

2016 Quality Program Description

Approved by Virginia Premier Health Plan, Inc. Board of Directors and
Continuous Quality Improvement Committee (CQIC)

August 2000

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Executive Summary:
2016 Quality Program Description:
Effective: January 1, 2016



Purpose

The Virginia Premier Health Plan, Inc.'s Quality Program has an ongoing commitment to provide all members with optimal quality care and access to care in a safe, culturally sensitive manner and to be compliant with NCQA and DMAS Standards. VPHP is committed to improving the communities where its members live through participation in public health initiatives at the national, state and local levels, and aspiring to meet public health goals, (e.g., Healthy People 2020, State goals, etc.).

Oversight of the VPHP Quality Program is provided by the Health Quality and Utilization Management Committee (HQUM) comprised of the Chief Medical Officer, VPHP Medical Directors, Practitioners and Quality Staff. The role of the committee is to review, recommend, develop and implement best practices, to include clinical and service initiatives/programs.

Scope

The Quality Program includes oversight and management of over 600 NCQA and DMAS process standards (spanning multiple departments), over 200 HEDIS Core and Sub-Measurements, clinical and service indicators and credentialing/re-credentialing of over 15,000 practitioners and providers.

Key Accomplishments for 2015

Overall, most activities planned in the Work Plan were achieved. The activities that were not completed will be considered for continuation in 2016. Key accomplishments during 2015 for the organization are outlined below:

- NCQA "Commendable" Accreditation Status
- Rated as one of "Top 3" Health Plans in Virginia
- HEDIS On-site Compliance Audit scored at 100%
- HEDIS Data Abstraction Season: Successfully completed (Feb-May 2015)
- External Quality Review Organization Performance Measure Validation: Passed
- Performance Improvement Projects (PIP) for Well Child Visits and Follow-up for Mental Health after Admission combined score of 94%
- Cultural competency assessments increased by 29% over previous year
- Completed Pilot Year of Department of Medicaid Services (DMAS) Performance Incentives Award (PIA) with 0.05% Hypothetical Award (No Withhold Penalty)
- Best practices identified during Quality Huddles and spread to other regions
- Implemented collaborative "Ride-Along" with Network Development to enhance HEDIS education and conduct strategy sessions with practices
- Increase in Disease Management Program participation rate-overall program participation was 84.6% (8.9% increase from 2014), asthma 83.4%, (7.6% increase from 2014), diabetes 89.5% (16% increase from 2014)
- Four measures (HbA1c test, HbA1c poor control, HbA1c control <8.0%, HbA1c control <7% for a select population) exceeded the national 50th percentile
- Percent of children receiving 6 or more well-child visits before 15 months of age exceeded the benchmark 75th percentile by 3.08 percentage points.

- Decrease in inpatient admits and ER visits in all of the disease management programs: 15% decrease in asthma admits, 9% decrease in diabetes admits, 16% decrease in COPD admits, and 9% decrease in asthma ER visits
- Established a collaborative Embedded Case Management program with Frontier Health, Inc. that works in partnership with Community Services Board, Planning District 1 to provide a full range of behavioral health services
- Created the Emergency Department(ED) Utilization Program to follow up with members within 24 hours after utilizing the emergency department.
- Member satisfaction with clinical program goals: Disease Management: 95.1%, Case Management: 92.7% and Utilization Management: 90%
- Call abandonment rate for Grievances and Appeals decreased from 12.9% to 2.9%, which exceeds compliance Standard of $\leq 5\%$
- Quality of Care Assessments were completed on average of 11 days which is below the DMAS requirement of 30 days
- 100% of VPHP employees completed HIPAA workforce training
- 100% of VPHP employees completed Crisis Intervention Training

Changes to the 2015 Program Description

- Included Corporate Overview
- Included Process for Quality Improvement
- Description and Measures for Performance Incentive Award (PIA)
- Updated Quality Director Responsibilities
- Included Chief Operating Officer, Quality Manager, HEDIS Program Manager, Quality Nurses and Quality Improvement Specialists role descriptions in support of QI Program
- Included Quality Satisfaction Committee as a Support Committee

2016 Quality Program's Core Indicators:

- NCQA Accreditation (includes Clinical and Service Medallion 3.0 HEDIS® Measures)
- Achieve 90% or greater on NCQA Internal Audits
- Member Satisfaction and Provider Satisfaction
- Member Grievances and Appeals
- Quality of Care/Service Indicators
- Member Safety
- Culturally Competent Care

2016 Quality Goals:

- Achieve 1st in the Commonwealth and Top 30 Best Medicaid Plans National Star Rating
- Achieve the 75th Percentile or Greater for Targeted HEDIS Measures
- Improve the Member Satisfaction through CAHPS® Survey Education for Membership, Providers and Internal Staff
- Achieve 3.0 score on all Performance Incentive Award (PIA) measures

The VPHP Quality Program Description, Quality Work Plan and previous year's Quality Evaluation are reviewed and updated, at least annually, based on VPHP, DMAS, CMS and/or NCQA requirements.

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Corporate History

In 1995, Virginia Premier Health Plan, Inc. (VPHP) (formerly Virginia Chartered Health Plan, Inc.) opened its doors for business, as a for-profit Medicaid managed care organization, owned by Virginia Commonwealth University (VCU) Health. In 2010, VPHP became not-for profit. The National Committee of Quality Assurance (NCQA) accredited VPHP in 2007. The last NCQA accreditation survey, which was conducted in 2013, resulted in “Commendable” status. VPHP is contracted exclusively with the Department of Medical Assistance Services (DMAS) to provide quality health care services to Medallion 3.0 and Family Access to Medical Insurance Security (FAMIS) eligible recipients in the Commonwealth of Virginia.

Headquartered in Richmond, Virginia, we also have offices in Bristol, Wise, Richlands, Winchester, Roanoke, and Tidewater. Our local presence enables us to serve vulnerable populations effectively. As a locally-owned, non-profit company, we focus our resources on member services. We service about 200,000 members in over 100 counties across Virginia. There are approximately 15, 000 practitioners in the network. We offer the following plans and services to our members:

Virginia Premier Health Plan, a Medicaid Plan

VPHP began operations as a full-service Medicaid health plan in 1996, providing health care services to recipients of the following in Virginia:

- Family Access to Medical Insurance Security (FAMIS)
- Medicaid’s Health and Acute Care Program
- Medicaid’s Temporary Aid for Needy Families
- Medicaid’s Aged, Blind, and Disabled residents

Virginia Premier CompleteCare (Medicare-Medicaid Plan)

As part of the Commonwealth Coordinated Care initiative, our **Virginia Premier CompleteCare** plan is for people who are dually eligible for both Medicaid and Medicare. This plan became available to eligible recipients in 2014.

Patient-Centered Medical Home

Our first Patient-Centered Medical Home, Virginia Premier Medical Home, opened in Roanoke, Virginia in early 2014. This innovative approach to healthcare coordinates primary care and preventative services to improve overall quality of care and patient satisfaction.

Virginia Premier's Commitment

Helping individuals and families find and fund quality healthcare is at the heart of what we do. “We fulfill this objective by delivering easy access to doctors, specialists, hospitals, referrals and emergency aid. In so doing, we act as a strong partner for our members in providing for their health and the health of their families.

Virginia Premier's Mission Statement

Virginia Premier Health Plan, a managed care organization owned by the Virginia Commonwealth University Medical Center, meets the needs of underserved and vulnerable populations in Virginia by delivering quality driven, culturally sensitive and financially viable healthcare.

Accreditation

Virginia Premier is accredited with the National Committee for Quality Assurance (NCQA). NCQA is an independent not for profit organization that ranks health insurance plans throughout the nation. NCQA evaluates how health plans manage all parts of their delivery systems — physicians, hospitals and other providers in order to continuously improve health care for its members. Accreditation surveys include rigorous on-site and off-site evaluation of over 600 standards and selected performance measures.

Accreditation is not a one-time event, but an ongoing journey to support quality services for customers, members and practitioners. Virginia Premier is committed to excellent services to our customers and have an ongoing plan to monitor the progress towards the goal of excellence. Virginia Premier earned a “Commendable” accreditation status from the National Committee on Quality Assurance for the Medicaid Product line on July 11, 2013. This accreditation will expire on July 11, 2016.

