2010 Quality Improvement Program Description

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

August 2000

Revision Date(s): 12/2001; 12/2002; 12/2003; 12/2004; 12/2005; 02/2007; 01/2008; 01/2009; **01/2010**

TABLE OF CONTENTS

I. History……………………………………………………. … 4

II. Company Program Overview…………………………………… 5

- A. Mission Statement
- B. Function
- C. Scope/Methodology

III. Objectives and Goals…………………………………………… 6

IV. 2010 Performance Indicators…………………………………… 7

- A. Clinical
- B. Service

V. Organizational Structure…………………………………………… 8-9

- A. The Board of Directors of VPHP (Board)
- B. Continuous Quality Improvement Committee (CQIC)

VI. Personnel Responsible for Quality Improvement Program………... 10-13

- A. Chief Executive Officer
- B. Chief Medical Officer (CMO) (Senior, Associate and Behavioral Health Medical Directors)
- C. Vice President, Medical Management
- D. Vice President, Quality, Accreditation and Credentialing
- E. Vice President, Network Development
- F. Director, Member Operations
- G. Vice President, Claims, Encounters and Claims System Configuration
- H. Vice President, Information Systems
- I. Director, Compliance Officer/Government Relations
- J. Vice President, Human Resources and Organizational Development
- K. Director, Finance

VII. Contractual Arrangements…………………………………….. . 14

- A. Non-delegated
- B. Delegated

VIII. Quality Improvement Program: Support Committees………….. . 15-26

- A. CQIC Support Committees
  1. Quality Improvement Committee
     - a. Member Safety Program
     - b. Member Safety Initiatives (MSI)
  2. Utilization Management Program & New Technology Committee
  3. Pharmacy and Therapeutics Committee
- B. Credentialing Committee

IX. 2010 Quality Improvement Program Activities…………………... 27-29

A. Monitoring Quality Performance Indicators: HEDIS
B. Monitoring Quality Performance Indicators: CAHPS
C. Clinical Practice Guidelines
D. Patient Safety
E. Disease Management
F. Peer Review Activity
G. Management of Quality of Care Complaints
H. Utilization Management
I. Web Site Committee
J. QI Annual Evaluation
K. QI Work Plan (See Attachment)

X. Recommendations for QI Program for 2010……………….......….30-32

XI. Resource Allocation………………………………………………. 33

XII. Feedback/Comments……………………………………………… 34

XIII. Signature Page …………………………………………………. 35

XIV. VPHP Organizational Chart………………………………………. 36

XV. Medical Management Organizational Chart……………………... 37

XVI. QI Work Plan ……………….. 38

I. HISTORY

In 1995, Virginia Premier Health Plan, Inc. (VPHP) (formerly Virginia Chartered Health Plan, Inc.) opened its doors for business. VPHP is a for-profit Medicaid managed care organization owned by University Health Systems of Virginia Commonwealth University. The National Committee of Quality Assurance (NCQA) accredited VPHP in 2007 and Utilization Review Accreditation Commission (URAC) accredited VPHP from 2006 until July 1, 2007. VPHP is contracted exclusively with the Department of Medical Assistance Services (DMAS) to provide quality health care services to Medicaid and Family Access to Medical Insurance Security (FAMIS) eligible receipts in the Commonwealth of Virginia.

The plan's current enrollment is approximately 143,612 and operates in 84 counties in Central, Tidewater, Southwestern and Western Virginia. There are approximately 9,000 practitioners in the network.

II. COMPANY PROGRAM OVERVIEW

A. MISSION STATEMENT

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

B. FUNCTION

- Provide the organization with an annual Quality Improvement (QI) Program Description, Quality Improvement Work Plan, and Quality Improvement Annual Evaluation
- Coordinate the collection, analysis, and reporting of data used in monitoring and evaluating care, including quality, utilization, member service, and credentialing functions delegated to vendor organizations
- Identify opportunities to improve care and develop quality improvement interventions
- Identify and address instances of substandard care including patient safety
- Track the implementation and outcomes of quality improvement interventions
- Evaluate its effectiveness of improving care and services
- Oversee organizational compliance with regulatory and accreditation standards

C. SCOPE/METHODOLOGY

The scope of the QI 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 QI Program will reflect the population served in terms of age groups, disease categories and special risk status. The QI 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 QI Program and activities includes the elements of: identification, performance goals and benchmarks, data sources, data collection, establishment of baseline measurements, trending, measuring, analyzing, interventions, development and implementation.

III. OBJECTIVES & GOALS

VPHP's QI Program primary objective 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 the use of Healthplan Effectiveness Data 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 both the national and local levels, and aspiring to meet public health goals, (e.g. Healthy People 2010, State goals, etc.).

The primary goals of the VPHP QI 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 in the areas of asthma, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease (COPD), diabetes, high-risk pregnancy and childhood obesity.
- Develop and implement interventions focused on member integration
- Enhance quality improvement collaboration with all levels of care to include; 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 partnering with community services and agencies
- Promote and facilitate the use of quality improvement techniques and tools to support organization effectiveness and decision-making.

IV. 2010 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, utilizes data that is statistically valid, reliable, and comparable over time. All performance indicator outcomes are reported at the QIC, CQIC and the Board, at least annually.

