VAYAHEALTH

QUALITY MANAGEMENT

2018

Introduction

Vaya Health ("Vaya") is committed to a robust Quality Management (QM) program that ensures:

- the accessibility of services,
- a comprehensive and well-qualified provider network, and
- a comprehensive array of clinically appropriate behavioral health and intellectual/developmental disabilities services that meet or exceed quality standards.

The program is committed to supporting the provision of the highest quality of services to recipients in Vaya's 23-county catchment area. The QM program encompasses all aspects of the care that is delivered by Vaya's network of providers, including mental health, substance use disorder, and intellectual/developmental disabilities services, regardless of the setting. In addition to continuously assessing clinical outcomes and indicators, the QM program monitors and addresses administrative issues that affect the delivery of care.

Vaya's QM program is designed to support, promote, and operationalize the organization's mission, vision, and values, which are as follows:

Mission Statement ("Who We Are")
Vaya Health is a public manager of care for individuals facing challenges with mental illness, substance use, and/or intellectual/developmental disabilities. Our goal is to successfully evolve in the health care system by embracing innovation, adapting to a changing environment, and maximizing resources for the long-term benefit of the people and communities we serve.

Vision Statement ("What We're Building")
Communities where people get the help they need to live the life they choose.

Values ("What We Believe In")

- Person-Centeredness: Interacting with compassion, cultural sensitivity, honesty and empathy.
- Integration: Caring for the Whole Person within the home and community of an individual's choice.
- Commitment: Dedicated to partnering with members, families, providers and others to foster genuine, trusting, respectful relationships essential to creating the synergy and connections that make lives better.
- Integrity: Ensuring quality care and accountable financial stewardship through ethical, responsive, transparent and consistent leadership and business operations.

Goals of the QM program

The overarching goals and objectives of Vaya's QM program are the following:

1. Vaya will ensure that individuals and families in its catchment area have **access to care:**
    a. The geographical proximity of services will meet or exceed acceptable standards and/or benchmarks.
    b. The timely availability of services will meet or exceed acceptable standards and/or benchmarks.
2. Vaya will ensure that the **quality and appropriateness of care** delivered within its system is adequate:
    a. Services will be delivered in accordance with service definitions and clinical guidelines.

    b. Services will be delivered in a culturally competent fashion, accounting for the diverse characteristics of the population served.
3. Vaya will ensure that the **over and under utilization of services** is within acceptable limits:
    a. Vaya's utilization management practices will ensure that funding for services is managed in a fiscally sound manner.
    b. Vaya's utilization management practices will be responsive to trends and patterns in utilization data and will ensure that the design of Vaya's service delivery system adequately reflects the service needs of individuals and families in its catchment area.
4. Vaya will ensure that **network provider performance** is adequate:
    a. All provider agencies and licensed individual practitioners within Vaya's provider network will meet or exceed all applicable requirements for network participation and service delivery.
    b. Providers will actively contribute to the overall management of the Vaya service delivery system.

Scope of the QM program

The Vaya QM program encompasses the following:
1. Oversight of the collection, integration, analysis, and reporting of data necessary for the evaluation of system performance;
2. Oversight of the application of quality management principles and techniques as a means of achieving organizational goals that further the mission of Vaya; and
3. Review of system performance indicators and advocating for the use of organizational resources to address identified areas for remediation or improvement.

Quality Management Program Structure

Organizational chart illustrating reporting channels for the QM program and the relationship to the Chief Medical Officer and executive management – (See Figure 1.) The Vaya Board of Directors is the statutory oversight authority and bears ultimate responsibility for ensuring the quality and effectiveness of Vaya's mental health, intellectual/developmental disabilities, and substance use disorder services. The Performance and Quality Committee of the Board of Directors was established in February 2014, and was re-formed as the Regulatory Compliance & Quality Committee (RCQC) effective July 2016. The committee meets at least six times per year to review key performance indicators and other internal LME/MCO quality measures to ensure that the LME/MCO is substantially meeting the requirements of all applicable laws, rules, regulations and DHHS contract requirements.

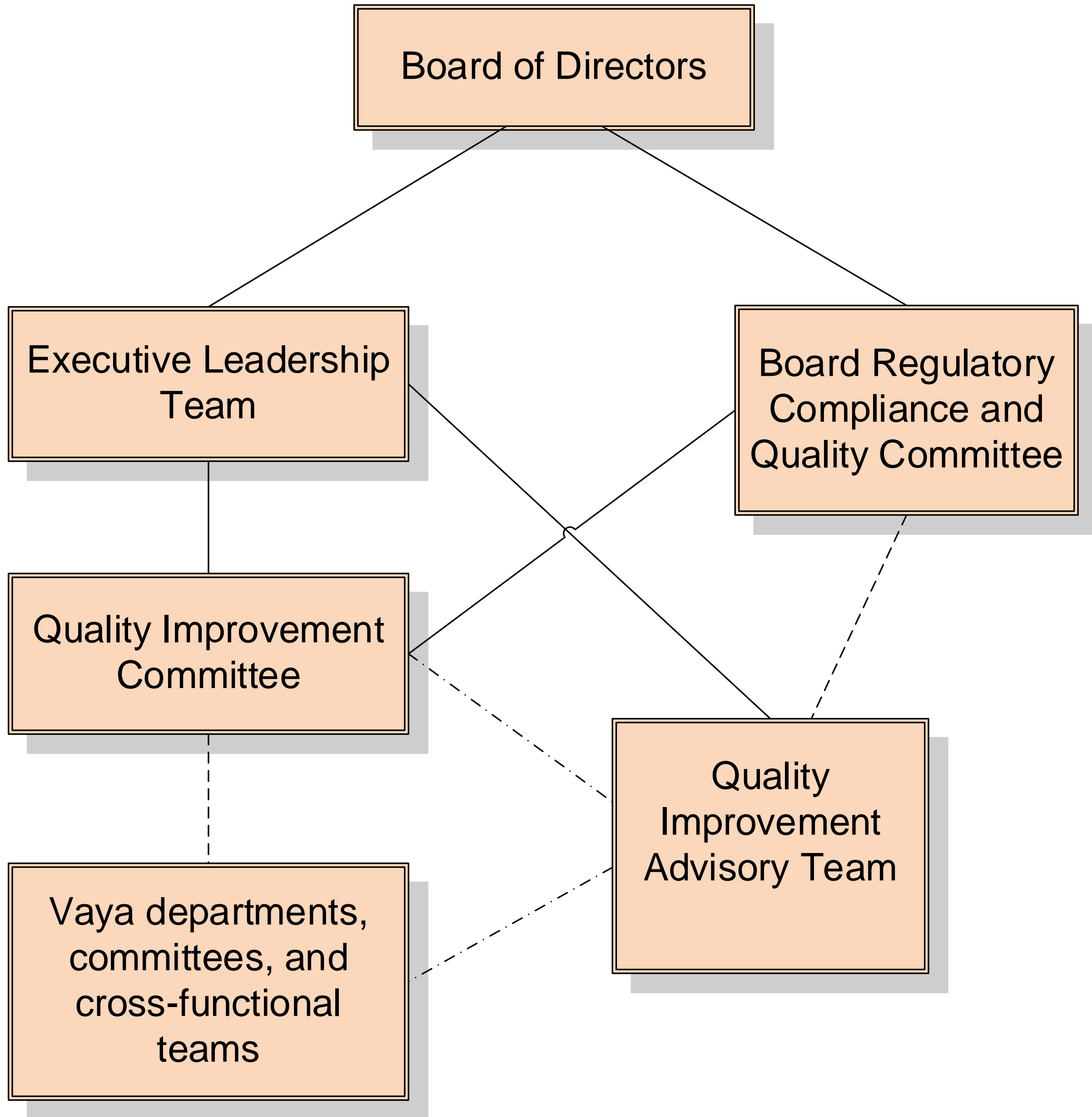


Figure 1 – Quality Management Program Structure

Vaya's Chief Executive Officer (CEO) oversees the implementation of all QM initiatives. The CEO delegates day-to-day QM program operational responsibility to the Quality Management Director who coordinates, facilitates, and monitors all components of Vaya's QM program. The QM Director regularly reports to Vaya's executive leadership regarding the organization's quality management efforts and ensures that executive-level quality management directives are carried out. The QM Director reports directly to the Performance and Quality Improvement (PQI) Senior Director. The PQI Senior Director and the Chief Medical Officer serve as co-chair(s) of the Quality Improvement Committee (QIC). The Quality Improvement Advisory Team (QIAT) carries out critical QM functions under the direction of the QM Director. The QIAT functions as a liaison with other Vaya departments to assist in identifying and addressing needs/opportunities for improvement through the application of quality management techniques. The QIAT also manages system-wide satisfaction surveys.

