# 2017 Quality Management Program
# Annual Evaluation

# Medallion 3.0

**Healthcare Quality & Utilization Management (HQUM)**
**Approval: 4/27/2018**

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# Table of Contents

# Executive Summary

**2017 Quality Improvement Program:**
***Effective: January 1, 2017***

## 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. Virginia Premier 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 Virginia Premier 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 2017

Overall, most activities planned in the Work Plan were achieved. The activities that were not completed will be considered for continuation in 2018. Key accomplishments during 2017 for the organization are outlined below:

### Accreditation & Quality (Medallion)

- NCQA *"Accredited"* Accreditation Status achieving 3.5 rating
- NCQA Standards scoring of 98%.
- Rated as one of "Top" Health Plans in Virginia
- HEDIS On-site Medical Record Review scored at 100%
- External Quality Review Organization Performance Measure Validation: No deficiencies
- Quality of Care Assessments were completed on average of 18 days which is below the DMAS requirement of 30 days
- NCQA File Audits (Denials, Appeals, Case Management, Credentialing) – 100%
- Internal File Audits scored at 95% or above placing them in the "Excellent Pass" scoring range
- Delegated File Audits scored at 99.33% for Policy/Procedure Reviews, 99.87% for Initial Credentialing Audit and 100% for Recredentialing Audit

### Case Management

- 95.2% satisfaction overall quality of the case management program compared to 94.2% in CY16

- NCQA commendable status with case management meeting 100% compliance in chart audits
- 91% of members identified in foster care had an HRA completed. Exceeded DMAS goal of 85%

**Chronic Care Management**

- 60% of members filled a prescription for controller medication after being identified as using at least 3 rescue inhalers
- Diabetes transition program achieved a readmission rate fifteen percentage points lower than the unmanaged population.
- Member satisfaction for Diabetes Program was 98.4% compared to 96.4% in 2016.
- Inpatient and ER Utilization fell for each diagnosis from 2016 to 2017.

**Credentialing Program**

- Average days of receiving application to completion decreased by 5% from 2016
- Processed >400 applications for a large medical system in the Tennessee in four weeks
- Processed 585 providers for initial credential and re-credential, representing an increase of 328 providers over FY 2017

**Grievances and Appeals**

- Average number days to resolution for decreased by five days (38%) from FY 2016
- Expedited appeals were resolved in an average of 0.8 days, two days below the regulatory requirement of three days
- Standard appeals resolved in an average of 17 days, four days below the internal benchmark of 21 days

**Health Education Program**

- Fully staffed with Health Educators located in each region, with a well-rounded set of skills and expertise
- Conducted 540 assessments for members to connect them with services that would assist them to reach their goals
- Documented over 8,000 contacts with member regarding exercise, nutrition, smoking cessation, health education classes, and other subjects
- Facilitated gym memberships per month for over 100 members and families

**Maternal Health Program**

- Increased participation in the HHB program 8.7 percentage points and implemented a strategy to engage more members in 2018
- Increased timeliness of prenatal care by 5.02 percentage points through a timeliness of prenatal care initiative
- Increased timeliness of postpartum care by 3.34 percentage points
- Increased the percentage of members in our HHB program that report they are breastfeeding at postpartum by 1.7 percentage points
- Partnered with the DSS, VCU, DMAS and Baby Box Company on the Safe Sleep Virginia Campaign, and with DentaQuest/Smiles for Children to promote oral health for infants

**Human Resources**

- 93% of new employees completed Crisis Intervention Training
- Transitioned Crisis Intervention to an e-learning course to reduce training time and increase efficiency

**Information Technology Services**

- Phone system upgrade and migration to cloud
- Secure printing implementation
- Implementation of the IT Business office
- Care Coordinator Remote Access implementation
- New satellite location in Alexandria.
- Three Richmond office consolidations, buildout, and move to Liberty Plaza at Innsbrook

**Member Operations**

- Average call abandonment rate for English and Spanish speaking members was 2.6%
- Average call hold time for both English and Spanish speaking members was well below VPHP's goal of a maximum hold time of less than 180 seconds
- Held 15 MAC Meetings during the evaluation period