A. Clinical Indicators:

- All NCQA Medicaid HEDIS® Measures
- Contract Specific DMAS HEDIS® Measures
- Chronic Care Survey
- Case Management Survey
    - Prenatal/Postpartum Care
    - Childhood Immunizations
    - Well-Child Visits 1st 15 Months
- Disease Management (DM) Initiatives/Programs:
    - Asthma
    - Diabetes
    - Heart Disease
    - Childhood Weight Management and Nutrition
    - Mental Health
    - Coronary Artery Disease
    - Congestive Heart Failure
    - Chronic Obstructive Pulmonary Disease (COPD)

B. Service Indicators:

- Consumer Assessment of Health Plans Study (CAHPS®) 4.0
- Provider Satisfaction Survey
- Provider Access and Appointment Availability Survey
- Member Operations Call Abandonment
- Member Operations Average Speed to Answer (Timeliness)
- Board Certification

V. ORGANIZATIONAL STRUCTURE

A. **The Board of Directors of VPHP (Board)** has ultimate authority, accountability and organizational governance for the QI Program. The Board exercises its oversight of the program by reviewing and approving annually the QI Program Description, Annual Evaluation and Work Plan for the subsequent year. Additional functions of the Board include review and approval of reports and ad- hoc studies. The Board meets at least annually.

B. **Continuous Quality Improvement Committee (CQIC)** has delegated oversight of the QI Program and reports to the Board. 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 Utilization Management and New Technology Committee, the Credentialing Committee, Pharmacy and Therapeutics Committee, the Quality Improvement Committee, the Quality Satisfaction Committee, Website Committee and other subcommittees are formed as needed and report to the CQIC. With the approval of the Board, 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.

The CQIC develops policies and provides direction for all activities described in the QI Program and QI Work Plan, including those QI activities that have been delegated. 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 Health Plans Study (CAHPS®) and provider satisfaction data and then the data is shared with both the members and practitioners by way of newsletters, Advisory meetings 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 (includes care access and availability)
- Medical record reviews
- Appeals data
- Grievance data
- Over and under-utilization data

VI. PERSONNEL RESPONSIBLE FOR QUALITY IMPROVEMENT PROGRAM

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 Improvement 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 chairs the Continuous Quality Improvement Committee. The CEO or designee is responsible for evaluating and coordinating risk management activities. All concerns and occurrences are investigated on behalf of the Legal Department in anticipation of litigation. Counsel advises and requests further review, as necessary. Such review and investigation activities may include grievance review; review of Member and Provider Satisfaction Surveys; monitoring and investigation of occurrence/transportation and ongoing claims and litigation. Findings and outcomes are discussed at the CQIC meetings, at least annually and recommendations made as appropriate.

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

The Senior Medical Director Officer or designee is responsible for providing direction for the development and implementation of the Quality Improvement, Utilization Management, New Technology, and Credentialing and Pharmacy and Therapeutics Committee programs. The Senior Medical Director is responsible for peer review activities, and for collaboration with practitioners on the development and implementation of the QI 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 QI program's goals and objectives. The Medical Directors report to the Chief Medical Officer and assists the Chief Medical Officer in carrying out all responsibilities, as set forth. The Behavioral Health Assistant Medical Directors report directly to the Chief Medical Officer. The Behavioral Health practitioner 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; attends the CQIC, as needed. The Senior and Associate Medical Directors are standing members of the CQIC. Findings and outcomes from each committee are reported to the CQIC, at least annually.

C. VICE PRESIDENT, MEDICAL MANAGEMENT

The Vice President of Medical Management (VPMM) provides the overall direction and leadership in the strategic planning process, development, implementation, and evaluation of the Quality Improvement, Utilization Management, and Pharmacy and Therapeutics. The VPMM ensures consistency of the Quality Improvement Program with other programs throughout VPHP. The VPMM assists the CEO, the Chief Medical Officer and the Medical Directors with related activities. The VPMM provides oversight of the Quality program in the development and implementation of all quality

improvement activities to include, but not limited to, HEDIS®, internal performance indicators, and quality improvement activities.

The VPMM is responsible for the Utilization Management Department (UMD), which conducts pre-certification, concurrent, and retrospective of appropriateness of care. Quality and resource management criteria are applied to all inpatient admissions as approved by the CQIC. The UMD utilizes the Interqual® Appropriateness Protocols as the standard criteria and information resource to determine the appropriateness of inpatient healthcare services. The UMD oversees case management for high-risk members including those identified through VPHP's disease management programs. The VPMM tracks and trends key utilization data, oversees VPHP's health management programs and conducts an evaluation of program activities each year. Findings and outcomes related to Medical Management are reviewed or reported at the CQIC meetings, at least annually.

D. VICE PRESIDENT, QUALITY, ACCREDITATION AND CREDENTIALING

The Vice President of Quality, Accreditation and Credentialing (VPQAC) provides the overall direction and leadership in the strategic planning process, development, implementation, and evaluation of the Quality Improvement, Grievances/Appeals, Accreditation, and Credentialing Programs. The VP of Quality Improvement is responsible for the advancement of VPHP's strategic directions by designing, developing, implementing and conducting on-going evaluation of quality improvement activities to measure and improve the quality of health care and service provided to members. The VPQAC assists the CEO, the Chief Medical Officer, and all VPHP medical Directors, and the VPMM with related activities. The Quality Improvement VP has oversight in assessing, analyzing and working collaboratively with the Executive Leadership Team to yield satisfactory clinical and service outcomes related to HEDIS®, internal, and other quality related outcomes.