QM Committee structure – Vaya's Quality Improvement Committee (QIC) ensures that the organization's quality improvement efforts are informed by and disseminated across a broad base of departments, providers, members, and caregivers/ relatives. The activities of the QIC include the following:

- Regular review of an array of reports that reflect a variety of key performance areas and that may identify areas for remediation or opportunities for improvement;
- Oversight of quality improvement goals and activities reflecting key performance areas throughout the Vaya system;
    - Compilation and transmission of information concerning such activities to DHHS, the Board of Directors RCQC, the Consumer & Family Advisory Committee (CFAC), and other stakeholders;
- Review and approval of Quality Improvement Project (QIP) proposals, updates, and final reports; and
- Review and preliminary approval of the QM Annual Reports, including the QM Program Description, the QI Program Evaluation, and the QM Annual Work Plan (with final approval by the Vaya Board of Directors).

Chief Medical Officer (CMO) involvement – The CEO delegates oversight of the QM program to the Chief Medical Officer (CMO). The CMO oversees utilization management and provides regular guidance for other QM program functions including credentialing and provider network monitoring. The CMO is Vaya's ultimate authority in all clinical matters. The primary responsibilities of the CMO in relation to quality management include the following:

- chairing the Credentialing Committee;
- chairing the Critical Incident Review Committee;
- co-chairing the Quality Improvement Committee;
- operational management of the UM Department;
- providing guidance for the development of clinical quality initiatives, studies, and projects, ensuring that thorough analyses of quality of care and service activity data is performed and that areas in need of remediation or opportunities for improvement are identified and addressed; and
- conducting or facilitating peer review of potential clinical quality of care issues and ensuring that validated quality issues are addressed.

Performance Measures and Quality Assurance Activities (QAA)

The Vaya QM Program includes an array of Quality Assurance Activities (QAAs) that are designed to provide an ongoing, comprehensive overview of the performance of Vaya in terms of four key performance areas: Access to Care; Quality and Appropriateness of Care; Over and Under Utilization of Services; and Network Provider Performance. Staff responsible for conducting a given QAA routinely monitor, evaluate, and report on Vaya's performance via the monthly Quality Management Reports to QIC. A QAA may identify a need for remediation and improvement, which may then be addressed by a Quality Improvement Activity (QIA).

Each QAA is associated with a set of related performance measures. All clinical performance measures required by Vaya's contracts with the state are associated with QAAs. QAAs also rely on Vaya-defined performance measures as needed to provide a comprehensive overview of the performance of the Vaya system.

Vaya's current array of QAAs is listed below, along with the associated performance measures. (Performance measures that are required by Vaya's contracts with the state are marked with an asterisk.)

Service availability

- Out of Network Services*
- Identification of Alcohol and Other Drug Services (Penetration)*
- Identification of MH Services (Penetration)*
- Network Capacity*
- Penetration Rates*

Cultural competency and access to care for underserved groups

- Diversity of Medicaid Membership*
- TCLI Housing Goals*
- IPS-Supported Employment Goals*
- Community-Based MH Services in Place Prior to Transition*
- Transition within 90 days*
- Timely Quality of Life Survey Completion*

Timely access to care

- Ambulatory Follow-Up within 7 calendar days of Discharge for Substance Abuse facility*
- Ambulatory Follow-Up within 7 calendar days of Discharge for Mental Health*
- Percent of psychiatric inpatient readmits assigned to Care Coordination*
- Access to substance use prevention services*
- Access to Timely Emergent Care*
- Access to Timely Urgent Care*
- Access to Timely Routine Care*
- Timely Support for Persons with IDD*
- Follow-Up After Discharge from a State Psychiatric Hospital*
- Follow-Up After Discharge from ADATC*
- Follow-Up After Discharge from Community MH Inpatient Treatment*
- Follow-Up After Discharge from Community SUD Inpatient Treatment*

- Follow-Up After Discharge from a Community Crisis Service*

Initiation and Engagement with MHSU treatment

- Initiation of Substance Use Disorder Services*
- Initiation for Persons Receiving Mental Health Services*
- Engagement in Substance Use Disorder Services*
- Engagement for Persons Receiving Mental Health Services*

Integrated care and access to primary care

- Care Coordination*

Use of state facilities and local hospitals

- Readmission Rates for Mental Health*
- Readmission Rates for Substance Abuse*
- MH Utilization - Inpatient Discharges and Average LOS*
- Short Term Care in State Psychiatric Hospitals*
- Admission Rate and LOS in Community Hospitals for MH Treatment*
- Admission Rate and LOS in Community Hospitals for SUD Treatment*
- State Hospital Readmissions within 30 days and 180 days*
- ADATC Readmissions within 30 days and 180 days*
- Community MH Inpatient Readmissions within 30 Days*
- Community SUD Inpatient Readmissions within 30 Days*

Use of emergency and crisis services and hospital ED's

- Crisis Care in Emergency Departments*

Service patterns and costs for high cost / high risk individuals

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*
- MH Utilization*
- SUD Utilization*

Use of evidence-based practices

- Service-specific utilization for selected services

Member outcomes

- NC-TOPPS*

Member satisfaction

- Experience of Care and Health Outcomes (ECHO) Survey*
- Perception of Care Survey*

Trends and patterns in grievances

- Quarterly incidence of grievances

Trends and patterns in incidents

- Monthly incidence of Level II and Level III incidents

Trends in denials and appeals

- Processed Service Authorization Request volume per quarter
- Clinical denial rate
- Percent of clinical denials resulting in reconsiderations

Provider compliance with State Rules

- Bi-annual Routine Monitoring reviews

Provider compliance with clinical practice guidelines

- Rate of compliance with guidelines for selected services

Provider compliance with LME/MCO contractual requirements

- Rate of compliance with selected contractual requirements

Incident response and reporting

- Rate of compliance with requirements for timely submission of incident reports

Prevention, detection, and remediation of fraud, waste, and abuse

- Data analytics utilizing FAMS and/or other data mining techniques

Grievance response and resolution

- Average days to send acknowledgment letter
- Percent of complaints resolved in 30 days*

Adequacy of MCO supports for providers

- DHHS Provider Satisfaction Survey*
- Payment Denials*
- Percent of claims processed within 30 days*

Conduct of calls

- Call Answer Timeliness*
- Call Abandonment*

Service authorization processes

- Inter-Rater Reliability
- Peer Review Concordance
- Percent of routine authorization requests processed in 14 days*
- Percent of expedited authorization requests processed in 3 days*

Credentialing and recredentialing of providers

- Average processing times for agencies
- Average processing times for Licensed Practitioners (LPs)
- Average processing times for Licensed Independent Practitioners (LIPs)

Quality Improvement Activities

Quality Assurance Activities or other means may be used to identify and prioritize needs for remediation or improvement. A Vaya department, committee, or cross-functional team may develop and implement a Quality Improvement Activity (QIA) to address such a need. Each QIA is associated with a Performance Improvement Goal that defines the conditions for satisfactory resolution of the need for improvement. The team responsible for conducting a QIA routinely monitors and evaluates Vaya's progress in terms of the Performance Improvement Goal and provides progress reports to QIC via Quality Management Reports.

Vaya's QIAs include the Quality Improvement Projects (QIPs) that are required to meet Vaya's contractual or accreditation requirements. Detailed reports concerning Vaya's current QIPs are included in the Appendices as shown below.

Current QIPs:

1. Improve Timeliness of Transitions to Community Living Initiative Quality of Life Survey Completion QIP
2. Inpatient Rapid Readmission QIP
3. Integrated Care (Access to Primary & Preventive Care) for Innovations Waiver Participants QIP
4. Follow-Up After Discharge from Inpatient Mental Health Treatment QIP
5. Follow-Up After Discharge from Inpatient Substance Use Disorder Treatment QIP
6. Increase housing placements through the Transitions to Community Living Initiative QIP

Performance improvement and feedback loops – Vaya departments, committees, and cross-functional teams develop and implement Quality Assurance Activities and Quality Improvement Activities that fall within the scope of the Vaya QM Program. As these activities are conducted, regular reports concerning performance and progress towards goals for improvement are provided to the QIC in Quality Management Reports. Reporting for the QAA and the QIA maintains the linkage between the two, thus completing the feedback loop between the effort to improve quality and the monitoring of performance that identified the need for improvement.