VPHP Quality Program

The Virginia Premier Health Plan, Inc.’s Quality Program provides a formal process to objectively and systematically monitor and evaluate the quality, appropriateness, efficiency, safety and effectiveness of care and service. A multidimensional approach enables VPHP to focus on opportunities for improving operational processes as well as health outcomes and satisfaction of members and practitioners. The VPHP Quality Program is essential to ensure that all medical care and service needs of members are being met and insures activities and strategies planned by the organization are “value added” benefits to our members. The Quality Program is formulated on the following three pillars:

- **Quality Program Description:** The Quality Program Description provides the structure and governance used to guide the formal processes for evaluating and improving the quality and appropriateness of health care services and the health status of the populations we serve.
- **Quality Program Work Plan:** The Quality Work Plan documents and monitors quality improvement activities throughout the organization for the upcoming year. The work plan includes goals and objectives based on the strengths and opportunities for improvement identified in the previous year’s evaluation and in the analysis of quality metrics. The work plan is updated as needed throughout the year to assess the progress of initiatives.
- **Quality Program Evaluation:** The annual Quality Program Evaluation is an evaluation of the previous years’ quality improvement activities and provides a mechanism for systematically completing an analysis of VPHP performance and to define meaningful and relevant quality activities for our members. Through a structured review of the various clinical, service, administrative and educational initiatives, the program evaluation serves to emphasize the accomplishments and effectiveness of the Quality Program as well as identify barriers and opportunities for improvement within the process.

The annual QI Program Description, QI Program Evaluation and QI Work Plan are reviewed and approved by the Continuous Quality Improvement Committee (CQIC) and the Board of Directors.

QUALITY PROGRAM FUNCTION

- Provide the organization with an annual Quality Program Description, Quality Work Plan, and Quality Annual Evaluation
- Coordinate the collection, analysis, and reporting of data used in monitoring and evaluating care and service, including quality, utilization, member service, credentialing and other related functions managed at the plan level or delegated to vendor organizations
- Identify and develop opportunities and interventions to improve care and service
- Identify and address instances of substandard care including patient safety
- Track and monitor the implementation and outcomes of quality interventions

- Evaluate effectiveness of improving care and services
- Oversee organizational compliance with regulatory and accreditation standards

SCOPE/METHODOLOGY

The scope of the Quality Program is integrated within clinical and non-clinical services provided for VPHP members. The program is designed to monitor, evaluate and continually improve the care and services delivered by VPHP practitioners and affiliated providers, across the full spectrum of services and sites of care. The program encompasses services rendered in ambulatory, inpatient and transitional settings and is designed to resolve identified areas of concern on an individual and system wide basis. The Quality Program will reflect the population served in terms of age groups, disease categories and special risk statuses and diversity. The Quality Program includes monitoring of VPHP's community focused-programs, practitioner availability and accessibility; coordination and continuity of care; and other programs or standards impacting health outcomes and quality of life.

The methodology of the Quality Program and activities includes the elements of: identification, performance goals and benchmarks, data sources, data collection, establishment of baseline measurements, barrier analyses, trending, measuring, analyzing, interventions, development and implementation.

OBJECTIVE & GOALS

The primary objective of VPHP's Quality Program is to continuously improve the quality of care provided to members, which enhance the overall health status of VPHP members. Improvement in health status is measured through Healthcare Effectiveness Data and Information Set (HEDIS®) information, internal quality studies, and health outcomes data. VPHP is committed to improving the communities where the members live through participation in public health initiatives on the national, state and local levels, and aspiring to meet public health goals, (e.g. Healthy People 2020, State goals, etc.).

Primary goals of the VPHP Quality Program

- Continuously meet VPHP's Mission, regulatory and accreditation requirements
- Ensure the delivery of high quality, appropriate, efficient, timely, and cost-effective health care and services
- Improve the overall quality of life of members through the continuous enhancement of VPHP's comprehensive health management programs [asthma, heart disease, Bipolar disorder, Schizophrenia, chronic obstructive pulmonary disease (COPD), diabetes, end stage renal disease, high-risk pregnancy, cancer and childhood weight and nutrition management].
- Develop and implement interventions focused on member integration
- Enhance quality improvement collaboration with all levels of care to include, but not limited to primary care, OB/GYN and behavioral health care
- Ensure a safe continuum of care through the application of VPHP's Member Safety Initiatives
- Improve health promotion/disease prevention messages and programs for members through quarterly member and provider newsletters and monthly mailings and reminders
- Review performance against clinical practice guidelines
- Continue to address improvements in member satisfaction through collaboration with network practitioners and providers and quarterly meetings with members
- Continue to address improvements in practitioner satisfaction via quarterly meetings with the practitioners

- Promote community wellness programs and partner with community services and agencies
- Promote and facilitate the use of quality improvement techniques and tools to support organization effectiveness and decision-making.
- Ensure culturally competent care delivery through collection of practitioner cultural education, and provision of information, training and tools to staff and practitioners to support culturally competent communication.

2016 PERFORMANCE INDICATORS

The performance indicators provide a structured framework in which to target and concentrate organizational (clinical and service) efforts. Through assessment and implementation of member-focused interventions, outcomes are measured. VPHP will maintain clinical and service improvement projects/activities that relate to key indicators of quality and utilizes data that is statistically valid, reliable, and comparable over time. All performance indicator outcomes are reported at the HQUM, CQIC and the Board, at least annually.

A. Clinical Indicators:

- NCQA Medicaid HEDIS® Measures
- Contract Specific DMAS HEDIS® Measures
- DMAS Performance Improvement Projects (PIPs)
- DMAS Performance Incentive Award (PIA) measures
- Chronic Care Survey
- Case Management Screening
 - Prenatal/Postpartum Care
 - Childhood Immunizations
 - Well-Child Visits 1st 15 Months
 - Lead Screening
 - EPSDT
- Disease Management (DM) Initiatives/Programs:
 - Asthma
 - Diabetes
 - Heart Disease
 - Childhood Weight Management and Nutrition
 - Mental Health
 - Heart Disease
 - Chronic Obstructive Pulmonary Disease (COPD)
 - End Stage Renal Disease (ESRD)
 - Cancer

B. Service Indicators:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0
- Provider Satisfaction Survey
- Provider Access and Appointment Availability Survey
- Member Operations Average Speed to Answer (Timeliness)
- Board Certification
- Member Grievances and Complaints

ORGANIZATIONAL STRUCTURE

Continuous Quality Improvement Committee (CQIC)

A. The CQIC has ultimate authority, accountability and organizational governance for the Quality Program. The CQIC exercises its oversight of the program by reviewing and approving annually the Quality Program Description, Annual Evaluation and Work Plan for the subsequent year. Additional functions of the CQIC include review and approval of reports and ad- hoc studies. The CQIC consists of the Executive Staff of VPHP, all members with voting privileges vote. Appointment to the Committee is by virtue of Executive Staff position. The CQIC meets at least four (4) times a year.

The CQIC develops policies and provides direction for all activities described in the Quality Program and Quality Work Plan, including delegated Quality activities. Additional responsibilities of the Committee include:

- Reviewing targeted instances of potential poor quality, and provide guidance as needed
- Ensuring that the appropriate agencies receive required reports and any additional information as outlined by governmental regulators
- Reviewing and acting on requirements/recommendations of external quality review organizations
- Reviewing summary data with comparison to industry standard benchmarks and providing recommendations as appropriate
- The CQIC reviews the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and provider satisfaction data and then the data are shared with both the members and practitioners via newsletters, Advisory meetings, website and site visits. Medical Record Review outcomes are discussed at the CQIC meeting and shared with the practitioners in the network to ensure ongoing compliance and facilitate improvement. Deficient elements, related to the CAHPS® Survey or the Medical Record Reviews, regardless of activity, are targeted for process improvements. Outcomes are monitored, tracked over time and reported to the Committee at least annually, when required. Data and service activities include, but are not limited to:
 - Quality Improvement studies
 - Trended data from sentinel events
 - Quality of care and service data
 - Member and Practitioner Satisfaction Surveys (access and availability)
 - Medical record reviews
 - Appeals data
 - Grievance data
 - Over and under-utilization data
 - Quality site visits