Grievances and requests for appeals are handled by the Medical Management Quality Department and are processed in accordance with established policies and procedures. Grievances that involve quality of care are forwarded to the designated quality improvement nurse for research and investigation. Quality Service grievances are managed by the Grievances/Appeals Coordinator.

Findings and outcomes related to quality, grievances/appeals, accreditation and credentialing are reviewed and reported at the CQIC meetings, at least annually.

E. VICE PRESIDENT, NETWORK OPERATIONS/DEVELOPMENT

The Network Director (ND) has daily oversight and operating authority for provider services, contracting, recruitment, and retention activities/functions. 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 ND reports credentialing grievances to the QI Director weekly. The Director monitors standards associated with accessibility, availability, and after hours coverage of services in VPHP's network. Ongoing monitoring and remedial action for non-compliance with access standards occurs as necessary. Network Development includes ensuring that the network is sufficient in number and type of practitioners.

Findings and outcomes related to access and availability are reviewed or reported at the CQIC meetings, at least annually.

F. DIRECTOR, MEMBER OPERATIONS

The Director of Operations is responsible for the direct administrative and supervisory activities of Enrollment, Member Services, Transportation Services, Mail Operations and special projects. Secondly, the Director of Operations will facilitate the integration of various operational systems within the organization. Finally, the incumbent will operate under the direct supervision of the Chief Executive Officer in areas of the Health Plan's activities in carrying out the business plan. 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. Findings and outcomes, to include CAHPS®, related Member Operations are reviewed or reported at the CQIC meetings, at least annually.

G. VICE PRESIDENT, CLAIMS, ENCOUNTERS and CLAIMS SYSTEM CONFIGURATION

The Vice President of Claims, Encounters and Claims System Configuration 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. The VP has additional oversight of other core operations such as the Claims System Configuration, the Centralized Mailroom, Claims Customer Service and the Cost Containment Unit. 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.

H. VICE PRESIDENT, INFORMATION SYSTEMS

The Vice President of Information Systems (IS) 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 IS Vice President 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. The IS Vice President reports outcomes on new technology to the CQIC, at least annually.

I. DIRECTOR, COMPLIANCE OFFICER/GOVERNMENT RELATIONS

The Director, Compliance Officer/Government Relations (DCO/GR) has daily oversight and operating authority for ensuring that all Protected Health Information (PHI) remains secure and confidential. Information processed through the QI Department including worksheets, study results and meeting minutes are confidential, proprietary and protected from discovery under the Health Care Quality Act of 1986. Materials and information pertaining to peer review, individual performance and clinical cases are confidential and privileged in accordance with HIPAA (Health Information Portability and Accountability Act), State and Federal quality assurance and/or medical record confidentiality laws. Access to peer review and individual practitioner performance information is limited to appropriate individuals. All staff and practitioners are required to follow the VPHP

Confidentiality policy. Each committee member is required to sign a confidentiality agreement, at least annually. The DCO/GR is also the VPHP regulatory liaison and responsible for submitting all regulatory reports to DMAS, as required per the State contract.

Quality monitoring data are only accessible to the following individuals: QI staff, physician committee members, appropriate State and Federal authorities, and any other individual and/or entity with whom or that VPHP has entered into a Business Associate Agreement. Confidentiality is maintained by the use of assigned identification codes instead of utilizing with names on all documentation and reports. Confidential materials are kept in secure files or areas, as deemed appropriate. The DCO/GR reports findings and outcomes related to compliance to the CQIC, at least annually.

J. VICE PRESIDENT, HUMAN RESOURCES & ORGANIZATIONAL DEVELOPMENT

The Vice President of Human Resources & Organizational Development has daily oversight and operating authority for the training, development, recruitment and retention of qualified personnel

K. DIRECTOR, FINANCE

The Director of Finance has daily oversight and operating authority for fiscal responsibilities. The Finance Director reports financial outcomes to the CQIC at least annually (not reflected in the minutes).

VII. CONTRACTUAL ARRANGEMENTS

A. 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 Improvement Program
2. Participate in peer review activity
3. Provide credentialing information as specified
4. Serve on the QI Committee 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 utilization, disease, and case management, and/or grievance resolution, as necessary

B. DELEGATED

Credentialing functions are delegated to contracted organizations. The delegated entities submit reports at least twice a year and undergo audits 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 QI Program, in accordance with VPHP and NCQA standards and guidelines.

Any delegation of responsibility for QI, UM, credentialing, member services 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. 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 or unannounced, and in accordance with standards set forth by the National Committee for Quality Assurance (NCQA) and VPHP policies and procedures.

The CQIC is responsible for oversight of VPHP's delegated QI functions. Findings and outcomes related to delegated functions are reported to the CQIC, at least annually.

The Delegated Credentialing Partners State-Wide Conference Call Meeting was established April 26, 2007. Meetings are held quarterly to ensure an ongoing exchange of information between VPHP and its credentialing partners. The content of the meetings include VPHP, accreditation and regulatory requirements. Streamlining and simplification of activities and processes are also discussed during these meetings.