The QIC regularly evaluates the performance monitoring and improvement efforts of Vaya departments, committees, and cross-functional teams and provides them with feedback and guidance in a cross-functional context.

Health Information System and Other System-Wide Information Sources

The Enterprise Analytics Team of the Management Information Services (MIS) Department focuses on Vaya's application, business intelligence, data warehouse, and analytics development, as well as data governance and advanced (predictive/prescriptive) analytics. The team's activities include the following:

- Data collection, integration, analysis, and reporting – The primary repository of data for performance and analysis purposes is a central data warehouse that integrates data from Mediware's AlphaMCS system, InfoMC's Incedo system, and other internal and external systems. This data warehouse supports and integrates all primary LME/MCO functions, including access and enrollment, patient information, submission and disposition of service authorization requests, care coordination, and submission and disposition of service claims.

Reports developed in AlphaMCS, Incedo, and Vaya's Enterprise Analytics environment support LME/MCO functions and address state reporting requirements.

The team continues to improve and expand the reporting and analytics capabilities of the organization. Data cubes are now in their fifth year of operation. Data cubes are refreshed daily from various data sources and supply key operational data to staff throughout the organization. In addition, MIS is expanding access to data through end-user data visualization tools and custom-developed applications. Although in its early stages, work has begun on developing advanced analytics capabilities using predictive and prescriptive algorithms. As a result, the customized reporting and data analysis capabilities of the organization have been expanded and expedited dramatically.

- The Enterprise Analytics Team maintains a single list of analytics work requests called a Product Backlog. The Product Backlog is managed within Microsoft's Team Foundation Server (TFS) which provides work item tracking, development project management, and source code control. Prioritization of the items on the Product Backlog has been rolled into the organization's overall project portfolio prioritization process by the cross-departmental Project Management Steering Committee (PMSC). The results have been: better alignment of development projects with corporate strategy; better tracking of work-in-progress and waiting requests; and greater transparency and visibility of analytics-related development work.

- The Enterprise Analytics Team has also implemented a task time tracking system that is integrated with the TFS data to capture actual versus estimated time for each development project. This system will enhance the team's ability to estimate the time required for new development projects.

Satisfaction surveys – Vaya's sources for measurement of member satisfaction are: the Experience of Care and Health Outcomes (ECHO) survey administered by DataStat, Inc. on behalf of DMA; and the Perception of Care Survey that is administered by LME-MCOs under the oversight of DMHDDSAS. Both surveys are administered annually. Upon receipt of consolidated survey data from the state, the QIAT analyzes and prepares a summary of the results and presents them to the Vaya Board of Directors RCQC, the CFAC, QIC, the Provider Advisory Council (PAC) and internally throughout Vaya. Throughout this process, areas in need of further study or improvement may be identified. The related Vaya department would then develop and implement quality improvement activities to address these areas. Data specific to individual providers may be shared with the providers at their request.

The Provider Satisfaction Survey is administered annually by the North Carolina Division of Medical Assistance (DMA) and allows for comparisons across LME/MCOs. Upon the completion of the survey, DMA provides Vaya with the raw data and basic analysis. The QIAT analyzes the data and summarizes the results to be presented to the Vaya Board of Directors RCQC, QIC, PAC and internally throughout Vaya. The QIC, PAC and members of the RCQC may identify a need for further study or improvement. The appropriate Vaya department develops and implements quality improvement activities to address any such areas. The results and any ensuing quality improvement activities are also reported to the QIC, PAC and RCQC.

Complaints and grievances – Vaya utilizes a "no wrong door" approach for complaints and grievances. All Vaya staff are trained to recognize and enter data concerning complaints and grievances in the Vaya electronic portal. Training on the recognition and documentation of grievances is provided during orientation. All staff are notified of changes to the grievance policy and procedure through the

electronic policy management system (Policy Tech). Staff are required to read the policy and complete an attestation of their understanding within Policy Tech.

The Grievance Team:

- follows up on all grievances to seek resolution;
- provides analysis concerning circumstances that may have contributed to the results;
- presents a monthly report to DMA and DMH/DD/SAS, detailing funding source, category of grievance and whether the standard for timeliness of resolution was met; and
- prepares a quarterly report that summarizes and identifies trends and/or patterns in grievance data.

These reports are presented to the Vaya Board of Directors RCQC, the Human Rights Committee (HRC), and the QIC. Any of these may identify areas in need of further study or improvement. The appropriate Vaya department develops and implements quality improvement activities to address these areas.

When a trend or pattern involving a provider is identified, Vaya's Contract Performance Unit may provide technical assistance, proceed with an investigation, and/or conduct focused monitoring as needed to address the issue. Specific complaints or grievances indicating a need for investigation are referred to the Investigation Oversight Committee for consideration and/or external oversight or to licensing agencies.

Incidents – Vaya oversees the submission of incident reports by its network of providers. Level 2 and Level 3 incidents are reported in the Incident Response Improvement System (IRIS). Level 1 incidents are tracked by each provider. The Vaya Incident Report Team prepares a quarterly report that identifies, analyzes, and summarizes trends and patterns in incidents. Incident data is reported at least quarterly to the Vaya Board of Directors RCQC, the CFAC, HRC, and the QIC. Any of these groups may suggest areas for further study or improvement. The appropriate Vaya department develops and implements quality improvement activities to address these areas. Incidents are communicated to Care Coordinators, Provider Network Specialists, and Contract Performance staff, as appropriate.

The Vaya Critical Incident Review Committee (CIRC) is chaired by the CMO and includes five other licensed professionals. CIRC performs clinical reviews of all reported Level 3 and certain Level 2 incidents and provides oversight of provider responses to ensure that appropriate measures are taken to protect the health and safety of members and to prevent similar incidents from occurring again. If necessary, a referral will be made to the Investigation Oversight Committee (IOC) to investigate the provider's response to an incident. If CIRC finds that an incident poses a current risk to the health and safety of members, the CMO may authorize an immediate suspension of a provider's network participation as well as an expedited investigation.

Administrative Health Records (AHR) and communication of clinical information – Vaya utilizes two platforms for administrative health records and the communication of clinical information: AlphaMCS, as its platform for Customer Services and Utilization Management purposes; and Incedo, as its complex care management platform for Care Coordination purposes.

In Vaya's Customer Services Department, all service requests and other requests received by the Call Center, both telephonic and non-telephonic, are documented in the AlphaMCS Call Log. Call Center staff complete and save a Screening, Triage, and Referral (STR) form in AlphaMCS for all service requests. The information entered by Call Center staff routinely includes members' preferences

regarding follow-up contact. All Call Log and STR documentation stored in AlphaMCS may be retrieved for future reference.

All emergent and urgent calls are handled by licensed clinicians. When a Customer Services Representative answers a call, they screen the caller for risk factors. If a risk factor is identified, the call is transferred to a licensed clinician.

Vaya's Utilization Management (UM) staff conducts most of their work in AlphaMCS. AlphaMCS is the key portal through which providers submit enrollments, admissions, service authorization requests (SARs), discharges, clinical documentation, as well as communicating member-specific information. While UM staff may utilize several different AlphaMCS modules when conducting their work, most of their time is spent in the Clinical/UM/SAR module (SAR tile, service tile, and previous authorizations tile). UM staff review SARs (which include Diagnoses, CALOCUS/LOCUS, ASAM and SIS scores, medications, Comprehensive Clinical Assessments (CCAs), Person Centered Plans (PCPs), etc.) and the corresponding documentation in this module to determine medical necessity. Once UM staff make decisions on medical necessity, the outcome is communicated to providers through AlphaMCS. In instances where medical necessity is not met or when a review results in an administrative denial, the Clinical Support Team provides written notification to the member. During medical necessity review, UM staff frequently contact providers by telephone and/or secure email to discuss clinical aspects of member care or to request additional documentation. These contacts are documented in the SAR comments tile or in the Patient Maintenance module in a Patient Note.