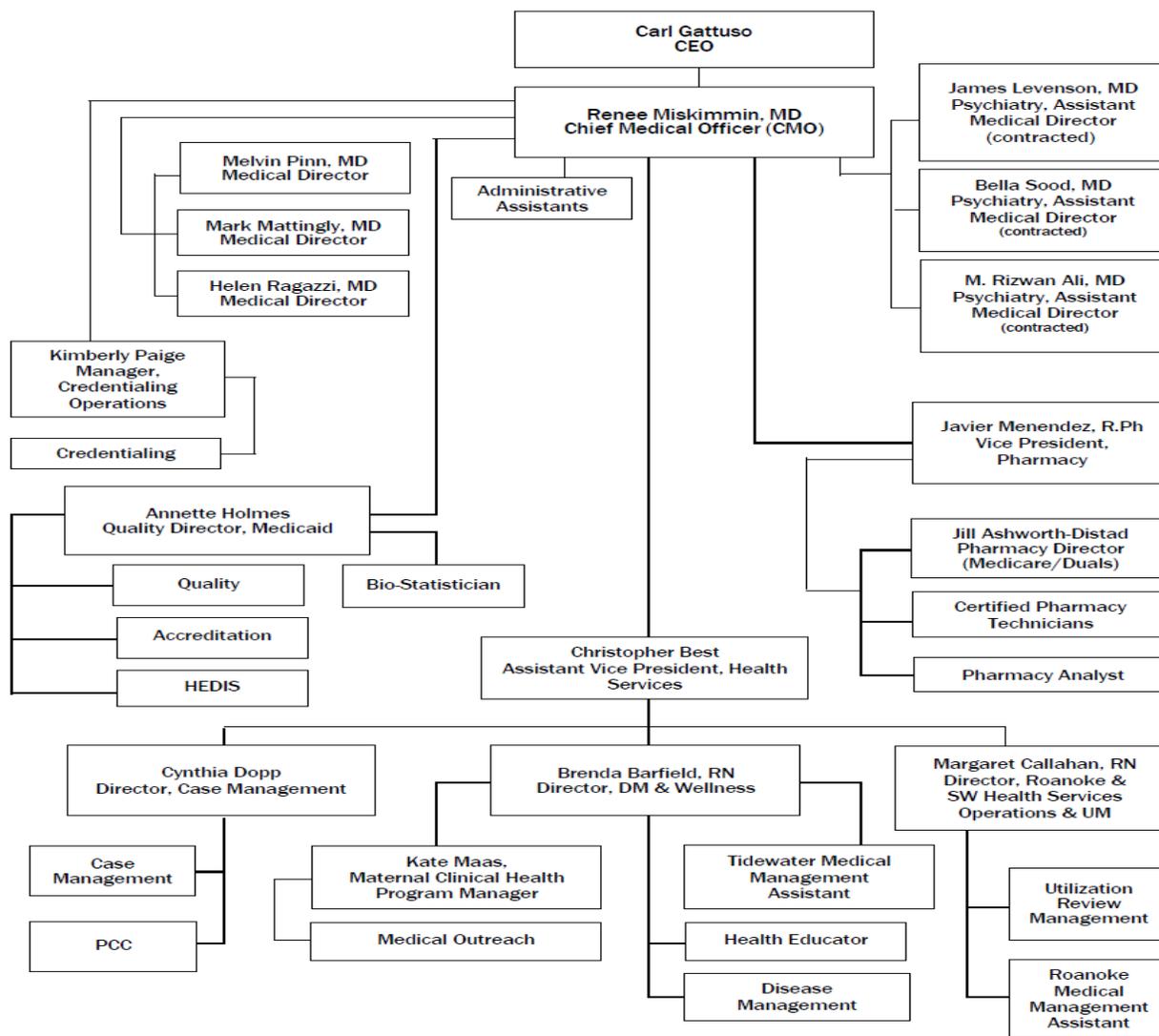
The Health Quality Utilization Management (HQUM) Committee

B. HQUM, effective January 2011, replaced The Utilization Management and New Technology Committee and the Quality Improvement Committee, an addendum to support committees to include Quality Satisfaction Committee, etc. are formed as needed and report to the CQIC. With the approval of the Board and/or CQIC, committees are created to meet specific organizational needs. Each committee operates to accomplish specific objectives and processes contained in the annual work plan. The CQIC provides direction to all committees and ensures coordination between committees.

OVERSIGHT OF THE QUALITY PROGRAM

The Board of Directors has ultimate responsibility for the QI Program and related processes and activities. The Board of Directors has delegated to the HQUM and the CQIC responsibility for ensuring the quality improvement processes outlined in this plan are implemented and monitored.

Below is an organizational chart depicting key staff of the health plan related to the QM Program, followed by brief descriptions of senior level positions and Quality Management positions.



A. CHIEF EXECUTIVE OFFICER

The Chief Executive Officer (CEO) is responsible for all Plan activities, to include but not limited to, oversight of the implementation of the Quality Program. The CEO is responsible for monitoring the results of the health plan’s quality of care and services, assuring that fiscal and administrative management decisions do not compromise the quality of care and service provided by VPHP. The CEO or designee chairs the Continuous Quality Improvement Committee. Findings and outcomes are discussed at the CQIC meetings, at least annually.

B. CHIEF MEDICAL OFFICER (CMO), MEDICAL DIRECTORS, AND BEHAVIORAL HEALTH MEDICAL DIRECTORS

The Chief Medical Officer or designee is responsible for providing direction for the development and implementation of the Health Quality Utilization Management, and Credentialing Committee programs. The Medical Director(s) is responsible for peer review activities, and for collaboration with practitioners on the development and implementation of the Quality Program. The Medical Directors have substantial involvement with participating practitioners on a regular basis, acting as a clinical

liaison, educator, role model and mentor to assist participating practitioners in achieving the Quality program's goals and objectives. The Medical Directors and the Behavioral Health Medical Director report to the CMO and assists the CMO in carrying out all responsibilities and duties. The Behavioral Health Medical Director serves as a peer reviewer on behavioral health cases; assists in the development and implementation of quality improvement activities related to behavioral health by identifying member focused interventions to promote improved behavioral health outcomes, and other related matters and attends the CQIC, as needed. The Medical Directors and Behavior Health Medical Directors are standing and/or ad hoc members of the CQIC.

C. CHIEF OPERATIONS OFFICER

The Chief Operations Officer or designee is responsible for the daily operation of the company and reports to the Chief Executive Officer. The COO has oversight responsibility for the following operational areas: Network Development and Contracting, Claims Payment, Information Systems and Facility Management, Human Resources & Organization Development, Member Operations and Transportation and Virginia Premier Complete Care (MMP for Financial Alignment Demonstration). The COO works collaboratively with the CMO to yield satisfactory clinical and service outcomes related to quality initiatives.

D. VICE PRESIDENT, HEALTH SERVICES

The Vice President of Health Services (VPHS) is responsible for the oversight, direction and strategic leadership of the Quality Improvement Program which includes quality of care issues, regulatory activities involving quality, HEDIS and accreditation. In addition, the VPHS has oversight and strategic leadership for the Utilization, Case and Disease Management Programs. The VPHS is responsible for the advancement of VPHP's quality strategy by designing, developing, implementing and conducting on-going evaluation of quality improvement activities, across the company, to measure and improve the quality of health care and service provided to members, to include delivering care in a culturally sensitive manner. The VPHS assists the CEO, the CMO, the VPHP Medical Directors and Behavioral Health Medical Directors, and impacted VPHP Departments with related activities.

E. DIRECTOR, QUALITY IMPROVMENT

The Director of Quality Improvement, under the direction of the Chief Medical Officer, is responsible for oversight of the implementation of the QI Program, including monitoring the quality of care and service complaints and provides the evaluation of quality improvement initiatives involving member and provider outreach. The Director of Quality Improvement is also responsible for oversight of activities designed to increase performance on HEDIS® measures, preparation of the annual QI program documents, oversight of submission of quality regulatory reports, oversight responsibility for implementation of quality improvement studies and patient safety initiatives, oversight of delegated vendors and managing the Health Plan Quality Improvement infrastructure. The Director of Quality Improvement is responsible for the CAHPS Surveys. The Director is responsible for coordinating the National Committee for Quality Assurance (NCQA) Health Plan Survey, the Annual Quality Survey, Performance Improvement Projects, Quality Improvement Activities and HEDIS for the Health® Compliance Audits, Performance Measure Validation (PMV) for the Health Plan. The Director of Quality Improvement is a point of contact for regulatory inquiries and works with the Compliance Officer to assure compliance with regulatory and accreditation standards. The Director of Quality Improvement works collaboratively with VPHS and CMO to provide oversight for the Quality Improvement Program, Evaluation and Work plan.

F. VICE PRESIDENT, PHARMACY

The Assistant Vice President of Pharmacy (AVPP) is responsible for the monitoring, management and oversight of pharmacy data and costs at VPHP. The AVPP ensures consistency of its Program with other programs throughout VPHP, including the Quality Program when applicable.