VIII. QUALITY IMPROVEMENT PROGRAM: SUPPORT COMMITTEES

The CQIC support committees include the Quality Improvement Committee, the Credentialing Committee, the Utilization Management Committee and New Technology Committee and other subcommittees. Each of these committees and teams perform activities targeted or for quality improvement and management within relevant areas of management scope. Findings and outcomes from each committee are reported to the CQIC, at least annually.

A. CQIC SUPPORT COMMITTEES

1. QUALITY IMPROVEMENT COMMITTEE

The QI Committee is responsible for developing, implementing and managing the quality improvement process. VPHP participating practitioners and providers are required through a contractual agreement to cooperate with all QI activities and allow VPHP staff access to sites and VPHP member medical records. The committee meets at least quarterly. Membership includes:

- Senior Medical Director (voting)
- Associate Medical Director (**Chair**/voting) - Roanoke
- Medical Director (voting) - Richmond
- Participating Primary Care Physicians (voting)
- Participating Specialty Care Physicians (voting)
- Behavioral Health Physician (voting)
- Vice President, Medical Management (non-voting)
- Vice President, Quality, Accreditation and Credentialing (non-voting)
- Statistician (as needed)
- Resource staff (as needed)

FUNCTIONS OF QI Committee:

- Oversee, evaluates and analyzes QI 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.
- Evaluate member and plan information compiled by the QI Department
- Approve and monitor the progress of the QI Program Description, Annual Work Plan and Evaluation
- 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
- Ensures practitioner participation in the QI program through planning, design, implementation, or review
- Institutes needed actions
- Ensures follow-up, as appropriate
- Assist VPHP in complying with reviews and evaluations conducted and/or required by oversight authorities

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 Improvement: Grievances/Appeals, Accreditation, Quality, and 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
- Information Systems
- Compliance
- Human Resources
- Finance

GOALS OF THE MSP

- To enhance the safety, quality, efficiency, and effectiveness of health care to ensure a safe and suitable healthcare environment
- To involve members and practitioners in the process
- To educate members and practitioners
- To obtain 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, focus groups and sending letters

- To improve 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
- To investigate grievances and appeals in a timely and accurate manner
- To validate practitioner and provider credentials in a timely and accurate manner
- To enhance 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 to providers and practitioners with reminders related to the delivery of quality healthcare
- Recognizing practitioners and providers who are leaders in quality and safety
- Practitioners who participate on the various quality committees. These practitioners also play an integral role in the MSP.

The program description is presented to the Quality Improvement Committee 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 QI department. Indicators development followed 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. The plan defines a sentinel event (also known as quality of care indicators) 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

Deaths are reported to DMAS on the 15th of each month. Each sentinel event is investigated by the quality improvement nurses, who are licensed registered nurses. 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, enable the plan to implement systemic modifications to prevent the event from reoccurring.

- Quality of Care Indicator: Any adverse event that is investigated by the quality improvement nurses. The Vice President of Quality, Accreditation and Credentialing, a Medical Director and/or the quality committees, if necessary, review each indicator. 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 complaint. A grievance can result from a medical record review and focused office visit, a practitioner report and 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 QIC 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 both the CQIC and the VPHP Board of Directors. 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 the 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.)

  - 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.

- Grievance monitoring:
- The objectives of grievance monitoring are:

- 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 Improvement Manager. All Quality of Care (QOC) and Quality of Service (QOS) grievances are forwarded to the Quality Improvement Nurses to investigate and/or review for quality issues or follow-up by Case Management or Provider Services. The QI department applies VPHP policies and to ensure timely response and resolution. Cases scored at a higher severity level are forwarded to a Medical Director for review and possible review by the CQIC Committee.

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 designated CQIC Support Committee and 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 and/or one or more of the CQIC Support Committees conduct the final review of investigation outcomes. Members and practitioners are informed of investigation outcomes in writing when inappropriately required.

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 and quality outcomes result.

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 are living in a safe environment and attending their prenatal visits. Postpartum, they visit the mother to ensure that both mom and baby are residing in safe environments and to assist the member in obtaining basic infant care supplies as needed.

Vaccines for Children Program: Physicians participate to ensure vaccines are available for Medicaid eligible population.

- Medical Errors:
  Medical errors are one of the Nation's leading causes of death and injury. A recent 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 majority 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.

Joint Commission on Accreditation Healthcare Organization (JCAHO): During site visits, the Quality Improvement Coordinators educate and distribute the JCAHO's National Patient Safety Goals "Do not use abbreviations." Annually, the "Do Not Use List" is communicated to the practitioners via the Provider Newsletter.

The National Patient Safety Goals 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 - 2010

The 2008 National Patient Safety Goals (NPSGs) were approved by the Joint Commission's Board of Commissioners in June 1, 2007. The purpose of the goals is to promote specific improvements in patient safety. The goals, in their entirety, can be located at:
http://www.jointcommission.org/GeneralPublic/NPSG/10_npsgs.htm.

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.