Per policy and to ensure continuity of care, Vaya's Care Coordinators (CC) document all relevant member contacts, attempted contacts, screenings/assessments, tasks, interventions and information exchange for coordination in the member's Incedo AHR within 24 hours of intervention, the standard documentation timeline. This documentation includes face-to-face and telephonic contacts and collateral conversations relative to member treatment and care. Care Coordinators also upload relevant clinical documentation to the Incedo CC platform including both internal and external documentation. Care Coordinators use the following documentation and logic to support information flow:

1. Assessment/Case Formulation. CC assessment/case formulation is completed by all CCs, regardless of credentials, within their scope of licensure or education. CCs will consult with respective interdisciplinary team members if there are concerns or questions regarding scope of practice/licensure.
2. Treatment Planning. CC ensures that treatment planning is developed in conjunction with the member's primary care provider, with member participation, and in consultation with any specialists caring for the Member.
3. Tasks/Interventions. Beginning during the care planning process, CC tasks and interventions may include but are not limited to the following:
    a. Establish rapport and begin assisting the member in facilitating a positive outcome;
    b. Outline the roles and expectations for all members of the care team;
    c. Inform the member of their rights as a Vaya Health Plan member;
    d. Provide relevant education and information to the member;
    e. Help link the member to primary care and specialty care based on initial evaluation of need or care plan directed needs;
    f. Provide or arrange for medication reconciliation;
    g. Coordinate and monitor behavioral health hospital and institutional admissions and discharges;

h. For IDD Care Coordination, the IDD Care Coordinator will refer to Vaya's policy concerning the Registry of Unmet Needs and potential eligibility for the NC Innovations Waiver.

4. Referral and Linkage to necessary specialists. Based on information identified during care coordination, care coordinators link individuals to both traditional services and community-based resources.
5. Monitoring. CC uses data at a population and individual level to measure and monitor outcomes associated with risk factors impacting multi-morbid conditions. A care coordinator may utilize perception of care measures to assess the member's experience of care. Care coordinators serve as the "eyes and ears" of the system and initiate follow-up on quality-of-care concerns and provider investigation referrals. This information, in combination with outcomes data, allows the larger system to respond to incidences of substandard care, waste, poor access or gaps in care.
6. Risk Management (individual and population levels). Risk management is an additional care coordination function based on national models.
    a. If the care coordinator becomes aware of an urgent health, safety or welfare concern involving a Member, the CC must immediately notify and/or seek consultation from the CMO, Chief Population Health Officer, Sr. Director of Performance & Quality Improvement and/or Sr. Director of Care Coordination.
7. Disease Management (DM) (at individual and population levels).
    a. At the individual level, care coordinators identify member-specific healthcare risks and needs associated with disorders,
    b. At the population level, care coordinators help develop care continuums to support traditional treatment and specialty services for specific diagnostic categories.

Privacy and confidentiality – Primary responsibility for the privacy and security of health information and other sensitive information lies with the Privacy & Security Committee, which reports to the Vaya Regulatory Compliance Committee. The Privacy & Security Committee ensures that Vaya's privacy and security policies are comprehensive and up-to-date. All new Vaya employees receive training on Vaya's privacy and security policies. Current employees receive annual refresher training on this topic. When changes to these policies occur, employees are required to complete an attestation to verify that they have read and understand the updated policy in PolicyTech. The Vaya Board of Directors and all members of Vaya committees who are not Vaya employees are required to sign a confidentiality statement acknowledging their responsibility to protect and maintain the confidentiality of health information and other sensitive information.

The Privacy & Security Committee conducts the required annual HIPAA Security Risk Analysis to identify areas in which the security of information may be at risk. Appropriate physical, administrative, and technical safeguards are developed and implemented by the Privacy & Security Committee and the MIS Department. The Regulatory Compliance Committee provides oversight of the Security Risk Analysis process and ensures that follow-up is performed in a thorough and timely manner. In 2016, Vaya engaged an outside vendor, Clearwater Compliance, to conduct the Security Risk Analysis and provide technical assistance in further developing and enhancing Vaya's Security Program.

Appendices

1. Improve Timeliness of Transitions to Community Living Initiative Quality of Life Survey Completion QIP
2. Inpatient Rapid Readmission QIP

3. Integrated Care (Access to Primary & Preventive Care) for Innovations Waiver Participants QIP
4. Follow-Up After Discharge from Inpatient Mental Health Treatment QIP
5. Follow-Up After Discharge from Inpatient Substance Use Disorder Treatment QIP
6. Increase housing placements through the Transitions to Community Living Initiative QIP

Quality Management Program Evaluation

2017-2018

Table of Contents

SUMMARY DESCRIPTION OF THE QUALITY IMPROVEMENT PROGRAM…… 1
MAJOR ACCOMPLISHMENTS OF THE 2017-2018 QUALITY IMPROVEMENT PROGRAM…… 1
QUALITY ASSURANCE ACTIVITIES…… 2
- Timely access to care…… 2
- Initiation and engagement with MHSU treatment…… 3
- Member outcomes…… 3
- Trends and patterns in grievances…… 4
- Incident response and reporting…… 5
- Integrated care and access to primary care…… 6
- Use of state facilities and local hospitals…… 8
- Use of emergency and crisis services and hospital ED's…… 10
- Service patterns and costs for high cost / high risk individuals…… 11
- Use of evidence-based practices…… 13
- Trends and patterns in incidents…… 14
- Grievance response and resolution…… 16
- Conduct of calls…… 17
- Service authorization processes…… 19
- Member satisfaction…… 21
- Trends in denials and appeals…… 23
- Adequacy of LME/MCO supports for providers…… 25
- Credentialing and recredentialing of providers…… 27
- Service availability…… 29
- Provider compliance with State Rules…… 30
- Cultural competency and access to care for underserved groups…… 30
- Provider compliance with clinical practice guidelines…… 31
- Provider compliance with LME/MCO contractual requirements…… 31
- Prevention, detection, and remediation of fraud, waste, and abuse…… 32

QUALITY IMPROVEMENT ACTIVITIES…… 33
- Inpatient Rapid Readmission…… 33
- Improve Timeliness of Transitions to Community Living Initiative Quality of Life Survey Completion…… 34
- Integrated Care (Access to Primary & Preventive Care) for Innovations Waiver Participants…… 35
- Increase housing placements through the Transitions to Community Living Initiative…… 36
- Complex Care Coordination Competencies…… 38
- RN Care Coordinator Utilization…… 38
- Clinical Best Practices for Autism Spectrum Disorder Members…… 39
- Clinical Best Practices for Children and Youth in Crisis…… 39
- Timely Submission of Incident Reports…… 40
- Assessment and Treatment of Mental Health Disorders in Innovations Beneficiaries…… 40
- Follow-Up After Discharge from Inpatient Mental Health Treatment…… 41
- Fidelity of Supported Employment Services…… 41
- Follow-Up After Discharge from Inpatient Substance Use Disorder Treatment…… 42

ADEQUACY OF RESOURCES, TRAINING, SCOPE AND CONTENT…… 42

Summary Description of the Quality Improvement Program

The Vaya Quality Improvement (QI) Program encompasses the following:

1. Identification of areas for further study or improvement based on continuous review of system performance measures; and
2. Application of quality improvement principles and techniques as a means of addressing identified areas for improvement.

Vaya departments, committees, and cross-functional teams develop and implement Quality Assurance Activities and Quality Improvement Activities that fall within the scope of the Vaya QI Program. As these activities are conducted, the departments, committees, and teams involved provide regular reports to the Quality Improvement Committee (QIC) concerning performance in key areas and progress towards goals for improvement.

Quality Assurance Activities consist of ongoing monitoring and analysis of key system performance measures. A given Quality Assurance Activity (QAA) may identify a need for remediation and improvement, which is then addressed by a Quality Improvement Activity (QIA). Reporting for the QAA and the QIA maintains the linkage between the two, thus completing the feedback loop between the effort to improve quality on the one hand and the monitoring of performance that identified the need for improvement on the other.

For further details concerning the Vaya Quality Improvement Program, please see the 2018 Vaya Quality Management Program Description.