**Network Development**

- Highest scoring of comparison health plans on overall satisfaction with the Health Plan - exceeded the lowest scoring health plan by 19.7 percentage points
- Statistically significant increase in the provider to patient ratio was observed for the Western Region OB/GYN and the Far Southwest Region Psychiatry providers

**Program Integrity**

- Special Investigations Unit (SI) investigations completed: 33
- Desk reviews completed: 16
- Delegate Oversight Committee implemented to monitor delegate performance

**Utilization Management**

- Passed internal Quality audit of Denial files with 100% compliance for 2017
- Three UR RNs and one UR LPN re-certified with InterQual© as certified trainers
- Number of cases referred to the Medical Directors for review increased from 17,386 to 22,949 - 32% increase in cases requiring review by a Medical Director
- Intake Coordinators (IC) and UM LPN Hunt Group sustained call abandonment rates at 4.3% and 1% respectively for FY2017, which exceeds compliance standard of 5%

## Changes to the 2018 Program Description

- Quality Program updated to include Department of Medical Assistance Services (DMAS) Quality Strategy
- Committee Structure changes to include Continuous Quality Improvement Committee (CQIC)
- Revisions to the roles and responsibilities along with committee structure updates
- Changes to wording and information flow

- Quality Program Vision Updated to include Triple Aims by Institute on Healthcare Improvement (IHI)
- Included Innovative Interventions to impact HEDIS outcomes and NCQA rating measures

### 2017 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 and Provider Experience
- Member Grievances and Appeals
- Quality of Care/Service Indicators
- Member Safety Program
- Culturally & Linguistically Appropriate Services (CLAS)

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.

In 2017, VPHP accomplished the following Quality HEDIS improvement activities:

| HEDIS Measure(s) | VPHP Rate 2015 | VPHP Rate 2016 | VPHP Rate 2017 | Benchmark | Goal Met |
|---|---|---|---|---|---|
| Cervical Cancer Screening | 64.96 | 61.92 | 60.05 | 55.94 | Exceeded |
| Well-Child Visits in the first 15 Months of Life (6+visits) | 69.32 | 67.99 | 63.66 | 59.57 | Exceeded |
| Childhood Immunizations (MMR) | 91.61 | 92.27 | 92.13 | 90.28 | Exceeded |
| Comprehensive Diabetes Care (Monitoring for Nephropathy) | 75.81 | 89.62 | 90.88 | 90.27 | Exceeded |
| Immunizations Adolescents: Tdap/Td immunizations | 94.26 | 94.48 | 93.52 | 86.86 | Exceeded |

### 2017 Quality Goals:

- Achieve 1st in the Commonwealth and Top 30 Best Medicaid Plans National NCQA Rating
- Achieve the 75th Percentile or Greater for Targeted HEDIS® Performance Incentive Award (PIA) Measures
- Improve the Member Experience through CAHPS® Survey Education for Membership, Providers and Internal Staff
- Achieve NCQA Star Rating of 4.0 or greater for Medicaid Health Plan
- Implement effective interventions that positively impact HEDIS® scores to include Effective of Care (EOC) measures (utilize innovative approaches and technology)

## Quality Assessment & Improvement Program (QAPI) Evaluation

The objective of the 2017 Annual Quality Improvement Program (QIP) Evaluation is to provide a systematic analysis of Virginia Premier Health Plan's (VPHP) performance and to define meaningful and relevant quality improvement activities for 2017 for approximately 188, 000 Medicaid members in the Commonwealth of Virginia. The Board of Directors (BOD), Chief Executive Officer (CEO), Chief Medical Officer (CMO), VP Population Health and the senior management team provide oversight of the health plan's quality, utilization, and operational QI functions. The annual QI Program Description, QI Program Evaluation and QI Work Plan are reviewed and approved by the Healthcare Quality & Utilization Management (HQUM) Committee prior to the BOD final review and approval. These entities serve as the foundation for making recommendations based upon identified opportunities for improvement, implementing interventions, and ensuring follow-up for effectiveness of adopted recommendations.