*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.*

Do Not Use	Potential Problem	Use Instead
U (unit)	Mistaken for “0” (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.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS MSO4 and MgSO4	Can mean morphine sulfate or magnesium sulfate confused for one another	Write "morphine sulfate" Write "magnesium sulfate"
> (greater than) < (less than)	Misinterpreted as the number “7” (seven) or the letter “L” Confused for one another	Write “greater than” Write “less than”
Abbreviations for drug names	Misinterpreted due to similar abbreviations for multiple drugs	Write drug names in full
Apothecary units	Unfamiliar to many practitioners Confused with metric units	Use metric units
@	Mistaken for the number “2” (two)	Write “at”
cc	Mistaken for U (units) when poorly written	Write "ml" or “milliliters”
µg	Mistaken for mg (milligrams) resulting in one thousand-fold overdose	Write "mcg" or “micrograms”

Additional Abbreviation
s, Acronyms and Symbols *(For possible future inclusion in the Official “Do Not Use” List)*

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.

2. UTILIZATION MANAGEMENT PROGRAM AND NEW TECHNOLOGY COMMITTEE

The purpose of the Utilization Management (UM) Program and New Technology (NT) Committee is to provide overall direction and consultation to VPHP's staff and practitioners on appropriate use of covered services. It meets quarterly and membership includes the Senior Medical Director, other CQIC Support Committee Members and designated administrative staff.

FUNCTIONS/ROLE OF UTILIZATION MANAGEMENT AND NEW TECHNOLOGY COMMITTEE

- Reviewing summary data of utilization management trends, sentinel events, and over and under utilization of services and evaluating opportunities for improvement.
- Development and implementation of the UM Program Description.
- Annual review of the program.
- Reviewing and development of utilization management criteria for decision-making
- Monitoring and ensuring delegated UM functions.
- Countersigning appropriate denials, 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.)

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 UM 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 2010, National Health Promotion and Disease Prevention Objectives, as well as the state requirements for Medicaid i.e. EPSDT program. Findings and distribution schedule of the guidelines are discussed at the CQIC meetings.

NEW TECHNOLOGY

The Committee is 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 under utilization of services are monitored to ensure that members are receiving necessary care and service in the most appropriate setting.

The data is 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

BEHAVIORAL HEALTH PROGRAM

The program outlines VPHP's efforts to monitor and improve behavioral health care. The behavioral health practitioner on the CQIC Support Committees is a medical doctor who 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 rending 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 QI Committee comprised of practitioners representing all VPHP geographical regions, numerous specialties, to include a behavioral health practitioner
- Meet requirements of the National Committee for Quality Assurance (NCQA®) and strive to meet the national average for the BH HEDIS measures, Anti-depressant medication, follow-up after Mental Health Admissions seven and thirty days and ABHD the Health Plan Effectiveness Data Information Set (HEDIS®)
- 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.

3. PHARMACY AND THERAPEUTICS COMMITTEE

The purpose of the Pharmacy and Therapeutics (P&T) committee is to provide direction and consultation regarding pharmaceutical management, in addition to communication of clinical information and news. The decisions of the committee are communicated in the VPHP Provider Newsletter and website and individual practitioner mailings, as necessary. It meets four (4) times per year and membership includes the CQIC Support Committee Members and PerformRx pharmacists.

FUNCTIONS/ROLE OF P&T COMMITTEE

- Selecting drugs for the Preferred Drug List (PDL)
- Evaluating and developing formulary policies
- Drug Utilization Management

OBJECTIVES OF P&T COMMITTEE

- Assess utilization and appropriateness of therapeutic agents
- Analyze and aggregate data on drug usage
- Provide feedback and education to practitioners in reference to drug utilization

B. 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.

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 Medicaid/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 Senior Medical Director makes 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 Senior Medical Director. 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, and member satisfaction and utilization management data. Practitioners have access to an appeals process in the event of an adverse credentialing decision.

IX. 2010 QUALITY IMPROVEMENT PROGRAM ACTIVITIES

A. 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 healthplan systems and analyzed by NCQA certified software. VPHP conducts further analysis of HEDIS® results to better understand clinical outcome patterns and identify areas of improvement.

B. Monitoring Quality Performance Indicators –Surveys:

Members:
Surveying member satisfaction provides VPHP with information on our members' experience with the plan and their practitioner. VPHP assesses member satisfaction in several ways, but the primary measurement tool is CHAPS®. Results from CHAPS® helps the Plan identify areas of member dissatisfaction and opportunities for improvement. Based on the results of CHAPS® 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 practitioners' experience with the plan and their members. VPHP assesses practitioner satisfaction in several ways, but the primary measurement tool is Provider Satisfaction Survey, the Access and Availability Survey and the After Hours Survey. Results from surveys helps 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.

C. Clinical Practice Guidelines:
The QI Program develops and the QIC 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.

D. 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 QI 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 keeping practices during the credentialing process or in response to Grievance or direction of one 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. 7) Encourage the completion of a Cultural Competency CME by at least 50% of the network physicians (especially primary care physicians) to aid in caring for members of diverse populations.

E. 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.

F. Credentialing Peer Review Activity:

Peer review is conducted according to the regulatory, accreditation, and VPHP established standards and/or laws and regulations. The Senior Medical Director, with the assistance of Associate Medical Directors, manages the peer review process. Cases requiring peer review are identified through member, practitioner, or provider grievances and other sources. The Senior Medical Director may perform peer review directly, or arrange for review, by an appropriate physician or committee of physicians, 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.

G. Management of Quality of Care Complaints:

All grievances or issues generated by members, practitioners, or providers, VPHP staff, state agencies, and other entities that involve quality of care are handled appropriately per established policy to include in 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.