G. VICE PRESIDENT, CONTRACTING/NETWORK DEVELOPMENT

The Vice President of Network Development/Contracting (VPND) has daily oversight and operating authority for provider services, contracting, recruitment, and retention activities/functions. The VPND ensures consistency of the Network Development/Contracting Program with other programs throughout VPHP, including the Quality Program. Provider Relations include managing communications with network providers. The CQIC works with Provider Relations and guides remedial action plans and communication with network clinicians. The VPND monitors standards associated with ongoing monitoring and remedial action for non-compliance with access standards as necessary. Network Development/Contracting ensures the network is sufficient in number and type of practitioners to assure accessibility, availability, after hours coverage and care is delivered in a culturally sensitive manner across VPHP's network.

H. VICE PRESIDENT, MEMBER OPERATIONS

The Vice President of Member Operations (VPMO) is responsible for the direct administrative and supervisory activities of Enrollment, Member Services, Transportation Services, Mail Operations and special projects. The VPMO ensures consistency of the Member Operations Program with other programs throughout VPHP, including the Quality Program. The VPMO will facilitate the integration of various operational systems within the organization. Member rights and responsibilities are published and distributed to both members and practitioners. The Member Advisory Committee (MAC) and annual CAHPS® survey are avenues for incorporating member suggestions and concerns into quality initiatives. The Member Operations Department is represented on the CQIC, which oversees quality improvement efforts aimed at increasing member satisfaction.

I. VICE PRESIDENT, CLAIMS

The Vice President of Claims (VPC) is responsible for the oversight, direction and strategic leadership of the Claims Department, which includes operations, configuration and cost containment. The VPC ensures consistency of the Claims processes/procedures with other processes throughout VPHP, including the Quality Program when applicable. The VPC is responsible for oversight of resources responsible for the timely and accurate adjudication of claims as well as the creation and submission of encounter files to regulatory agencies. These areas function to support the overall success of timely and accurate claims adjudication and to provide key assistance to our provider/vendor network regarding claims.

J. VICE PRESIDENT, INFORMATION SYSTEMS AND OPERATIONS MANAGEMENT

The Vice President of Information Systems and Organizational Management (VPISOM) is responsible for the oversight, direction and strategic leadership of the Information Systems (IS) Program, which includes data management, integration and security. The VPISOM ensures consistency of the IS Program with other programs throughout VPHP, including the Quality Program when applicable. The VPISOM has daily oversight and operating authority for the enhancement and improvement of health and quality outcomes through the use, implementation and advancement of information systems and technology. The VPISOM is responsible for ensuring data integrity and meeting the medical informatics and analytical needs related to the collection of quality improvement data necessary for HEDIS® and other internal quality improvement activities.

K. PROGRAM INTEGRITY OFFICER/GOVERNMENT RELATIONS

The Program Integrity Officer/Government Relations (PIO) is responsible for the oversight, direction and strategic leadership of the Compliance Program, which includes compliance to the regulatory contracts, ensuring that all Protected Health Information (PHI) remains secure and confidential, organizational information (e.g., minutes) are confidential, proprietary and protected from discovery under the Health Care Quality Act of 1986. The PIO ensures consistency of the Program Integrity Department with other programs throughout VPHP, including the Quality Program. The PIO is also the VPHP regulatory liaison and responsible for submitting all regulatory reports to DMAS, as required per the State contract. Confidential materials are in secure files and/or areas, as deemed appropriate.

L. VICE PRESIDENT, HUMAN RESOURCES & ORGANIZATIONAL DEVELOPMENT

The Vice President of Human Resources/Organizational Development (VPHROD) is responsible for the oversight, direction and strategic leadership of the Human Resources Program, which includes training, development, recruitment and retention of qualified personnel. The VPHROD ensures consistency of its Program with other programs throughout VPHP, including the Quality Program when applicable.

M. CHIEF FINANCIAL OFFICER

The Chief Financial Officer (CFO) is responsible for the oversight, direction and strategic leadership of the Finance Operations, accounting, analytics, medical informatics, medical economics and payroll. The CFO has daily oversight and operating authority for VPHP fiscal responsibilities. The CFO ensures consistency of its processes/procedures with other programs throughout VPHP, including the Quality Program when applicable.

N. VICE PRESIDENT, STRATEGIC PLANNING AND BUSINESS INTEGRATION

The Vice President of Strategic Planning and Business Integration (VPSP/BI) is responsible for the oversight, direction and strategic leadership for VPHP, which incorporate strategy and business development. The VPSP/BI ensures consistency of its Program with other programs throughout VPHP, including the Quality Program when applicable.

O. QUALITY MANAGER

The Quality Manager is responsible for leading and coordinating clinical quality improvement activities, assisting in the development of the Annual QI Program Description and Work Plan, analysis and reporting on continuous monitors of clinical quality. The Quality Manager is also responsible for regulatory reporting, as well as supporting the Health Plan's NCQA survey and annual regulatory surveys. The Quality Manager reports to the Director of Quality Improvement regarding all quality management functions.

P. HEDIS PROGRAM MANAGER

The Manager of HEDIS® is responsible for management of the internal analysis and review of quality outcomes at the provider level, provider education on quality programs, monitoring and reporting on key measures to ensure providers meet quality standards and implementation of pay for performance initiatives.

Q. QUALITY NURSES/HEDIS NURSES

The quality nurses are licensed registered nurses who support QI activities at the Health Plan level. There is a quality nurse located in each region and they report to the Quality Manager who reports to the Director of Quality Improvement. They communicate routinely with the Medical Director regarding issues related to Quality of Care/Service or Critical Incidents. The quality nurses compile and maintain report data in a standard format to support the quality program. They prepare quarterly regulatory reports, manage investigations of peer review, critical incident, quality of care and quality of service issues and interface with the CMO, Health Services, Provider Service Representatives (PSRs), Health Plan Operations, and Administrative management to ensure appropriate resolution of these issues. Oversight of these activities is reviewed by the HQUM and by the CQIC. The quality nurses are responsible for educating providers and internal staff about reporting and investigation of Critical Incidents and Care and Service complaints as needed. In addition, the Clinical Quality Analysts assist with preparation of Performance Improvement Projects.

R. QUALITY IMPROVEMENT SPECIALISTS

The Quality Specialist is responsible assuring ongoing organization-wide regulatory and accreditation readiness. Core functions also include full responsibility for all quality related activities to include, but not limited to, accreditation and regulatory efforts associated with or required by the National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS®), a registered trademark of NCQA, the Department of Medical Assistance Services (DMAS) and other required entities associated with or required by the State and/or Federal Government. The Quality Specialist is also responsible for performing internal mock audits, maintaining interdepartmental communication and education/training related to quality standards, and serving as the liaison for regulatory and accreditation quality standard requirements

QUALITY PROGRAM: SUPPORT COMMITTEES

The CQIC core support committees are the (A) HQUM, the (B) Credentialing Committee, (C) Quality Satisfaction Committee and other subcommittees as needed. Each of these committees and teams perform activities targeted for quality improvement and utilization management within relevant areas of managing scope. Findings and outcomes from each committee are reported to the CQIC, at least annually.

A. **HEALTH QUALITY UTILIZATION MANAGEMENT COMMITTEE (HQUM)**

The Health Quality Utilization Management Committee combines (1) Quality and (2) Utilization Management and New Technology Committee activities for the purpose of developing, implementing and managing the quality and utilization improvement processes, and providing overall direction and consultation to VPHP staff and practitioners on appropriate use of covered services. It meets monthly. The committee members include:

Committee Structure:

- Chief Medical Officer (voting) – Chair
- Medical Directors (voting) – Richmond and Roanoke
- Participating Primary Care Physicians (voting)
- Participating Specialty Care Physicians (voting)
- Behavioral Health Physician, Associate Medical Director (voting)
- Vice President, Health Services (non-voting)
- Director, Quality Improvement (non-voting)

- Assistant Vice President of Pharmacy (non-voting)
- Resource staff (as needed non-voting)
- Statistician (as needed non-voting)

FUNCTIONS OF HQUM Committee:

- Approve and monitor the progress of the Quality Program Description, Annual Work Plan and Evaluation
- Approve and monitor the progress of the UM Program Description and Annual Evaluation
- Oversee, evaluates and analyzes quality activities for improvement opportunities such as CAHPS® and practitioner survey outcomes, appeals (upheld and overturned), patient safety data, grievances (quality of care and quality of service), and pharmacy utilization. Outcomes are tracked, trended and reported to the CQIC for feedback and recommendations on improvement. Additionally, outcomes are shared with the members and practitioners at least annually.
- Oversee all quality pharmacy and utilization management and new technology activities
- Evaluate member and plan information compiled by the Quality Department
- Select and schedule initiatives based upon the needs of the population, external requirements, and likelihood of effective interventions
- Approve clinical performance standards and practice guidelines
- Recommends policy decisions
- Assist VPHP in complying with reviews and evaluations conducted and/or required by oversight authorities
- Ensures practitioner participation in the Quality Program through planning, design, implementation, or review
- Institutes needed actions
- Ensures follow-up, as appropriate
- Reviewing summary data of utilization management trends, sentinel events, and over and underutilization of services and evaluating opportunities for improvement.
- Reviewing and development of utilization management criteria for decision-making
- Approve clinical practice guidelines
- Monitoring and ensuring delegated UM functions.
- Reviewing and rendering decisions on grievances resulting from denials of, or modifications in, requests for medical services from practitioners based upon medical necessity and treatment protocols. (If denied, appeals process is offered for all denials.)