The QIP provides a formal process to objectively and systematically monitor and evaluate the quality, appropriateness, efficiency, safety, and effectiveness of care and service utilizing a multidimensional approach. This approach enables VPHP to focus on opportunities for improving operational processes as well as health outcomes and satisfaction of members and practitioners/ providers. The QIP promotes the culture of quality and accountability to all employees and affiliated health personnel to provide quality of care and services to members. The QI Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of health care provided to all members, including those with complex care needs. This systematic approach provides a continuous cycle for assessing the quality of care and service among Virginia Premier's quality initiatives covering a range of services for preventive health, over and underutilization, continuity and coordination of care, and member safety.

During 2017, the QI program continued to reinforce its approach to quality improvement by actively involving the entire organization with the responsibility of improving the quality of care and services delivered to its members and providers. The QI Department, while performing core functions such as quality of care investigations, quality of service concerns, National Committee for Quality Assurance (NCQA), and Healthcare Effectiveness and Data Information Set (HEDIS®) oversight also coordinated and monitored progress on QI activities performed in other departments such as QI 8 and 9 Quality Initiatives and integrated data and outcomes through the committee structure of the Plan.

Throughout 2017, VPHP's QI Department remained focus and committed to this structure for organization-wide quality improvement. This approach has led to improved performance throughout the year as evidenced in the departmental analyses and accomplishments. Also, opportunities for improvement have been identified and will be the focus for 2018.

**Challenge(s)/Opportunities for Improvement:**

- Streamlining interventions/initiatives to gain efficiencies in impacting quality measure outcomes
- Increasing HEDIS scores above the 75$^{th}$ percentile
- Chart retrieval vendor support to ensure streamlined processes and best practices
- Partnering at the Network level with data sharing – "Care Gap" discussions and interventions – data portals

- Strengthen data reporting capabilities
- Implement strategies to improve HEDIS and Performance Measure rates and maintain statistically significant improvements in rates
- HEDIS measurement improvement:
    - Adolescent Well Care
    - Adult Body Mass Index (BMI)
    - Hep B Immunizations
    - Lead Screening
    - Comprehensive Diabetes Care: HBA1C testing and control, Eye Exams, Controlling BP total,
    - Immunizations Adolescents (Meningoccocal and Combo 1)
    - Prenatal and Postnatal Care
    - Weight Assessments (all measures)
    - Well Child 3-6 Year