Major Accomplishments of the 2017-2018 Quality Improvement Program

- The number of members who utilize Psychiatric Residential Treatment Facility (PRTF) services was reduced by approximately 35% (see pp. 11 and 39).
- The number of Emergency Department (ED) admissions for Medicaid members was reduced by approximately 26% (see p. 10).
- Provider satisfaction with the Provider Network Department, the Provider Council and investigations of providers including Plans of Correction has continued a four-year upward trend and is now at or near the highest in the state (see p. 25).
- The Quality Improvement Project (QIP) to improve the timely submission of the Transition to Community Living (TCLI) Quality of Life (QOL) Survey resulted in improvement from 40 % in August 2017 to 100% currently and has met the state requirement of 80% for four consecutive months (see p. 34).
- Timely submission of incident reports by providers has achieved the goal of 85%, and this level has been maintained or exceeded since the goal was achieved (see p. 40).

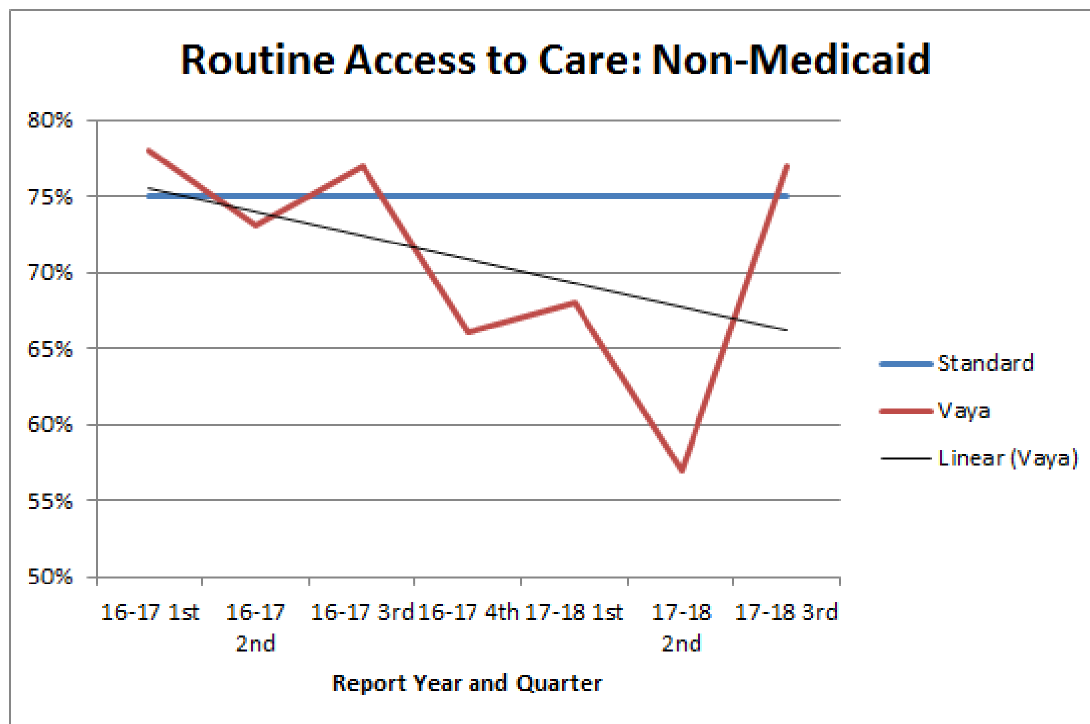
2017-2018 Quality Assurance Activities

Quality Assurance Activity: Timely access to care

Lead staff: Karla Mensah, MBA - Customer Services Senior Director

Planned monitoring period (renewable): Jul-2017 to Jun-2018

Performance notes: Access to Care Report - 3nd Quarter (January - March 2018)
Emergent - 55 calls - 98% Received Timely Service Combined (State Standard is 97% Combined) Missed Emergent Medicaid only percentage by 3% (1 call) - member connected by phone with MCM within timeframe but chose to wait until the next day to meet with them.
Urgent - 129 calls - 88% Received Timely Service (State Standard is 82%)- This is the combined score for Medicaid and Non-Medicaid.
Routine - 263 calls - 82% Received Timely Service (State Standard is 75%) - This is the combined score for Medicaid and Non-Medicaid. Previous reports indicated non-Medicaid routine access was on a downward trend (see below); however, in the latest quarter it has improved to 77% which is above the state standard.



Recommendations: Call logs have continued to improve over the last three quarters. Corrections needed have decreased drastically. An email with trends was sent out to staff as a whole along with individual emails for staff that needed to make corrections to their call logs. Continue to monitor non-Medicaid routine access to ensure that improvement is sustained.

Updated by Karla Mensah *on* 5/9/2018

Related QI Activities:

p. 41 Follow-Up After Discharge from Inpatient Mental Health Treatment

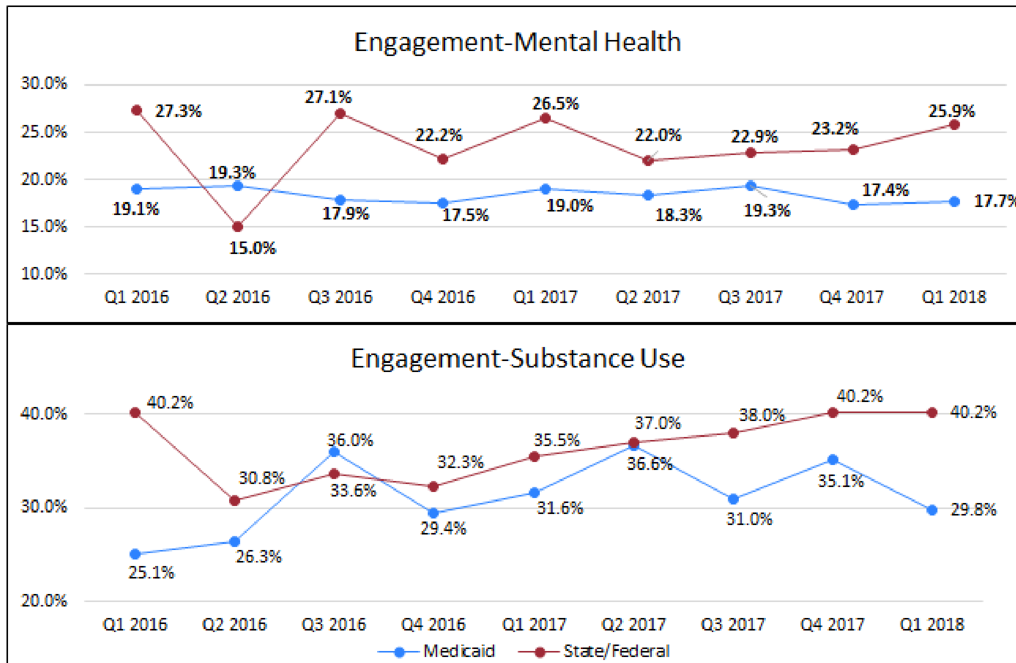
p. 42 Follow-Up After Discharge from Inpatient Substance Use Disorder Treatment

Quality Assurance Activity: Initiation and engagement with MHSU treatment

Lead staff: Steven Kozicki, MS, ASQ-CMQ/OE - Quality Management Director

Planned monitoring period (renewable): Jul-2017 to Jun-2018

Performance notes: The graph below shows trends in engagement measures, i.e., the rate at which members engage in at least two visits in the 30-day period following the initiation of services. Engagement for state-funded Substance Use Disorder services has trended steadily upwards since mid-2016, from about 31% to about 40%. Otherwise, these measures do not indicate any marked recent trends. Engagement for Medicaid services appears to be consistently lower than engagement for state-funded services. No benchmark has been set for these measures.



Recommendations: Conduct further analysis of the state-funded Substance Use Disorder engagement data to determine the cause of the apparent trend toward improvement. Examine service-specific utilization and engagement rates to determine why engagement tends to be lower for Medicaid than for state-funded services. Consider establishing engagement benchmarks for a subset of services for which engagement tends to have a critical impact on outcomes. Track initiation of services in addition to engagement and incorporate in the overall analysis.