1. **QUALITY MANAGEMENT**

VPHP participating practitioners and providers are required through a contractual agreement to cooperate with all quality activities and allow VPHP staff access to sites and VPHP member medical records.

(a) **MEMBER SAFETY PROGRAM**

VPHP is committed to providing quality services, enhancing the safety of members, practitioners, providers and staff while preserving its financial integrity and stability to continue its mission. The Member Safety Program (MSP) proactively identifies, evaluates and resolves potential safety issues. VPHP is not a direct provider of care and, therefore, has a special role in improving patient safety that involves fostering a supportive environment to help practitioners and providers improve the safety of their practices and the care they deliver. Practitioners who participate on the various quality committees also play an integral role in the MSP. A multidisciplinary team approach is utilized to implement the program. The team includes participants from the following departments:

- Quality: Accreditation and Quality Credentialing
- Utilization Management: Medical Outreach, Health Education, Case Management, DM, Utilization Review and Coordination
- Member Operations: Enrollment, Member Services, Transportation, and Mailroom
- Network Operations: Contract Management and Provider Relations
- Claims: Claims System Configuration, Cost Containment, Customer Service, Electronic Data Exchange,
- Information Systems: System Integration Team
- Program Integrity: Compliance, Grievances/Appeals and HIPAA Information
- Human Resources: Human Resources and Organizational Development
- Finance: Business Performance Analytics and Financial Analytics,

According to the Agency for Healthcare Research and Quality (AHRQ), patient engagement in outpatient safety involves two related concepts: first, *educating* patients about their illnesses and medications, using methods that require patients to demonstrate understanding (such as "[teach-back](#)"); and second, *empowering* patients and caregivers to act as a safety "double-check" by providing access to advice and test results and encouraging patients to ask questions about their care. Success has been achieved in this area for patients taking [high-risk medications](#), even in patients with low health literacy at baseline.

GOALS OF THE MSP

- Enhancing the safety, quality, efficiency, and effectiveness of health care to ensure a safe and suitable healthcare environment
- Involving members and practitioners in the process
- Educating members and practitioners
- Obtaining feedback that will result in significant improvements in healthcare delivery by:
- Conducting health care assessments on each new enrollee
- Conducting surveys (i.e., CAHPS®), interviews, and focus groups
- Improving outcomes related to disease management programs or associated initiatives, i.e., prenatal and postpartum, diabetes, depression, pain management and asthma outcomes, Healthy Heartbeats, pediatric obesity, congestive heart failure, COPD, ESRD
- Investigating grievances and appeals in a timely and accurate manner
- Validating practitioner and provider credentials in a timely and accurate manner
- Enhancing prevention efforts across the continuum of care
- To comply with all requirements related to safety and quality per state, federal, and other accrediting agencies standards and guidelines

SCOPE OF MSP

Scope of the VPHP MSP is broad-based and comprehensive. It includes:

- Sending prevention letters to members
- Educating members on how to communicate with their doctor
- Medical Outreach staff efforts
- Quarterly newsletters mailed and/or on website for providers and practitioners with reminders related to the delivery of quality healthcare
- Recognizing practitioners and providers who are leaders in quality and safety
- Internal and community practitioners who participate on the various quality committees providing insight into current clinical practice
- Providing Quality Toolkits to providers that provide resources on patient safety

- Conducting quality office site visits to insure providers are meeting standards related to safety

The program description is presented to the HQUM and CQIC annually. Goals are set each year and outcomes are evaluated annually.

(b) MEMBER SAFETY INITIATIVES (MSI)

The following activities are ongoing initiatives that help assure VPHP enrollees receive the best healthcare on a continuous basis. The Plan assesses health care safety by using readily available administrative data (survey, claims, etc.), grievance data, and medical record data.

The MSIs are a set of indicators providing information on adverse outcomes following surgery, procedure, or childbirth. The indicators also include occurrences that are unusual or may indicate a concern in quality of care or service in either an inpatient or outpatient setting. The MSIs serve as the core factors that are reported monthly, quarterly, and/or annually (as applicable). The indicators are screened, investigated, analyzed, trended and monitored by the Quality Department. Indicators developed are followed by an in-depth assessment by the quality department and medical informatics departments. Outcomes are aggregated and reported to the CQIC, at least annually.

MSIs include:

Sentinel Events: As defined by DMAS, a sentinel event is a death. However, VPHP defines a sentinel event (also known as a quality of care indicator) as one of the following:

- Trauma suffered while in a healthcare facility/provider's office/HMO site
- Surgery on wrong body part
- Surgery on wrong patient
- Loss of function not related to illness or condition
- Rape in 24 hour care facility
- Suicide in 24 hour care facility
- Infant abduction or discharge to wrong family
- Death

Deaths are reported to DMAS within 48 hours of receipt. Each sentinel event is investigated by a licensed, registered nurse in the quality area. Investigation assists the Plan to detect omissions in the process that occur during the delivery of care. Conducting root cause analyses on adverse events, such as sentinel events, enables the Plan to implement systemic modifications to prevent the event from reoccurring.

Quality of Care Indicator: Any adverse event that is investigated by a nurse in the quality area. A Medical Director and/or the quality committees, if necessary, review indicators. The indicators are used to help the Plan identify potential adverse events that might need further study. Conducting root cause analyses on adverse events enables the Plan to implement systemic modifications to prevent the event from reoccurring. Indicators are received from various sources and include grievances, defined as any expression of dissatisfaction about any matter other than an "action." Grievance defines the overall system that includes grievances and appeals that are handled at the managed care organization level. A grievance can result from a medical record review and focused office visit, a practitioner report or other sources.

- The VPHP Medical Director, acting as a first level peer reviewer, reviews all referrals for quality of care issues. These issues are presented to the HQUM and one or more of the CQIC Support Committees in an aggregated form.
- All unresolved cases at the first level peer review will be submitted for second level peer review for determination of severity level and appropriate corrective action.

- Final determinations regarding any serious disciplinary actions will require approval by the CQIC.. VPHP will adhere to the reporting requirements of the VA State Medical Board, Office of Inspector General (OIG), the National Practitioners Data Bank (NPDB), and VPHP Policies and Procedures.

Credentialing: The process of verifying the credentials of a practitioner or provider, which ensures that each member is treated by a practitioner or provider licensed to conduct business in the Commonwealth of Virginia. (Further information contained in the credentialing section.) Any practitioner that is on the Office of Inspector General list will not be paneled to the plan or will be terminated upon identification.

Medical Record Review:

The objectives of the Medical Record Review (MRR) are:

- Evaluate the structural integrity of the medical record
- Evaluate the medical record for the presence of information that is necessary to provide quality care and determine the appropriateness and continuity of care
- Evaluate the medical record for documentation that conforms to good medical practice
- Assess and improve medical record keeping practices of practitioners who provide primary care
- Conduct focused follow-up to improve medical records of primary care practitioners who do not meet VPHP medical record standards

Clinical reviewers are trained in the use of the MRR tool to collect data. Data summary and opportunities for improvement are reported to the plan's CQIC committee as needed. MRR results are also disseminated to the practitioners and follow-up reviews are conducted as necessary and per the established plan policy.

All instances of suspected fraud, waste and/or abuse at the practitioner/provider level (e.g., during MRR, site visits, quality of care issues/grievances and/or during the credentialing process) will be referred to the Compliance Department for investigation within 24 hours of identification.