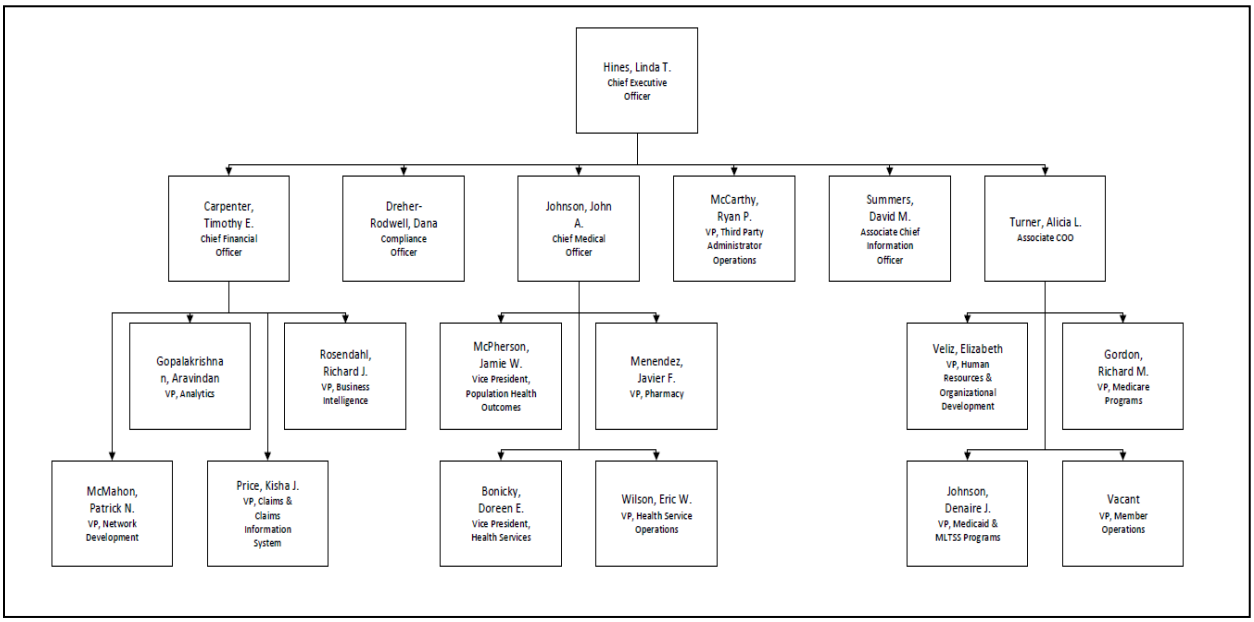
## Recommendations for 2018

- Implement strategies to improve HEDIS (PIA) and NCQA Performance Measure rates and maintain statistically significant improvement in rate
- Continue the HEDIS Steering Committee comprised of senior management to review results, remove barriers or roadblocks that impede successful program outcome measures
- Analyze the effectiveness of the 2017 Interventions Impact Initiatives (Triple I) and creating an Interventions repository on effectiveness organization-wide
- Develop targeted/strategic interventions for practitioners and members identifying those in need of specific services
- Expand the supplemental database to capture 2017 services on an ongoing basis
- Maintain compliance with all NCQA Standards, EOC measures, and CAHPS scores to obtain 4.0 rating
- Continue ongoing periodic file audits of denials, appeals, grievances and credentialing
- Continue to collaborate with Medical Management to take action to improve the continuity of care and services
- Enhance member and provider outreach and education-based initiatives related to clinical practice guidelines
- Conduct annual audits of delegated entities through the Delegated Oversight Committee (DOC)
- Drill down on Provider Satisfaction to conduct barrier analysis on decrease in overall satisfaction

## Quality Program Infrastructure

The Virginia Commonwealth University (VCU) Board of Directors has ultimate responsibility for the Quality Management Program and related processes and activities. The Board provides oversight by reviewing and approving the Quality Program Description, Annual Evaluation and Work Plan on an annual basis. The Board of Directors has delegated to the Continuous Quality Improvement Committee (CQIC) responsibility for ensuring the quality improvement processes outlined in this plan are implemented and monitored.

Below are organizational charts depicting key staff of the health plan related to the Quality Management Program, followed by brief descriptions of senior level and Quality Management positions. The QI Program has the necessary organizational infrastructure in place to support the needs of its members.