H. Quality Satisfaction Committee:

The Member Satisfaction Committee (MSC) was redesigned in January 2008, as it only assessed Member Satisfaction. 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, the VPHP Quality Satisfaction Committee (QSC) was established in 2009. The QSC's scope now includes satisfaction for an organizational (i.e., member and practitioner/provider) standpoint.

The QSC was redesigned to be a part of the Quality Improvement Program. The purpose of the QSC is to assist and/or work in conjunction with impacted departments to help develop interventions that will improve organizational effectiveness and overall customer and practitioner satisfaction. The interventions developed and discussed, at the QSC, are then communicated to the impacted departments. The QSC member representing the department is responsible for communicating the QSC activities to his/her department for review and implementation, if deemed appropriate by the departmental Manager/Director/Vice President. The QSC is responsible for tracking, trending, monitoring, and reporting of satisfaction outcomes for the organization, from a member and practitioner/provider perspective, using the Six Sigma Quality Principles. The QSC consists of members from the impacted operational departments, and this collective work group works collaboratively to improve satisfaction outcomes.

The relevant NCQA standards requirements are:

- QI6 –Member Satisfaction:
  - the organization monitors member satisfaction with its services and identifies potential areas for improvement
- RR1 –Member Rights and Responsibilities
  - the organization recognizes the specific needs of and maintains a mutually respectful relationship with members
- RR3 –Policies for Complaints and Appeals
  - the organization has thorough and consistent process for addressing member complaints and appeals
- QI2 –Program Operations
  - the organization's QI Committee and practitioners develop, implement and oversee the QI program
- QI3-Health Services Contracting
  - the organization's contracts with practitioners and providers foster open communication and cooperation with QI activities
- QI5–Accessibility of Services
  - the organization provides and maintains appropriate access to primary care, behavioral healthcare and member services,
- UM 11–Satisfaction With UM Process
  - the organization continually assesses customer satisfaction with it's UM process to identify areas of improvement

I. <u>Web Site Committee</u>:

A representative from the Information Technology Department assumed chairmanship of the VPHP Web Site Committee. The Committee includes a representative from every operational department at VPHP. It ensures that the web site includes accurate, current and valid, which ensures reliability and a high satisfaction level 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 Improvement Evaluation and discussed at the meetings during the year.

J. <u>QI Annual Evaluation:</u>

The Chief Medical Officer, one of the Medical Directors, the Vice President of Quality, Accreditation and Credentialing, and/or the Vice President of Medical Management presents the

annual report for review and approval by the VPHP QIC, CQIC and the Board of Directors. The report contains, at a minimum: a description of all measurement activity, findings from the analysis, the data in graphical display, recommendations to improve care, action plans and a summary of the progress made to improve care and services, and an evaluation of the QI Program.

K. QI Work Plan *(See Attachment B):*

The QI 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 QI Work Plan, which tracks the data collection projects of the QI Program for the year. Additional projects are developed in response to member grievances and findings from performance measurement activities. In addition, the QI 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.

X. RECOMMENDATIONS FOR QI PROGRAM FOR 2010

In 2010, VPHP will investigate the possible implementation of the following QI 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 these activities will be implemented by VPHP. The following are recommendations and/or topics for discussion to improve VPHP's QI activities:

(1). Implementation of:

- Practitioners and Provider Data Sharing:
  Plan is to develop reliable reports that detail targeted practitioners' performance in key quality measures (e.g. Emergency Room utilization) and provide benchmark data.

- Practitioner Quality Incentive Performance Program:
  Plan is to further enhance VPHP's Pay for Performance incentive plans for practitioners/providers for quality care outcomes based on HEDIS national benchmark data.

(2). Proactively educate members, practitioners and providers on all patient safety materials that are available and ensure they obtain this information.

(3). Continue to become 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). Identify and implement interventions that will lead to improved HEDIS® outcomes Goal: National average or greater for all measures reported to DMAS and those measures used to calculate the Plan's annual HEDIS score

Develop and implement work plans, with defined interventions, for all HEDIS® measures < national average. The goal will be to move the following measures to the national average. The measures include, but are not limited to:

Clinical
- Adolescent Well-Care Visits
- Comprehensive Diabetic Eye Exams
- Breast Cancer Screenings
- Cervical Cancer Screenings
- Lead Screening in Children
- Follow Up After Hospitalization for Mental Illness – 7 and 30 Days
- Pharmacotherapy Management of COPD Exacerbation - Bronchodilator

Non Clinical
- Call Abandonment
- Call Timeliness

(5). Collaborate with all organizational departments to incorporate QI initiatives into ongoing interactions with participating practitioners

(6). Share examples of QI work occurring interdepartmentally with CQIC.

(7). Analyze chart review results for all HEDIS® hybrid measures and/or measures reported to DMAS then disseminate results to the network.

(8). Continue VPHP Primary Care Physician Quality Incentive Program, which is a Pay-for-Performance program designed to create a collaborative, quality centered partnership with our Physicians and Members to align incentives and reward quality of care improvements

(9). Work with the Information Technology Department and the Website Committee to ensure the quality section and all other sections of the web site are accurate.