Grievance Monitoring:

The objectives of grievance monitoring are to:

- Trend, evaluate and monitor grievances
- Effectively resolve member or practitioner grievances in a timely manner
- Identify opportunities for improvement in the quality of care and services provided to VPHP members and practitioners.

Issues are tracked, trended and aggregated by the Quality Manager. All Provider Care, Treatment, and Access to Services/Providers grievances are forwarded to a nurse in the quality area to investigate and/or review for quality issues and/or referred for follow-up to Case Management or Provider Services. The Quality area applies VPHP policies to ensure timely response and resolution. Cases scored at a higher severity level are forwarded to a Medical Director for review. Cases with higher severity may also be reviewed by the HQUM and CQIC Committees.

Data related to administrative and quality of care/service issues are collected, reviewed and analyzed in aggregate for trends and opportunities for improvement. The aggregated data is presented to the CQIC as needed. The regulatory reporting categories for quality of care and quality of service issues are Transportation, Access to Services/Providers, Provider Care and Treatment, MCO Customer Service, Administrative Issues, and Reimbursement Related Issues.

A Medical Director will conduct the final review of investigation outcomes. Members and practitioners are informed of investigation outcomes in writing or orally if received orally.

When members are not satisfied with the outcome of a grievance, an appeals process allows for inclusion of additional information and reconsideration of the issue. During the grievance resolution process, members are notified in writing and/or verbally of their right to file an appeal at any time, and provided the necessary information to file the appeal.

Medical Outreach Activities/Health Education:

The Plan has ongoing outreach and health education efforts to ensure patients are informed of quality outcome results.

Prenatal Outreach Activities:

Medical Outreach Representative (Workers) of Plan benefits and health information visit pregnant members on a routine basis to ensure that the member is living in a safe environment and attending their prenatal visits. Postpartum visits are scheduled with the mother to ensure that both mom and baby are residing in safe environments and assist the member in obtaining basic infant care supplies as needed.

Vaccines for Children Program:

Physicians participate to ensure vaccines are available for Medallion 3.0 eligible population

Medical Errors:

Medical errors are one of the Nation's leading causes of death and injury. A report, *To Err is Human: Building a Safer Health System*, by the Institute of Medicine estimates that as many as 44,000 to 98,000 people die in U.S. hospitals each year as the result of medical errors. This means that more people die from medical errors than from motor vehicle accidents, breast cancer, or AIDS. The report concludes that the majorities of these errors are the result of systemic problems rather than poor performance by individual practitioners, and outlined a four-pronged approach to prevent medical mistakes and improve patient safety.

National Patient Safety Goal for Ambulatory Care – 2016

The **2016 National Patient Safety Goals (NPSG) for Ambulatory Care** promotes specific improvements in patient safety. The goals highlight fundamental areas affecting member safety. VPHP educates our practitioners on the goal(s) associated with this safety initiative and a list of problematic abbreviations. The National Patient Safety Goals that are routinely provided to network practitioners and providers. The goals in their entirety can be located at: http://www.jointcommission.org/assets/1/6/2016_NPSG_AHC_ER.pdf.

The Joint Commission:

During site visits, the Quality Staff educates and distributes The Joint Commission's National Patient Safety Goal "Do not use abbreviations." Annually, the "Do Not Use List" is communicated to the practitioners via the Provider Newsletter.

The National Patient Safety Goals, (NPSG) promote specific improvements in patient safety. The goals highlight fundamental areas affecting member safety. The following list includes "Do Not Use" abbreviations that are often the cause of medical errors. VPHP educates our practitioners on the goal(s) associated with this safety initiative and a list of problematic abbreviations. The National Patient Safety Goals that are routinely provided to network practitioners and providers are given below:

National Patient Safety Goal on Abbreviations - 2016

In 2001, The Joint Commission issued a Sentinel Event Alert on the subject of medical abbreviations, and just one year later, its Board of Commissioners approved a National Patient Safety Goal requiring accredited organizations to develop and implement a list of abbreviations not to use. In 2004, The Joint Commission created its “do not use” list of abbreviations as part of the requirements for meeting that goal. The purpose of the goals is to promote specific improvements in patient safety. The “Do Not Use” Abbreviation list may be found at:

http://www.jointcommission.org/facts_about_do_not_use_list/

The goals, in their entirety, can be located at:

http://www.jointcommission.org/standards_information/npsgs.aspx

Each year, VPHP highlights the “**Do Not Use**” list, which is included under NPSG – 2B. In May 2005, The Joint Commission affirmed its "Do Not Use" list of abbreviations, acronyms, symbols and dose designations. The list was originally created in 2004 by the Joint Commission (formerly JCAHO) as part of the requirements for meeting NPSG requirement 2B (Standardize a list of abbreviations, acronyms and symbols that are not to be used throughout the organization). Participants at the November 2004 National Summit on Medical Abbreviations supported the "do not use" list. Summit conclusions were posted on the Joint Commission website for public comment. During the four-week comment period, the Joint Commission received 5,227 responses, including 15,485 comments. More than 80 percent of the respondents supported the creation and adoption of a "do not use" list. VPHP supports the use of this list and encourage all practitioners and providers to utilize it in practice.

Official Do Not Use List¹

Do Not Use	Potential Problem	Use Instead
U, u (unit)	Mistaken for “o” (zero), the number “4” (four) or “cc”	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d, qod (every other day)	Mistaken for each other Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (X.o mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write o.X mg
MS MSO ₄ and MgSO ₄	Can mean morphine sulfate or magnesium sulfate confused for one another	Write "morphine sulfate" Write "magnesium sulfate"

The Joint Commission Last updated 06/2015

¹The list applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

**Exception: A “trailing zero” may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.*

Annually, VPHP reviews The Joint Commission (formerly JCAHO) National Patient Safety Goals for relevance to the care and services related to the VPHP practitioner and provider networks. For more

information, contact the Standards Interpretation Group at 630-792-5900 or complete the [Standards Online Question Submission Form](#).

2. UTILIZATION MANAGEMENT

PREVENTIVE CARE GUIDELINES REVIEW

The objective of the Preventive Care Guideline Review is to monitor the use of scientifically based preventive care guidelines for improving the quality of care provided. VPHP continuously monitors the effectiveness of adopted preventive care guidelines. The HQUM Committee reviews and approves these guidelines based on the most current and reasonable medical evidence available from the US Preventive Services Task Force, the CDC and Healthy People 2020, National Health Promotion and Disease Prevention Objectives, as well as the state requirements for Medallion 3.0 i.e. EPSDT program. Findings and distribution schedule of the guidelines are discussed at the CQIC meetings.

NEW TECHNOLOGY

Responsible for reviewing new technology based on requests from providers and members as well as changes in the industry.

OVER AND UNDER UTILIZATION

Over and underutilization of services are monitored to ensure that members are receiving necessary care and service in the most appropriate setting. Data are gathered from the following sources:

- Member and provider satisfaction surveys
- Grievance and appeals data
- Provider utilization data
- Pharmacy utilization reports
- Utilization management reports
- Quality of care reports
- Medical record/site visit reviews
- HEDIS® outcomes

(a) BEHAVIORAL HEALTH PROGRAM

The program outlines VPHP's efforts to monitor and improve behavioral health care. The behavioral health medical director acts as a consultant and provides feedback at the various quality committee meetings. Covered benefits include physician, outpatient and inpatient services for behavioral health and medical diagnosis. Members may self-refer for the initial three (3) behavioral health visits of the benefit year. VPHP's UM/CM staff may authorize additional visits when a treating practitioner completes an outpatient treatment report and submits it to VPHP prior to rendering services. Authorization requests will not be reviewed retrospectively except in cases of emergency services.

GOALS OF THE PROGRAM

- Coordinate and provide high-quality managed behavioral healthcare services
- Sustain a formal Committee comprised of practitioners representing all VPHP geographical regions and numerous specialties including behavioral health.
- Meet minimum requirements of the National Committee for Quality Assurance (NCQA®) 50th percentile and strive to meet the national 75th percentile for the all Behavioral Health (HEDIS®) measures, Anti-depressant medication, Follow-up after Mental Health Admissions seven and thirty days and Follow Up Care for Children Prescribed ADHD medication.

- Improve the impact of behavioral health treatment on physical health status
- Patient satisfaction with care provided and all aspects of the delivery system

SCOPE OF THE PROGRAM

Quality of direct patient care in behavioral health while seeking care from network practitioners and in outpatient and inpatient settings for adults, adolescents and children

COORDINATION OF CARE

Licensed, behavioral healthcare case managers manage behavioral healthcare services for Plan members. The Plan benefit covers twenty-four hour clinical coverage for mental health services. Members have open access to participating behavioral health practitioners, up to a maximum of three visits in a benefit year. Four or more visits require preauthorization.