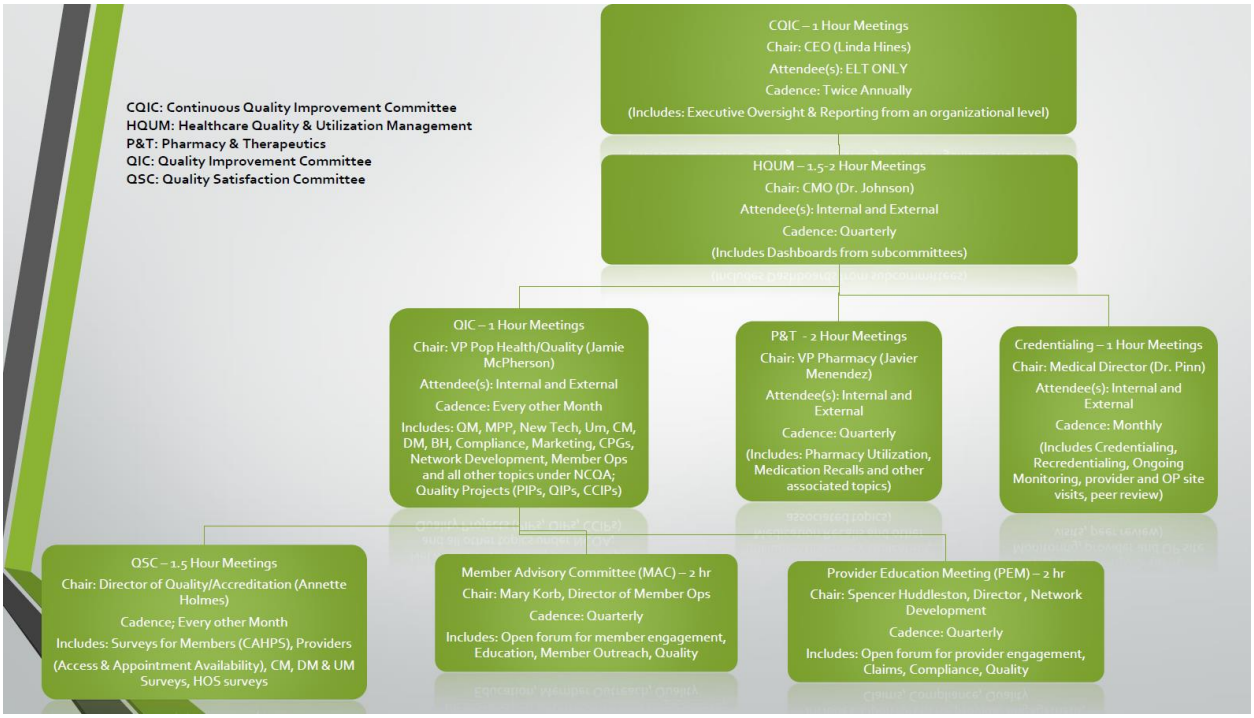



Virginia Premier Executive Team Organization Chart

## Committee Oversight & Functions

Virginia Premier's Board of Directors (BOD) has delegated program oversight to the Continuous Quality Improvement Committee and subcommittees; however, the Board has ultimate authority, accountability and organizational governance for the Quality Program. The Quality Committee structure was designed to provide appropriate oversight of all quality functions by reviewing and approving annually the Quality Program Description, Annual Evaluation and Work Plan for the subsequent year. Additional functions include review and approval of reports and ad- hoc studies. The Quality Committees meet regularly as defined below in each description.

## Committee Structure




## Continuous Quality Improvement Committee (CQIC)

The CQIC, chaired by the Chief Executive Officer (CEO), has ultimate authority, accountability and organizational governance for the Quality Program. The CQIC consists of the Executive Staff of Virginia Premier and all members have voting privileges. Appointment to the Committee is by virtue of Executive Staff position. The CQIC meets at least twice per year. The CQIC approves 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:

- Advising the Health Quality and Utilization Committee (HQUM) and subcommittees on quality initiatives and give recommendations for improving practices
- 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
- Providing input on incorporating quality improvement throughout the organization and evaluating the effectiveness of continuous quality improvement activities across the organization

## Healthcare Quality and Utilization Management (HQUM) Committee

The HQUM is chaired by the Chief Medical Officer (CMO) and is responsible for the development, implementation and management of quality and utilization improvement processes as well as providing overall direction to Virginia Premier staff and providers on appropriate use of covered services. The HQUM meets every other month and the findings and outcomes are reported to the CQIC. The committee will meet at least six times per year, the committee members includes the following:

- Chief Medical Officer (voting) – Chair
- Medical Directors (voting) – Richmond
- Participating Primary Care Physicians (voting)
- Participating Specialty Care Physicians (voting)
- Behavioral Health Physician, Associate Medical Director (voting)
- Vice President, Population Health Outcomes (Quality) (voting)
- Vice President, Health Services (voting)
- Vice President, Health Services Operations (voting)
- Vice President, Pharmacy (voting)
- Resource staff (as needed non-voting)

Functions of the HQUM Committee:

- Oversee, evaluate and analyze data for improvement opportunities. The types of data (dashboards) that will be collected and reviewed include:
  - Star Ratings
  - Healthcare Plan Effectiveness Data and Information Set (HEDIS)
  - Consumer Assessment of Healthcare Providers and Services (CAHPS®)
  - Health Outcomes Survey (HOS) results
  - Home and Community Based Services (HCBS) Experience Survey results
  - A quality of life survey, such as the Young and Bullock 2003 survey, adapted for general populations
  - Appeals (upheld and overturned)
  - Patient safety data
  - Grievances (quality of care and quality of service)
  - Pharmacy utilization data
- Track and trend outcomes and report and provide feedback and recommendations to subcommittees on improvement
- Oversee all activities related to pharmacy, utilization management and new technology
- Approve clinical performance standards and practice guidelines
- Ensures provider participation in and compliance with the Quality Improvement Program
- Review summary data of utilization management trends, Sentinel Events, Critical Incidents, Serious Reportable Events, and over- and under-utilization of services and evaluate opportunities for improvement
- Review and approve utilization management criteria for decision-making
- Approve clinical practice guidelines
- Monitor and oversee delegated Utilization Management functions
- Review and render decisions on grievances resulting from denials or modifications in requests for medical services from providers based upon medical necessity and treatment protocols.