Updated by Charley Barry *on* 5/3/2018

Related QI Activities: none

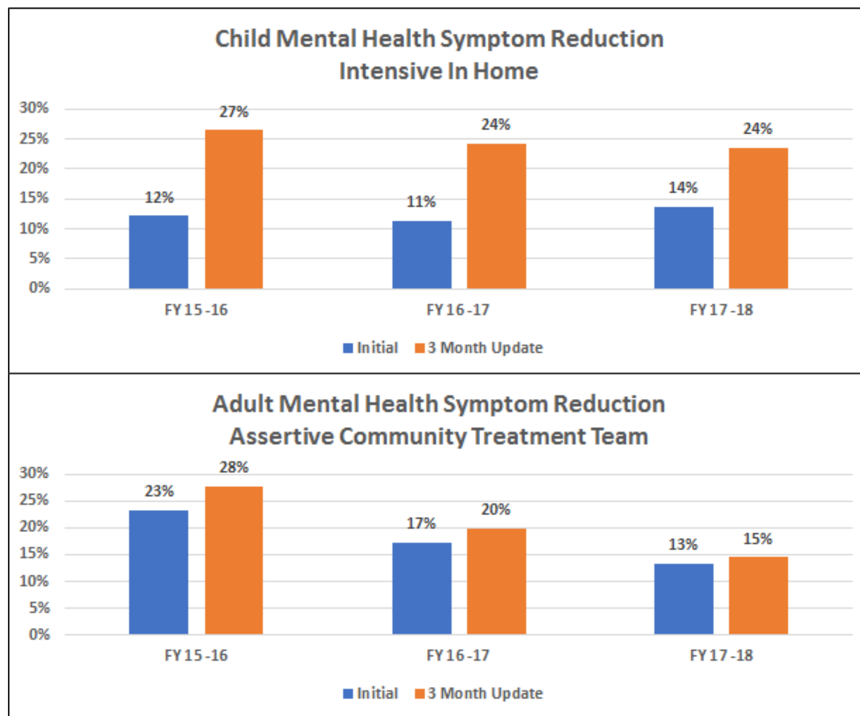
Quality Assurance Activity: Member outcomes

Lead staff: Alison McCall, BS, CI - Site Review Specialist

Planned monitoring period (renewable): Jul-2017 to Jun-2018

Performance notes: Vaya's review and analysis of member outcomes has focused on symptom reduction in the first three months of an episode of care for children receiving Intensive In-Home (IIH) services and adults receiving Assertive Community Treatment Team (ACTT) services. Vaya's source for measurement of this outcome is NC-TOPPS, the statewide outcomes measurement tool that providers are required to administer to members with mental health and substance use disorder diagnoses. NC-TOPPS includes an assessment at the beginning of an episode of care and an update assessment three months later. The measure indicates the percentage of members who experienced improvement, i.e., a reduction in symptoms, since beginning treatment.

The graph below shows trends in this measure for IIH and ACTT services over the past three years. IIH services appear to consistently produce a reported reduction in symptoms for about a quarter of the members served after three months of treatment. ACTT services, on the other hand, show a significant downward trend, with the percentage of members reporting a reduction in symptoms after three months of treatment declining by almost 50% in the three-year period.



Recommendations: Analyze the ACTT results further to determine statistical significance. Cross-reference with other measures reflecting the quality and appropriateness of ACTT services to determine if further action is indicated to improve ACTT outcomes.

Updated by Charley Barry *on* 5/11/2018

Related QI Activities:

p. 34 Improve Timeliness of Transitions to Community Living Initiative Quality of Life Survey Completion

---

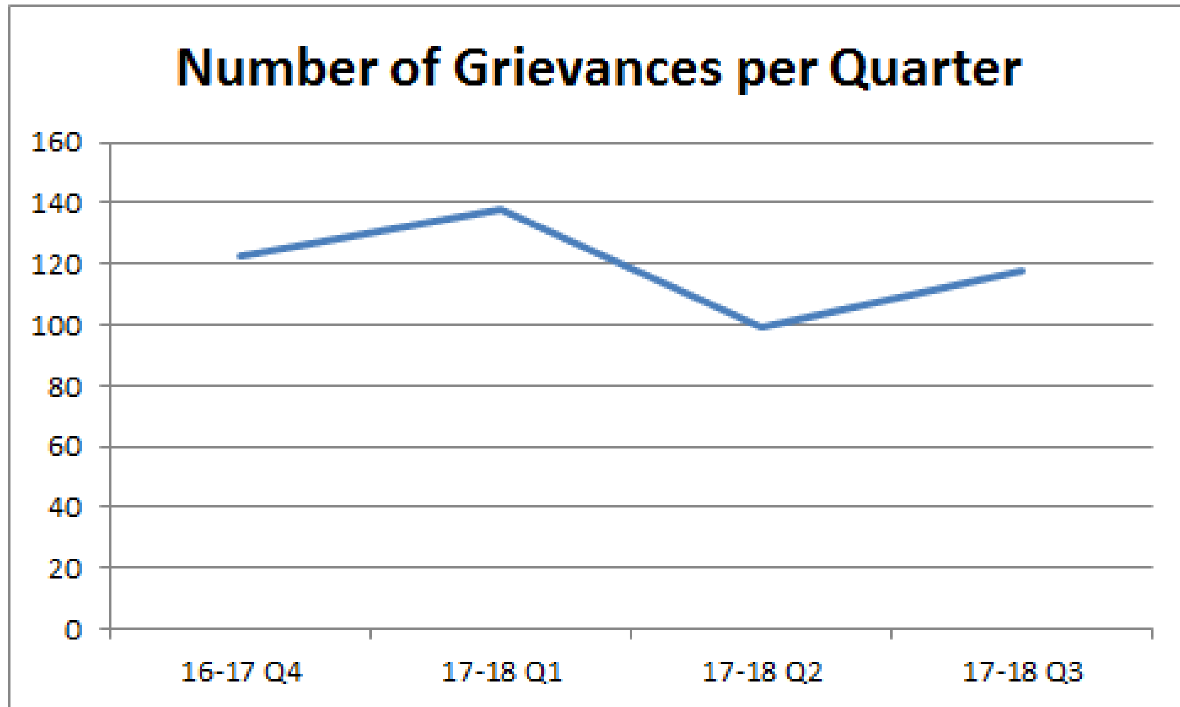
Quality Assurance Activity: Trends and patterns in grievances

Lead staff: Stephanie Hopfinger, BS - Grievance Specialist Lead

Planned monitoring period (renewable): Jul-2017 to Jun-2018

Performance notes: Grievances increased in Quarter 3, 2018 from Quarter 2, 2018. In Quarter 2, 2017-2018, Vaya received 99 grievances and in Quarter 3, 2017-2018, Vaya received 118 grievances.

The Grievance Team referred 21 grievances to the Vaya Investigation Oversight Committee for investigation. Nine of these grievances were referred due to an allegation of abuse/neglect/exploitation, six were referred to investigation based on an identified



Recommendations: Continue to monitor for any trends.