(10). Continue to identify strategies to ensure participating primary care physicians open their panels, which will provide for increased availability and access to practitioners especially in the hard recruit areas such as orthopedics, pain management, behavioral health to name a few. The plan representatives will continue to retain and recruit quality practitioners.

(11). Continue to work with the Department of Medical Assistance Services Managed Care Collaborative Work Group to improve Childhood Immunizations and Well Child Visit compliance rates across the State of Virginia.

(12). Proactively identify technology that will support and ensure more efficient and effective processes for quality activities.

(13). Collaboratively support and work with the VCUHS to incorporate VPHP quality activities.

(14). Continue to streamline processes that ensure quality outcomes for members through lean and cost-effective opportunities; identify opportunities for cost savings in disease management and quality programs.

(15). Require the completion of a cultural competency course to qualify for the Pay for Performance Program.

XI. RESOURCE ALLOCATION

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

Chief Medical Officer	(100%)	Associate Medical Director	(80%)
Medical Director (2)	(100%)	VP of Quality, Accreditation, Credentialing	(100%)
VP of Medical Management	(90%)	Accreditation Manager/Staff (4)	(100%)
QI Manager /Staff (7)	(100%)		

Total Direct FTE Level: 23

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

Chief Executive Officer
Chief Medical Officer
Vice President, Network Operations/Development
Vice President, Claims and Encounters
Vice President, Information Technology
Vice President, Human Resources and Organizational Development
Vice President, of Claims and Encounters
Director, Member Operations
Director, Medicare Operations
Director, Compliance Officer/Government Relations
Director, Finance
2 Administrative Assistants

XII. FEEDBACK/COMMENTS:

Feedback related to VPHP's QIP, quality assurance and improvement activities, and clinical or service studies should be mailed to:

Quality Improvement Department
Attn: Vice President, Quality, Accreditation and Credentialing
600 E. Broad Street – Suite 400
Richmond, VA 23219
Toll-Free #: (800) 819-5179
Fax #: (804) 819-5176

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

2010 Quality Improvement Program Description Signature Page

APPROVED BY:

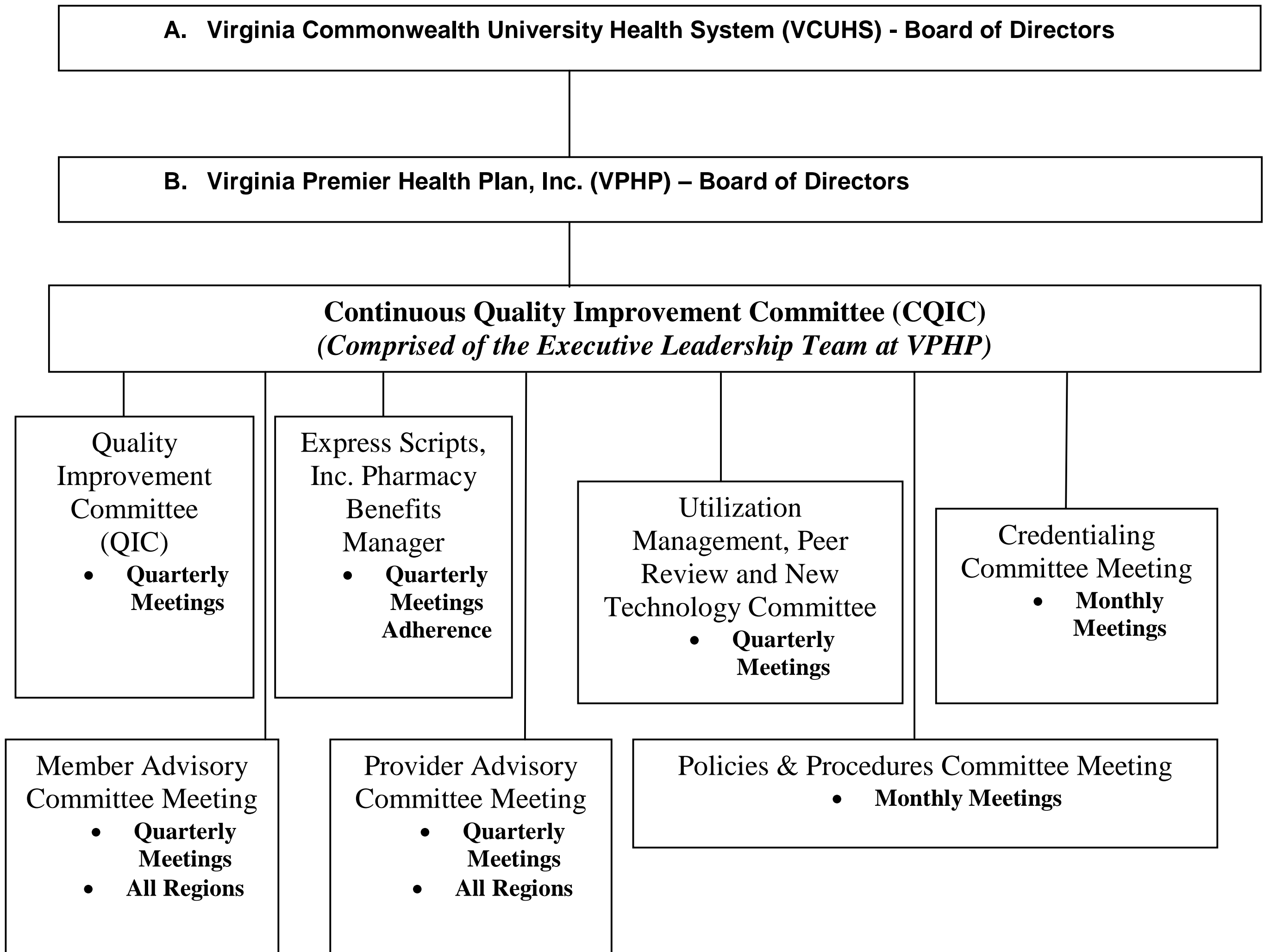
______________________________	____________________
VPHP Quality Improvement Committee	Date
______________________________	____________________
VPHP Senior Medical Director	Date
______________________________	____________________
VPHP Continuous Quality Improvement Committee	Date
______________________________	____________________
VPHP Board of Directors	Date