- Medical Record Review outcomes are discussed at the HQUM committee 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.

### Quality Improvement Committee (QIC)

The QIC chaired by the Vice President of Population Health Outcomes (Quality) is the foundation of the Quality Management Program (QMP). The QIC assists the CMO and administration in overseeing, maintaining, and supporting the QMP and Work Plan activities. The purpose of the QIC is to monitor and assess that all Quality activities are performed, integrated, and communicated internally and to the contracted network providers, practitioners and partners to achieve the end result of improved outcomes and services for members.

Committee membership includes Vice Presidents and Directors from across the organization. This provides an interdisciplinary and interdepartmental approach is taken and adequate resources are committed to the program and drives actions when opportunities for improvement are identified. The QIC meets, at a minimum, every other month, or more often as needed.

Functions of the QIC:

- Approve and monitor the progress of the Quality Management Program Description, Annual Work Plan and Evaluation
- Approve and monitor the progress of the Utilization Management Program and Annual Evaluation
- Approve and monitor the progress of the Case Management Program Description and Annual Evaluation
- Approve and monitor the progress of delegated entities program descriptions and annual evaluations
- Share outcomes with the members and providers at least annually
- 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
- The HQUM 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 by way of newsletters, advisory meetings and site visits. 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 assessments
    - Medical record reviews
    - Appeals data

- Grievance data
- Over and under-utilization data

**QI Program Integration**
The QI Program Evaluation, QI Program Description, and the QI Work Plan are integrated. The year-end QI Program Evaluation identifies barriers, opportunities for improvement, results and recommended interventions. The QI Evaluation is then used to make modifications to the coming year's QI Program Description and to create the key metrics of the QI Work Plan.

The QI program is integrated throughout Virginia Premier through its committees. The Quality Improvement Committee and the support committees are comprised of members from multiple departments to enhance communication throughout the Plan. In order to integrate feedback from stakeholders into the QI Program, participating network physicians are members of the HQUM and the Credentialing Committee. The HQUM core support committees 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 HQUM, at least annually.

Virginia Premier's QI Program enables the Health Plan to positively impact the delivery of patient care in all areas of the health care delivery system through collaboration and input from all departments. Member Services, Network Development, Credentialing, Quality Improvement, Utilization Management, Case Management, Health Education, Disease Management and Pharmacy collaborate effectively to determine the most efficient mechanisms to address key issues. Some examples of collaborative efforts include:

- Member Communication – Member Services/QI/UM/DM/Marketing
- Practitioner Education regarding HEDIS - QI/Network Development
- Member Satisfaction – Member Services/QI/CM/DM
- Grievance Investigation – Grievance & Appeals/QI/Member Services/Pharmacy
- Timely Appointment Access Evaluation- Network Development/QI
- Community Linkage Activities – Member Services/Member Outreach/QI/Marketing
- Delegation Oversight Activities – Network Development/Compliance/QI/Credentialing

## Committee Evaluations

**Healthcare Quality & Utilization Management Committee (HQUM)**
The HQUM is the senior level committee, accountable to the BOD. This committee promotes a system wide approach to QI. The Committee approved all submitted Annual Program Descriptions, Annual Evaluations and the Quality Work Plan and Reporting Schedule. Also, delegated entity quality program descriptions and evaluations were reviewed and approved by the Committee. The HQUM met 12 times in 2017, meeting the frequency expectation with all voting members meeting the attendance requirement.