CREDENTIALING COMMITTEE

The Credentialing Committee is responsible for oversight of activities of the Plan's Credentialing Program. Policies and procedures related to Credentialing are reviewed and approved by the CQIC. The committee meets at least 12 times per year and includes the CQIC Support Committees, with the addition of a voting VPHP Contracting/Network Development staff member.

Committee Structure:

- Chief Medical Officer – (voting) –Chair
- Medical Directors (voting)
- Participating Primary Care Physicians (voting)
- Participating Specialty Care Physicians (voting)
- Behavioral Health Physician (voting)
- Vice President, Network Development or designee (voting)
- Manager of Credentialing (non-voting)
- Director of Quality (non-voting)
- Resource staff (as needed non-voting)
- Statistician (as needed non-voting)

FUNCTIONS OF CREDENTIALING COMMITTEE:

- Reviewing all practitioner applicants to ensure compliance with credentialing requirements and ultimately making recommendations for approval or denial. If denied, the appeals process is offered.
- Reviewing all practitioner applicants for the following prior to recredentialing:
 - Selection criteria suitability
 - Medical record standards compliance
 - Member grievance trends
 - Results of quality review studies
 - UM activities
 - Member satisfaction surveys
 - Reviewing independent practitioners prior to credentialing and recredentialing
 - Giving periodic updates and annual evaluation of the credentialing program to the CQIC
 - Reviewing delegated credentialing activities
 - Sanctions and/or limitations related to state licensure and Medallion 3.0/Medicare

CREDENTIALING AND RECREDENTIALING

VPHP conducts credentialing and recredentialing activities for physicians to include doctors of medicine, doctors of osteopathy, doctors of podiatry, doctors of obstetrics and/or gynecology, family nurse practitioners, licensed clinical social workers, psychiatrists, psychologists, and other licensed practitioners with whom it contracts to provide services to members.

The Credentialing Committee and/or Medical Directors make the final approval or denial decision on every practitioner. Upon approval or denial, a letter is mailed out within 60 calendar days of the decision, signed by the CMO or their designee. Credentialing and recredentialing includes primary source verification in accordance with VPHP policies and procedures set forth by NCQA. Site visits will be conducted for complaints involving physical accessibility, physical appearance and adequacy of waiting and examining room space, Site visit will also be conducted on a random basis for all network practitioners to ensure VPHP office site standards are met.

At the time of recredentialing, individual practitioner performance profiling is evaluated through consideration of information from: licensure sanction reports, Medicare/Medicaid sanction reports, adverse actions, member grievances, site visits, medical records reviews, quality improvement projects, member satisfaction and utilization management data. Practitioners have access to an appeals process in the event of an adverse credentialing decision.

Office of the Inspector General (OIG): The Health and Human Services Office of Inspector General is responsible for excluding individuals and maintaining a sanctions list that identifies those practitioners and providers who have participated or engaged in certain impermissible, inappropriate, or illegal conduct to include, but not limited to fraudulent billing and misrepresentation of credentials. The OIG's List of Excluded Individuals and Entities (LEIE) provides information on all individuals and entities currently excluded from participation in the Medicare, Medicaid, and all other Federal health care programs.

CONTRACTUAL ARRANGEMENTS

(1) NON-DELEGATED

By signing the practitioner addendum to the Participating Provider Group Contract (PPG), the Consultant Agreement, the Medical Specialty Group Agreement, the Primary Care Physician Agreement, and/or a Hospital Agreement, network primary care practitioners (PCP) and groups, specialty practitioners, organizational providers, home health agencies, and hospitals agree to:

1. Abide by the policies and procedures of the VPHP Quality Program
2. Participate in peer review activity
3. Provide credentialing information as specified
4. Serve on the HQUM, Credentialing and/or specialty peer review committees, as necessary
5. Allow VPHP to collect information for the purposes of quality assessment and improvement
6. Cooperate with quality, disease, and case management, and/or grievance resolution, as necessary

(2) DELEGATED

Credentialing functions are delegated to contracted organizations. The delegated entities submit reports at least twice a year and undergo comprehensive audits of processes and files (as

applicable) at least annually. Vendors that VPHP has entered into a contractual arrangement with are responsible for monitoring and evaluating the contracted services provided to VPHP members and providing VPHP with routine reports on quality findings and results of quality improvement activities. The delegated entity develops its own Quality Program, in accordance with VPHP and NCQA standards and guidelines, when applicable.

Any delegation of responsibility for Quality, UM, Credentialing, or other activities must be approved by VPHP's CQIC and/or the CEO. The delegation will be conducted only after a written and signed agreement between the CEO of VPHP and the designated executive with signature authority of the vendor organization is completed. Any such agreement shall specifically state the terms of the delegation and the policies and methods for oversight by VPHP. VPHP's oversight of delegated entities shall be at least annually, announced and unannounced, and in accordance with standards set forth by the National Committee for Quality Assurance (NCQA), DMAS and VPHP policies and procedures.

The CQIC is responsible for oversight of VPHP's delegated quality functions. Findings and outcomes related to delegated functions are reported to the CQIC, HQUM and Credentialing committees, as appropriate at least annually.

The Partners State-Wide Conference Call Meeting (formally called The Delegated Credentialing Partners State-Wide Conference Call Meeting) was established November 2011. Meetings are held quarterly to ensure an ongoing exchange of information between VPHP and its quality and credentialing partners. The content of the meetings include VPHP policies and procedures (new, revised or terminated), accreditation outcomes, regulatory requirements and other pertinent information. Streamlining and simplification of activities and processes are also discussed during these meetings.

2016 QUALITY PROGRAM ACTIVITIES

Monitoring Quality Performance Indicators - Clinical and Service HEDIS® Measures:

The purpose of HEDIS® is to ensure that health plans collect and report quality, cost and utilization data in a consistent way so that regulators, accreditors and the plan itself can compare performance across health plans regionally and nationally. VPHP uses HEDIS® measures to provide network practitioners and providers with a standardized assessment of their performance in key areas in comparison to plan-wide findings. All HEDIS® data is collected through claims and other health plan systems and analyzed by NCQA certified software. VPHP implemented a new HEDIS Application in 2013 called Inovalon. VPHP conducts further analysis of HEDIS® results to better understand clinical outcome patterns and identify areas of improvement.

Monitoring Quality Performance Indicators –Surveys:

Members:

Surveying member satisfaction provides VPHP with information on our members' experience with the plan and their practitioners. VPHP assesses member satisfaction in several ways, but the primary measurement tool is CAHPS®. Results from CAHPS® helps the Plan identify areas of member dissatisfaction and opportunities for improvement. Based on the results of CAHPS® along with other member satisfaction feedback mechanisms, such as the Member

Advisory Committee Meetings, VPHP prioritizes improvement initiatives that are most meaningful to members.

Practitioners:

Surveying practitioner satisfaction, access and availability provides VPHP with information on our practitioner's experience with the plan and their members. VPHP assesses practitioner satisfaction in several ways, but the primary measurement tool is the Provider Satisfaction Survey, the Access and Availability Survey and the After Hours Survey. Results from surveys help the Plan identify areas of practitioner dissatisfaction and opportunities for improvement. Based on the results, along with other practitioner feedback mechanisms such as the Provider Advisory Committee Meetings, VPHP prioritizes improvement initiatives that are most meaningful to practitioners and members.

Clinical Practice Guidelines:

The Quality Program develops and the HQUMC approves the clinical practice guidelines in areas in which its evaluation reveals the greatest need for such guidelines. The guidelines are complementary to the established medical practices of the Plan. Practitioners are educated regarding the VPHP's clinical practice guidelines via the web site, provider newsletters, and the Provider Manual. Practitioners are informed that they may receive a paper copy of the guidelines upon request.

Patient Safety:

Patient safety needs are addressed through the following activities: 1) review of grievances and determination of quality of care impact; 2) notification to patients, practitioners, and providers of medications recalled by the FDA 3) notification to the Quality Team of any potential quality or safety cases (e.g., re-admissions within 30 days when a premature discharge is a question, significant provider errors include pharmacy, unexpected deaths, missed diagnoses or treatments, missed follow-up, or insufficient discharge planning); 4) comprehensive site surveys and medical record review, or in response to a Grievance or direction of the Quality Committee; 5) targeted and general member educational outreach; and 6) Encourage the completion, for at least 50% of the network physicians, especially primary care practitioners, to complete a cultural competency CME to aid in caring for members of diverse populations.

