and Epic into warehouse tables “scrubbed” and enhanced with value-added attributes. In addition, for various applications or reporting needs, datamarts are developed with specific information needed for that reporting or by those applications. This team includes the following staff:

• Engineer, Data Warehouse (6 quality specific positions/20 total) – gather requirements and create source-to-target mapping of data; develop, maintain, and administer data integration (ETL) processes and tools; develop, maintain, and administer ad-hoc and standard reporting applications, dashboards and tools; manage the ongoing loading and optimization of the data warehouse; quality assurance/validation of all data loads from the source systems into the data warehouse; build ad-hoc and operations reporting solutions for accessing data and information.
• Manager, Enterprise Data Warehouse (1 quality specific position/2 total) – responsible for the day-to-day load operations of the Data Warehouse; ensures that all data are loaded as required; manages resources for data integration development projects within EIM
• EDW Data Architect (1 position) – creating holistic data flow documentation of the EDW, logical and physical design of database/data mart structures.
• Business Intelligence admin and Data Warehouse Admin (2 positions) – Administer deployments and tool maintenance.
Business Intelligence Services
Group Health dedicates significant staff and information systems to analyzing and reporting the large volume of clinical and service quality data available. This team includes the following staff:

- Business Intelligence Analyst (1 position) – to perform deep analysis including data profiling, hypothesis testing and statistical analysis for quality related initiatives; provide support analysis to drive clinical and process improvements; provide ad hoc analysis using standard statistical methods; evaluate effectiveness of new programs.

Additionally, the following staff moved from Informatics in to the Quality department for more direct support of Quality:

- Product Managers (2 positions) – work with organization leaders to understand issues, questions being asked, and data needed to support decision-making; provide leadership to teams doing the analysis and HEDIS reporting
- Medical Record Review Manager/lead (1 position) – manage HEDIS medical record review process, hire reviewers, schedule medical record review visits to non-owned/operated facilities, manage compilation of materials for and staff the annual HEDIS compliance audit.

Tools/Applications
These staff use a number of applications to produce results and reports for clinical and service quality indicators including:

- General Dynamics Information Technology (GDIT): NCQA-certified HEDIS measure build engine
- Informatica PowerCenter (Extract, Translate, & Load “ETL” software application)
- SAS
- Microsoft Visual Basic
- Microsoft SQL Server
- Microsoft Access
- Microsoft Excel
- Business Objects reporting tools, including Crystal Reports
- Teradata
- ERWin
- PERL