**Policy & Procedure Committee (P&P)**
The P&P is to insure there is a standardized set of organizational policies and procedures for all lines of business and meet regulatory and accreditation requirements. The P&P met 12 times in

2017. WebEx is used for the satellite offices to participate in the meeting. Attendance met the requirement.

**Compliance Committee (CC)**
The CC is an integrated team overseeing all facets of VPHP's regulatory compliance programs, monitoring performance and support and provide guidance to the Program Integrity Officer (PIO). The CC met four times in 2017, meeting the requirement. Attendance met requirements.

**Member Advisory Committee (MAC)**
The MAC is an advisory committee of the HQUM with a goal of providing a forum for members to interaction with plan staff to include Member Services, Health Education, and Quality. A total of 15 MAC meetings were held throughout the Tidewater, Richmond, and Bristol regions. 250 members were invited per meeting. The overall MAC meeting attendance continues to be steady. Meetings in more remote office areas tend to draw smaller crowds, while the metro areas see the largest turn out. The MAC meeting requirements were met.

**Credentialing Committee (CC)**
The CC is a standing subcommittee of the HQUM. It is responsible for oversight and operating authority of the Credentialing Program. The CC met 12 times in 2017 which met the meeting requirements. Attendance of voting members met the requirement.

**Pharmacy and Therapeutics Committee (P&T)**
The P&T Committee is responsible for oversight and operating authority of the Pharmacy Program. The P&T committee bases formulary decisions on cost factors only after safety, clinical efficacy, and therapeutic need is established and supported by evidence-based data and clinical guidelines. The P&T met 12 times in 2017, meeting the minimum requirement.

**Quality Satisfaction Committee**
The QSC is an internal, cross-functional QI team that facilities the integration of a culture of QI throughout the organization focusing on member and provider experience. CAHPS data, Provider Satisfaction and Access were agenda topics. Also, the committee was restructured for efficiency and combined all lines of businesses' member experience. The focus areas for the committee: Member and Enrollee Advisory Committees, Member Grievances, Member Surveys to include CAHPS for Medicaid and Medicare members, Enrollee Satisfaction, Enrollee Quality of Life and Home & Community Based Services survey, CM and DM Survey, Practitioner Grievances, Practitioner Surveys for Provider Satisfaction, Access and Availability of Appointments. The QSC met four times during 2017, meeting the minimum goal of required meetings. Attendance of voting members met the requirement.

**Committee Structure Assessment**
The committee structure was acceptable, but it was found that some of the quality meetings such as Quality Satisfaction combined for both lines of business (Medallion and VPCC/MLTSS).

**Improve:**
- Assessment of committee membership and engagement

- Timeline on survey administrations for all lines of business

**Control:**
- Continue with consolidated committees for efficiency
- Utilize systematic approach for survey administration and intervention deployment

**Network Development Committee (NDC)**
The NDC is responsible for maintaining a sufficient number and mix of services, specialists and practices sites to meet covered persons health care needs. The Network Development Committee meeting is held 12 times a year on the first Monday of the month. There are approximately 50-60 people that attend the meeting. The purpose of the meeting is to get updates and changes from other departments that involve provider relations. The forum is also used to present requests forms to the committee to determine if the providers are needed with the network. The committee met 12 times during 2017 meeting the requirements.

**Ongoing Monitoring Committee (OMC)**
The OMC has operational authority to monitor practitioner sanctions, complaints and quality issues between recredentialing cycles. The committee met three times in 2017 not meeting the frequency requirements. Corrective action put in place to not cancel meetings unless no events are available for viewing. Meetings scheduled in advance to alleviate the problem with meeting frequency requirements.

**Committee Structure Assessment**
This committee membership was extended to have a sitting Medical Director to review quality of care and services for providers.

**Improve:**
- Correlating member grievances with a specific provider
- Reporting all Levels Above 1 to Credentialing Committee
- Ability to drill down to identify Unknown Providers
- Reporting Summary Reports to HQUM

**Control:**
- Continue to correlate grievances with a provider
- Reporting to HQUM summary provided by Medical Directors

**Virginia Premier Partners Meeting (VPPM)**
The VPPM meets to insure there is an ongoing exchange of information between the Health Plan and its credentialing partners. This meeting is not a mandated committee by any regulatory or companywide standard. It was implemented as a best practice for the organization to communicate more effectively and efficiently with the delegated credentialing community as a whole and at the same time. The VPPM met three times in 2017. There is no minimum meeting requirements for this meeting.

