

Health Plan of Nevada

2010 Quality Improvement Workplan

for SmartChoice and Nevada Check Up Members

Health Plan of Nevada prepares a workplan each year that shows the quality projects that are in place. Health Plan of Nevada's ***2010 Quality Improvement Workplan*** spotlights projects that help maintain the quality of health care and services for health plan members.

Key Focus Areas in the 2010 *Quality Improvement Workplan*:

- Child and Teen Health
- Women's Health
- Management of Chronic Conditions
- Behavioral Health
- Customer Service
- Member Satisfaction
- Patient Safety
- Case Management

Please contact Health Plan of Nevada's Quality Improvement Department for any questions about the current quality projects. Upon request, you may also get a written copy of the quality program description or evaluation. Please contact Deborah Wheeler, Director, Quality Improvement at 702-242-7254.

Health Plan of Nevada
2010 Quality Improvement Workplan
All Areas Shown in Red are New Focus Areas for 2010.

Project Name	Key Objectives/Activities
Child and Teen Health	
Adolescent Immunizations	<ul style="list-style-type: none"> Improve the rate of childhood shots for children and teens aged 4 to 13 years old.
Childhood Immunizations	<ul style="list-style-type: none"> Improve the rate of childhood shots for children aged 2 years old.
Lead Screening	<ul style="list-style-type: none"> Improve the rate of lead screening tests for children aged 2 years old.
Well Child Visits	<ul style="list-style-type: none"> Improve the rates of well child visits and well care for children and teens.
Dental Visits	<ul style="list-style-type: none"> Improve annual dental visit rates for children and teens aged 3 to 21 years old.
Early Preventative Screening Diagnosis and Treatment (EPSDT) Screenings and Referrals	<ul style="list-style-type: none"> Improve EPSDT screening and referral rates for children related to initial visits, periodic screenings, vision screenings, hearing tests and dental services.
Women's Health	
Breast Cancer Screening	<ul style="list-style-type: none"> Improve the breast cancer screening (e.g., mammogram) rate for women aged 52 to 69 years old.
Cervical Cancer Screening	<ul style="list-style-type: none"> Improve the cervical cancer screening (e.g., Pap smear) rate for women aged 21 to 64 years old.
Prenatal & Postpartum Care	<ul style="list-style-type: none"> Improve the rates of timely prenatal and postpartum care for pregnant woman.
Management of Chronic Conditions	
Childhood Asthma and Adult Asthma	<ul style="list-style-type: none"> Improve the proper asthma medication use by members who are aged 5 to 56 years old. Put in place projects that will help people with asthma better manage their health.
Chronic Obstructive Pulmonary Disease (COPD)	<ul style="list-style-type: none"> Improve care for members aged 18 years and older with COPD. Put in place projects that will help people with COPD better manage their health.
Diabetes	<ul style="list-style-type: none"> Improve care for members aged 18 to 75 years old with diabetes. Improve the numbers of members with diabetes who receive key diabetes tests and exams. These tests and exams include hemoglobin A1C tests, eye exams, cholesterol tests and kidney disease monitoring tests.
Heart Failure	<ul style="list-style-type: none"> Improve care for members aged 18 years and older with heart failure. Continue projects to reduce the numbers of hospital stays for health plan members with heart failure.
Cholesterol Management For Individuals With Heart Disease	<ul style="list-style-type: none"> Improve care for members aged 18 to 75 years old with heart disease. Put into place projects to address issues related to cholesterol management.

Project Name	Key Objectives/Activities
Persistence Of Beta Blocker Treatment	<ul style="list-style-type: none"> • Increase proper medication use of beta blockers for members aged 35 years and older who have Ischemic Vascular Disease.
Health Management Program Operations	<ul style="list-style-type: none"> • Expand the telephone calls made to health plan members with high blood pressure, adult asthma and heart disease. • Ensure that telephone calls are made to members with childhood asthma, COPD, heart failure and diabetes. • Show the success of the telephone calls being made.
Behavioral Health	
Follow-Up After Hospital Stays for Mental Health Issues	<ul style="list-style-type: none"> • Improve follow-up care for members aged 6 years and older who were in the hospital for treatment for selected mental health issues.
Follow-Up Care For Children With Attention Deficit Hyperactivity Disorder (ADHD)	<ul style="list-style-type: none"> • Improve follow-up care for children with ADHD.
Member Satisfaction	
Member Satisfaction	<ul style="list-style-type: none"> • Improve the numbers of health plan members who are satisfied with the health plan. • Look at how satisfied health plan members are with programs designed to help them stay well. Programs being looked at include the Health (e.g., Disease) Management Program, the Case Management Program and Telephone Advice Nurse line.
Patient Safety	
Patient Safety	<ul style="list-style-type: none"> • Educate health plan members more about how to use medications safely. • Ensure that health plan members sign up for Portable Medical Records and advance directives through the Southwest Medical Associates' medical group. • Evaluate the success of the Post Discharge Clinic at the Southwest Medical Associates' medical group. • Work with health care providers to improve the discussions between health care providers and members. • Improve the coordination of care between primary providers and other providers such as hospitals, home health agencies, skilled nursing facilities and surgical centers.
Practitioner Availability	<ul style="list-style-type: none"> • Ensure that health plan members have access to medical and behavioral health care providers for routine, urgent and after hours care. • Make sure that providers are available to members in all service areas.
Case Management	
Case Management	<ul style="list-style-type: none"> • Ensure that health plan members with acute health care needs are followed by case managers. • Evaluate the success of the Case Management Program.