Disease Management:

Disease Management is a multidisciplinary, continuum-based approach to health care delivery that focuses on the identification of populations with, or at risk for, established medical conditions. VPHP's Disease Management Programs strive to: support the relationship between practitioners and their patients and reinforce the established plan of care; emphasize the prevention of exacerbations and complications utilizing cost-effective evidence-based practice guidelines and patient empowerment strategies such as self-management; and continuously evaluate clinical, humanistic, and economic outcomes with the goal of improving overall health.

Credentialing Peer Review Activity:

Peer review is conducted according to the regulatory, accreditation, and VPHP established standards and/or laws and regulations. The CMO, with the assistance of the Medical Directors, manages the peer review process. Cases requiring peer review are identified through member, practitioner, or provider grievances and other sources. Peer review may be performed directly or arranged for review by an appropriate committee physician or external physician reviewer in accordance with VPHP's policies and Procedures. Remedial and disciplinary action shall be taken in a timely manner in accordance with the Plan's policy.

VPHP contracts with Medical Evaluation Specialists (MES) to provide external reviews for cases requiring specialties not represented by VPHP Medical staff or committee.

Management of Quality of Care Complaints:

All grievances or issues generated by members, practitioners, providers, VPHP staff, state agencies, and other entities that involve quality of care are handled appropriately per established policy that includes response to grievances. Member contacts concerning access for a current illness or condition are routed to a clinician in VPHP's utilization management department. The clinician is accountable for timely assessment and resolution. The VPHP Medical Staff performs an objective review of all quality of care complaints and issues in accordance with VPHP's Policies and Procedures.

Quality Satisfaction Committee:

The Director of Quality or designee, who reports to the Vice President of Health Services, chairs and is responsible for the VPHP Quality Satisfaction Committee. The Committee includes representatives from operational departments that have a direct impact on accreditation, member compliance and member and practitioner/provider satisfaction. (The Committee ensures that there is a coordination of activities, reduction/elimination in duplication of efforts, and streamlined activities to ensure maximum output and outcomes. This includes sharing of information that could be beneficial to all related satisfaction activities that could adversely impact the satisfaction level of members, practitioners/providers, consumers, regulators, or accrediting organizations as well as a review and audit of VPHP processes, procedures, activities and programs.) This Committee also makes certain that collaboration and sharing of information occurs periodically to improve organization, membership and network-wide satisfaction. The organization annually makes information about its Quality Program available to member and practitioners.

The VPHP Quality Satisfaction Committee has been developed in response to growing VPHP, DMAS, and NCQA requirements/standards and the need for a more streamlined and collaborative process that encompasses organizational-wide satisfaction.

Web Site Committee:

The Communications Manager chairs the VPHP Web Site Committee. The Committee includes a representative from every operational department at VPHP, to include Quality. It ensures that the web site is accurate, current and valid providing reliability and high satisfaction for members, practitioners, providers, consumers, regulators, accrediting organizations, and others who access the website for plan specific information. Website data and metrics are included in the Annual Quality Program Evaluation and discussed at the meetings during the year.

Quality Annual Evaluation:

The Vice President of Health Services or designee presents the annual report for review and approval by the HQUM and CQIC. The report contains a description of all measurement activity, findings from the analysis, data in graphical display, recommendations to improve care, action plans, a summary of the progress made to improve care and services, and an evaluation of the Quality Program.

Quality Work Plan (*See Attachment*):

The Quality Program undertakes specialized quality initiatives in addition to those identified during the annual evaluation process. The areas of concentration for each year are defined in an annual Quality Work Plan, which tracks the data collection projects of the Quality Program. Additional projects are developed in response to member grievances and findings from performance measurement activities. In addition, the Quality Program will develop clinical

practice guidelines in areas in which its evaluation reveals the greatest need for such guidelines. The guidelines will be in addition to the regular medical practices of the Plan.

RECOMMENDATIONS FOR QUALITY PROGRAM FOR 2016

In 2016, VPHP will investigate the possible implementation of the following quality activities through effective and ongoing collaboration with other departments to problem solve and improve work processes across the organization. This is not to imply that all these activities will be implemented by VPHP. The following are recommendations and/or topics for discussion to improve VPHP's quality activities:

- (1) Collaboratively support and work with the VCUHS to incorporate VPHP quality activities.
- (2) Identify and implement interventions that will lead to improved HEDIS® outcomes Goal: 75th percentile or greater for all measures reported to DMAS and those measures used to calculate the Plan's annual HEDIS score
- (3) Continue as a member-centric organization by engaging members in plan processes; develop and implement new strategies that will gain greater and more diverse participation at the Member Advisory Committee meetings across all regions.
- (4) Proactively educate members, practitioners and providers on all patient safety materials that are available.
- (5) Develop and implement work plans with defined interventions for all HEDIS® measures < 50th percentile. The goal will be to sustain and or improve the following measures to the 50th percentile or greater. The measures include, but are not limited to:

Clinical

- Well Child Care 3-6 years
- Blood pressure control
- Childhood Immunizations
- HgbA1C < 8
- Breast Cancer Screenings
- Lead Screening in Children
- Cholesterol Management for Patients with Diabetes
- Asthma-Appropriate Use of Medication (all age categories set forth by the HEDIS technical specifications)
- Control of High Blood Pressure (140/90) among members diagnosed with hypertension
- Follow Up After Hospitalization for Mental Illness – 7 and 30 Days

Non Clinical

- Call Timeliness
- CAHPS

- (6) Collaborate with all organizational departments to incorporate quality initiatives into ongoing interactions with participating practitioners and members.
- (7) Enhance VPHP Primary Care Physician Quality Incentive Program, which is a Pay-for-Performance program designed to create a collaborative, quality centered partnership with Physicians to reward quality of care improvements.
- (8) Continue to work with the Department of Medical Assistance Services Managed Care Collaborative Work Group to improve Follow Up After Admission for Mental Health Treatment (7 and 30 day follow up) and Adolescent Well Care Visits, or other activities as indicated based on compliance rates across the Commonwealth of Virginia.
- (9) Continue to identify strategies to ensure that participating primary care physicians have open panels to provide increased access to practitioners especially in specialties such as orthopedics, pain management, and behavioral health. The plan representatives will continue to retain and recruit quality practitioners.
- (10) Continue to improve processes that ensure quality outcomes for members through lean and cost-effective opportunities; identify opportunities for cost savings in disease management and quality programs.

RESOURCE ALLOCATION

In addition to the quality improvement support committees, the individuals below are directly allocated for quality improvement activities:

Chief Medical Officer (1)	(100%)
Medical Director (3)	(100%)
Associate BH Medical Director (1)	(80%)
VP of Health Services (1)	(80%)
(Includes Biostatistician)	
Director of Quality Improvement (1) & Staff (12)	(100%)

Total Direct FTE Level: 19.0

The following Plan Personnel and/or designated departmental staff fully support and are fully engaged in quality improvement activities, as needed and in a timely manner:

Chief Executive Officer
 Chief Operating Officer
 Vice President, Network Operations/Development
 Vice President, Claims and Encounters
 Vice President, Information Technology
 Vice President, Human Resources and Organizational Development
 Vice President, Member Operations
 Vice President, Finance
 Program Integrity Officer
 Vice President of Pharmacy
 2 Administrative Assistants

FEEDBACK/COMMENTS:

Feedback related to VPHP’s Quality Program, quality assurance and improvement activities, and clinical or service studies should be mailed to:

Medical Management Department - Quality
600 E. Broad Street – Suite 400
P.O. Box 5307
Richmond, VA 23220-0307
Toll-Free #: (800) 819-5151, ext. 55429
Fax #: (804) 819-5176

Comments and suggestions will be reviewed and assessed for quality improvement opportunities.



XII. 2016 Quality Program Description Signature Page

APPROVED BY:

VPHP HQUM Committee Chair

Date

VPHP Continuous Quality Improvement Committee

Date

Original Date: August 2000

Revised Date(s): 12/2001;
12/2002;
12/2003;
12/2004;
12/2005;
02/2007;
01/2008;
01/2009;
01/2010;
01/2011;
01/2012;
01/2013;
02/2014;
03/2015;
03/2016;

Effective Date: January 1, 2016

XIII. VPHP Organizational Chart

XIV. Medical Management Organizational Chart