Original Date: August 2000

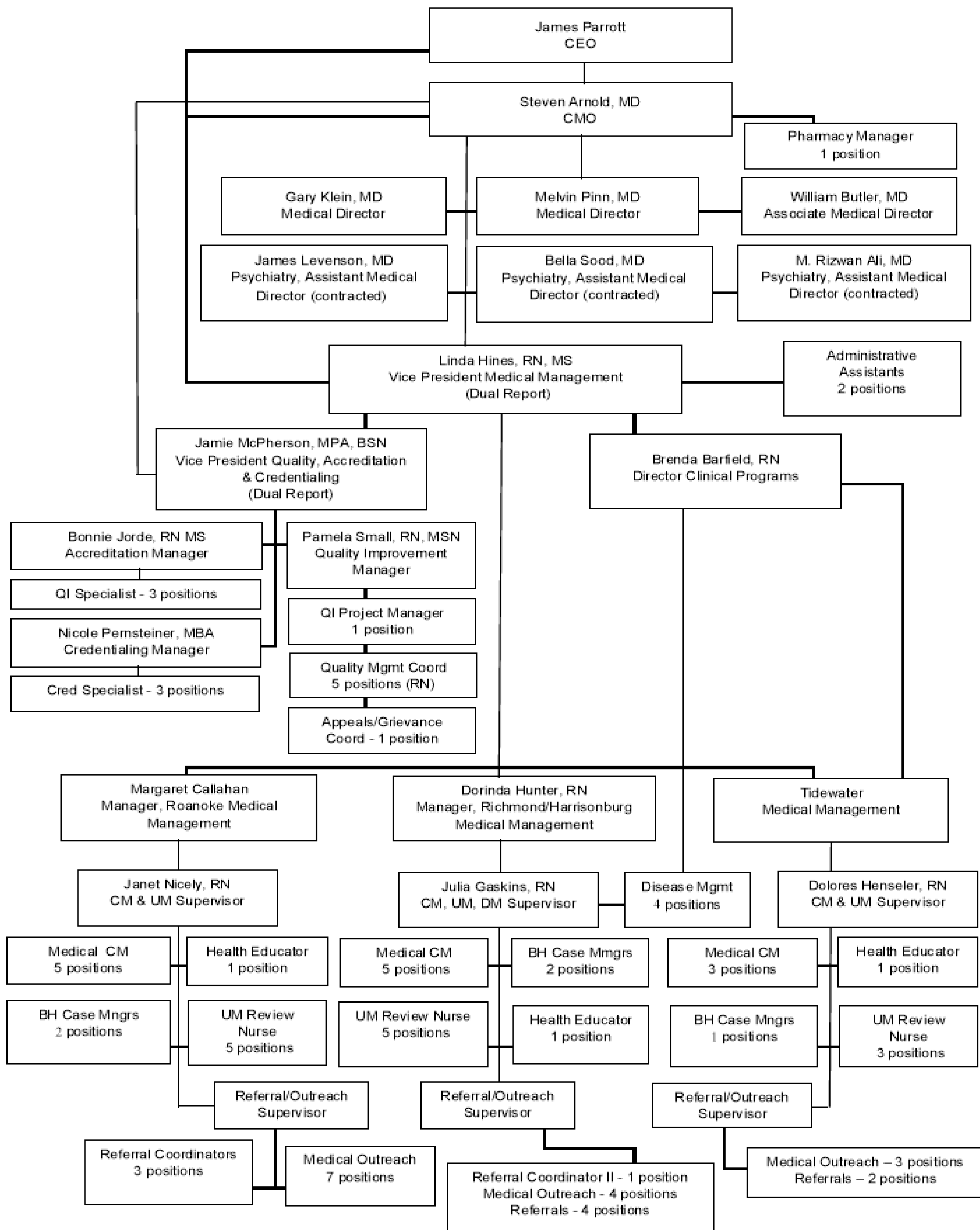
Revised Date(s): 12/2001;
12/2002;
12/2003;
12/2004;
12/2005;
02/2007;
01/2008;
01/2009
01/2010

Effective Date: January 1, 2010

XIV. VPHP Organizational Chart



XV. Medical Management Organizational Chart



Attachment B

XVI. Quality Implementation Work Plan

The QI 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 QI Work Plan, which tracks the data collection projects of the QI Program for the year. Additional projects are developed in response to member grievances and findings from performance measurement activities. In addition, the QI 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.