Updated by Stephanie Hopfinger *on* 5/9/2018

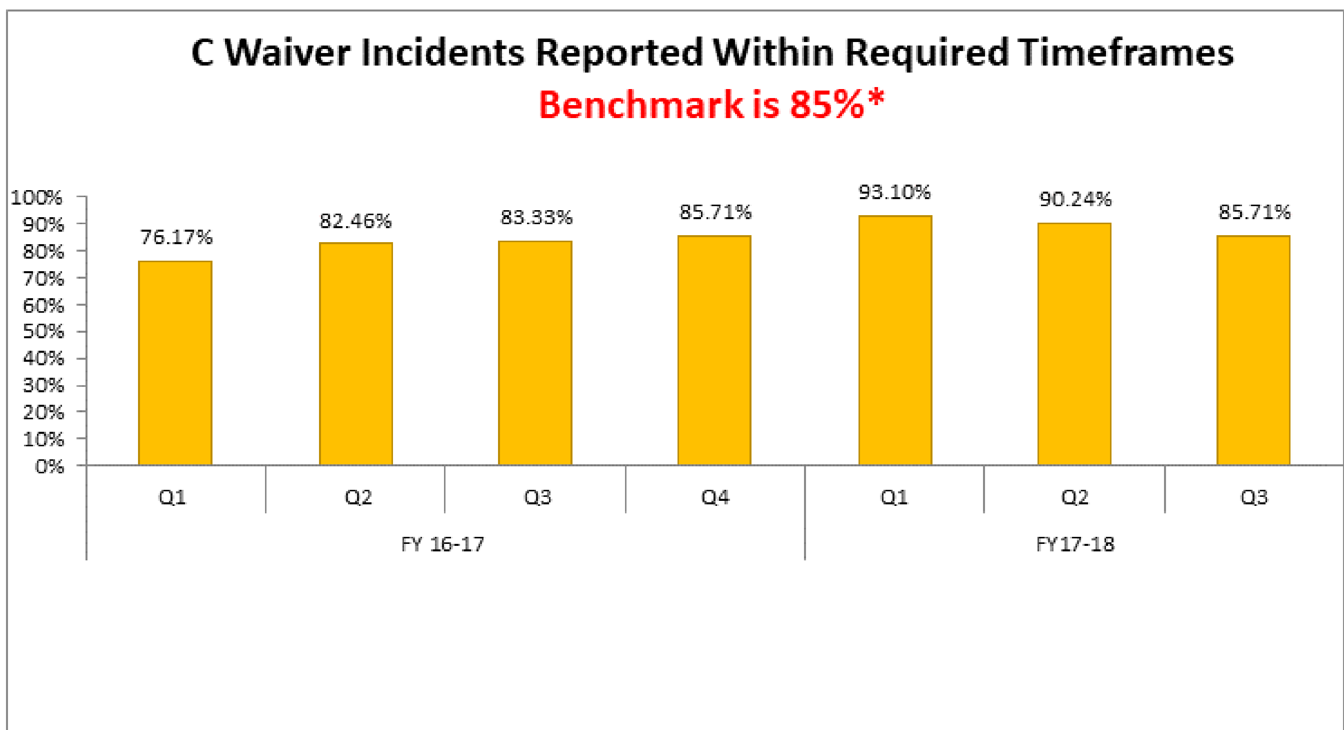
Related QI Activities: none

Quality Assurance Activity: Incident response and reporting

Lead staff: Angela Lewis-Myers, MA - Healthcare Data Integration Manager

Planned monitoring period (renewable): Jul-2017 to Jun-2018

Performance notes: A QIA was conducted to make sure all Innovations providers were meeting the timeliness standard (72-hour standard). The benchmark for this goal is 85%. This goal has been met for the past year.



Recommendations: Innovation providers will continue to be monitored. Expand monitoring of incident submission timeliness to all providers.

Updated by Angela Lewis-Myers *on* 5/8/2018

Related QI Activities:

p. 40 Timely Submission of Incident Reports

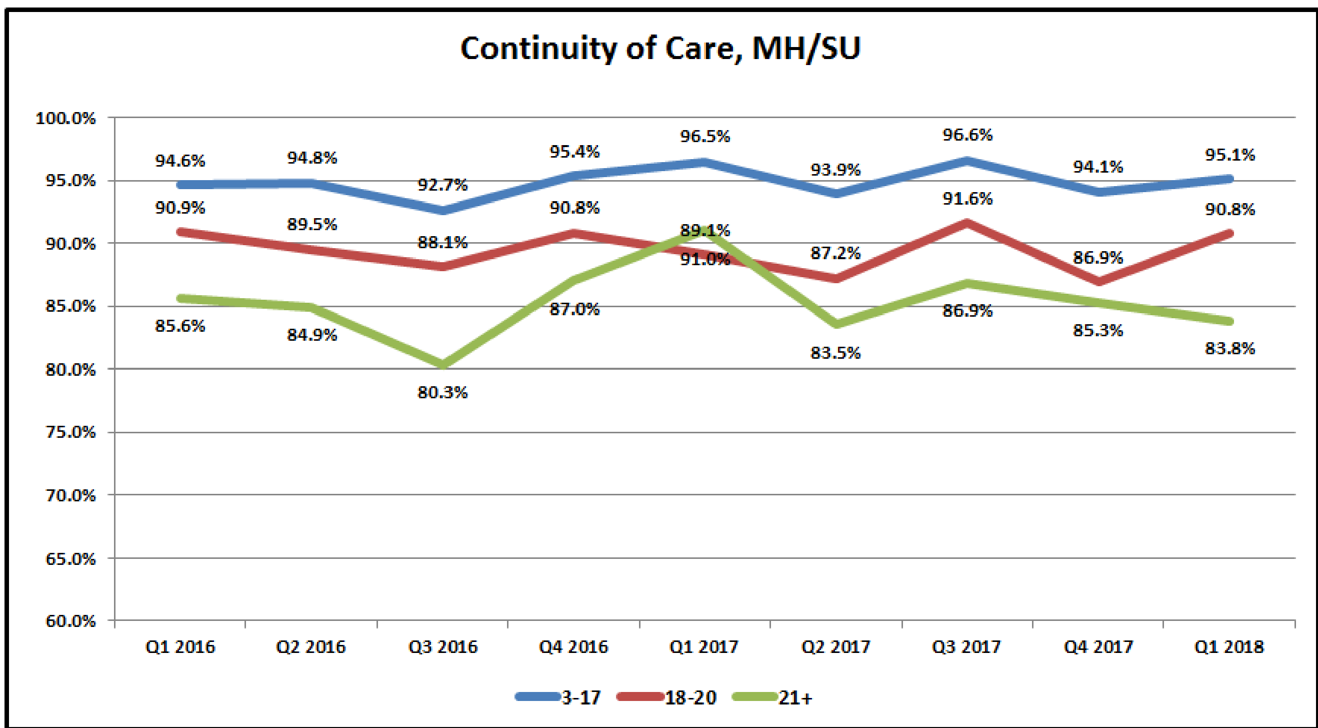
Quality Assurance Activity: Integrated care and access to primary care (continuity of care, per DMA/DMH)

Lead staff: Nina Vinson, MPH - Clinical Informatics Director

Planned monitoring period (renewable): Jul-2017 to Jun-2018

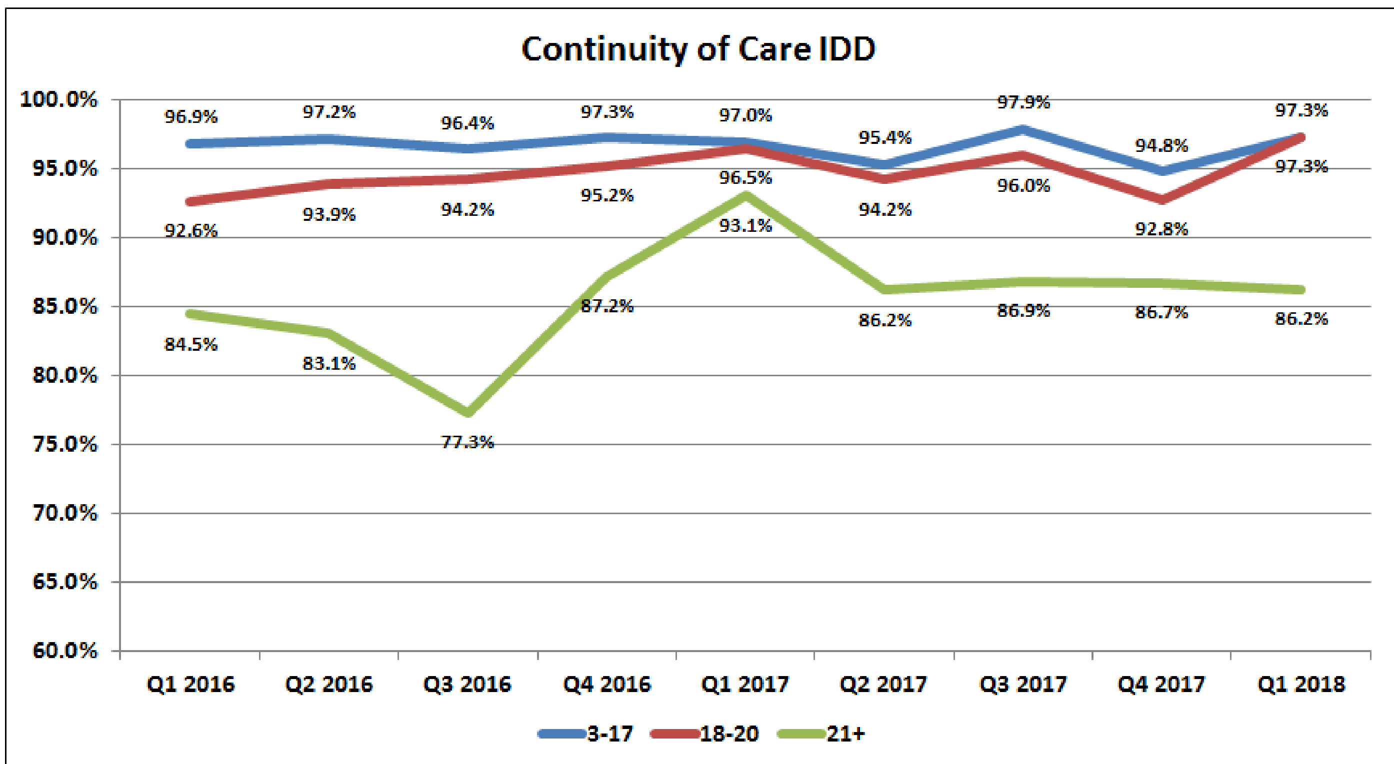
Performance notes: The graphs below illustrate measures for the rate at which members have received a primary care visit in the past year for ages 3 to 6 and 20 and older. For ages 7 to 19 the primary care visit can be in the past two years. A generally accepted benchmark for these measures is 90%.