**Provider Education Meetings (PEM)**
The PEM provides an opportunity for the Health Plan to engage the network providers and gives them a forum to ask questions, receive regulatory updates and receive care gap data for improvement. Virginia Premier Health Plan held 18 PEM meetings throughout the five regions and had a grand total of 482 attendees. The PEM met the meeting requirements.

## Quality Improvement Work Plan

The 2017 QI Work Plan defines the activities, the person(s) responsible for the activity, the date of expected task completion and the monitoring techniques that will be used to insure completion within the established timeframes. The QI Work Plan is presented to the Quality Committee on an annual basis for approval, through the annual evaluation process and at regular intervals throughout the year.

**Work Plan Assessment**
The Work Plan covered 2017's planned QI activities and timeframes for completion or submission to the HQUM (See Appendix 1). Areas presented to the QIC and HQUM to support the Work Plan are outlined below and Analyses are complete throughout the Evaluation:

- Quality of clinical care
  - HEDIS Annual Analysis – determines how well the health plan performed on a variety of outcome measures and opportunities to improve
  - Quality of care investigations
  - External HEDIS Audit – passed with no deficiencies, 100% medical record compliance
  - Clinical Practice Guidelines – review, adoption and distribution of guidelines and mapping to HEDIS measures to show success or areas of improvement
  - Culturally and Linguistically Appropriate Services Analysis (Language Match)
  - Performance Improvement Projects (Eye Exams)
  - Complex Case Management – Program participation and satisfaction
  - Disease Management Monitoring – Program participation and satisfaction
  - Utilization Management- under and over utilization and satisfaction

- Safety of clinical care
  - Patient Utilization Management and Safety Programs (PUMS)
  - Continuity of Medical Care – QI 8 initiatives in place
  - Sentinel Events Monitoring
  - Clinical Practice Guidelines monitoring and implementation
  - Medical Record Reviews
  - Organizational Provider Site Visits
  - Quality of Care investigations
  - Credentialing Activities
  - Grievance Monitoring
  - National Patient Safety Goals (Joint Commission)

- Quality of service
  - Monitoring internally through complaints and appeals
  - Monitoring satisfaction with UM, CM, DM
  - Consumer Assessment of Healthcare Providers (CAHPS) Annual Analysis

- Quality of Care concerns
- Practitioner and Provider Satisfaction and Access
- Ongoing Monitoring of Network Practitioners and Providers

- Members' experience
  - Monitoring satisfaction with UM, CM, DM
  - Chronic Care Surveys
  - Consumer Assessment of Healthcare Providers (CAHPS) Annual Analysis
  - Quality of care and service concerns

- Providers' experience
  - Practitioner and Provider Satisfaction and Access

- Time frame for each activity's completion
  - A reporting schedule for each activity is a part of the Work Plan, each department's completed activity has a reporting date to QIC and HQUM

- Staff members responsible for each activity
  - The responsible executive and department manager is outlined in the reporting schedule

- Monitoring of previously identified issues
  - If an issue is identified, an action item is created to be reported at next meeting and listed as an Outstanding Item for follow-up.

- Evaluation of the QI program
  - An overall assessment of the QI program is included in the Annual Evaluation with Recommendations for the Preceding Year's Program Activities.

**Scope of the QAPI Program**

Virginia Premier systematically monitors and evaluates the QI Program throughout the year by analyzing and reporting key indicators of clinical and non-clinical outcomes. These indicators include but are not limited to:

- Healthcare Effectiveness Data and Information Set (HEDIS®) results
- Performance Measure Validations (PMVs)
- Delegation oversight
- Practitioner credentialing
- Telephone service statistics for practitioners and members
- CM, DM, and UM participation metrics and outcomes
- Clinical Practice Guidelines adherence
- Member and provider experience survey results
- Cultural competency and healthcare disparities data
- Complaints, grievances, and appeals data
- Monitoring of practitioner office site quality
- Performance Improvement Projects (PIPs)
- Performance Incentive Awards (PIAs)
- Continuity and coordination of care measures
- Member/Patient safety metrics