For members with a Mental Health (MH) or Substance Use Disorder (SUD) diagnosis, data for the past nine quarters indicates that the 3 to 17 age group consistently exceeds the benchmark, the 18 to 20 age group is generally very close to the benchmark, and the 21 and older group consistently falls short of the benchmark, with the exception of a spike in the first quarter of 2017 (91%).



For members with an Intellectual and Developmental Disabilities (IDD) diagnosis, data for the past nine quarters indicates that both the 3 to 17 and the 18 to 20 age groups consistently exceed the benchmark, while the 21 and older group consistently falls short of the benchmark. Like its MH and SUD counterparts, data for the latter group shows a spike in the first quarter of 2017 (93.1%). This suggests that there may be issues with the validity of the data for that quarter.

A Quality Improvement Project (QIP) is currently in progress that addresses this measure for Innovations beneficiaries, which represents a significant subset of the global population of Vaya members with IDD.



Recommendations: Review and validate the data for the first quarter of 2017 to rule out extraneous factors affecting the data for the 21 and older age group.

Integrated care of co-occurring conditions is widely recognized as a critical factor affecting outcomes for the population that Vaya serves. Review and assess the likely impact of the current Innovations QIP on the continuity of care measure for all members with IDD in the 21 and older age group. Consider development of a Quality Improvement Activity to address the continuity of care measure for Vaya members aged 21 and older with MH and SUD diagnoses.

Updated by Charley Barry *on* 5/4/2018

Related QI Activities:

p. 38 RN Care Coordinator Utilization

p. 35 Integrated Care (Access to Primary & Preventive Care) for Innovations Waiver Participants

p. 38 Complex Care Coordination Competencies

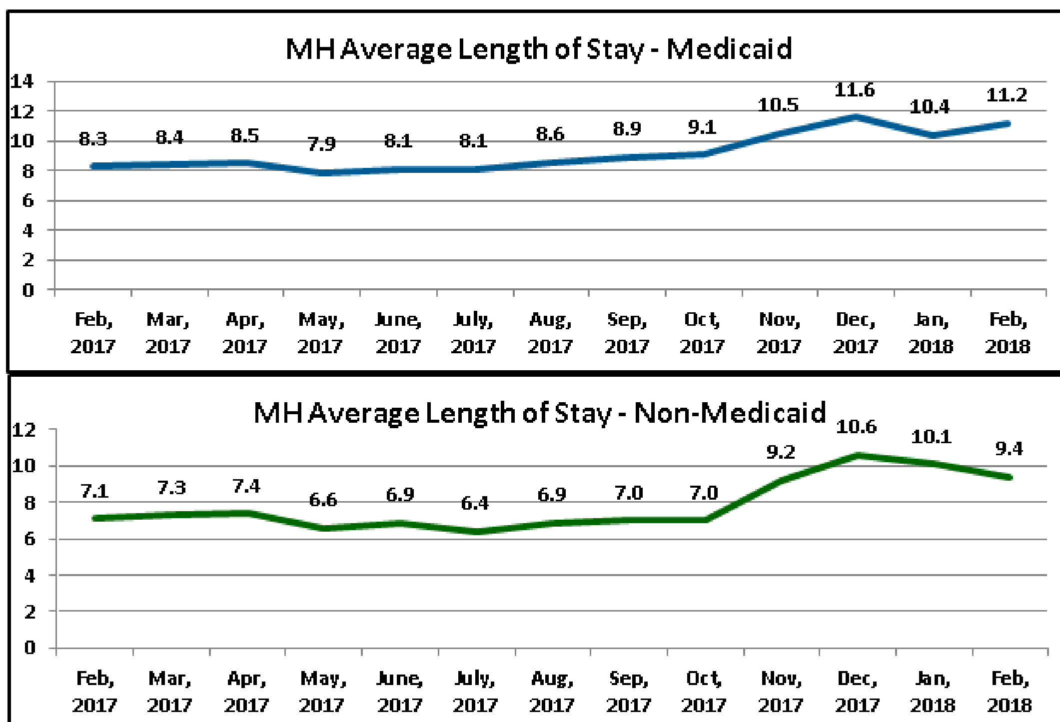
Quality Assurance Activity: Use of state facilities and local hospitals

Lead staff: Maggie Farrington, MA - Utilization Management Director

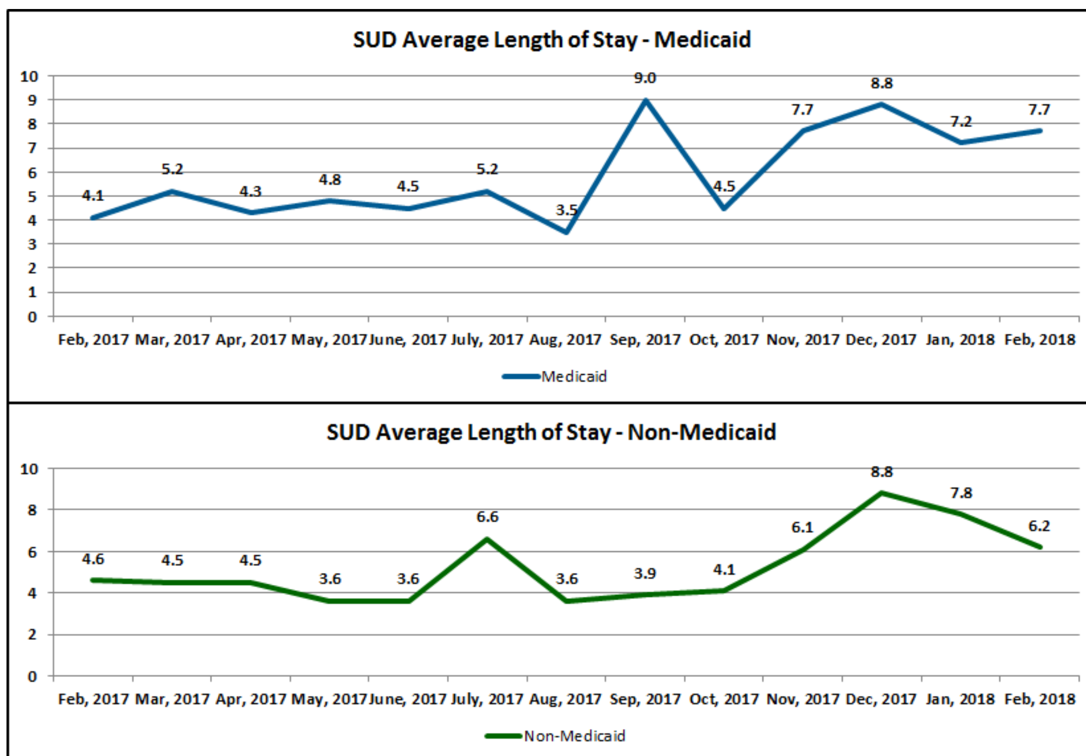
Planned monitoring period (renewable): Jul-2017 to Jun-2018

Performance notes: Currently, the most pressing concern related to utilization of state facilities and local hospitals is the average length of stay (LOS). As shown below, the average LOS for inpatient services over the past thirteen months shows a recent upward trend for both Medicaid and non-Medicaid admissions. In an effort to address this issue, the Utilization Management and Care Coordination departments have begun conducting a weekly review of all admissions that have a LOS greater than 14 days.

Data for the average LOS for Mental Health inpatient admissions shows an upward trend since October 2017.



Data for the average LOS for Substance Use Disorder inpatient admissions likewise shows an upward trend since October 2017.



Recommendations: Continue weekly review for inpatient admissions with LOS greater than 14 days. Develop a data structure for the results of these reviews, compile the data, and analyze it to determine the primary factors contributing to the upward trends in average LOS.

Updated by Charley Barry *on* 5/10/2018

Related QI Activities:

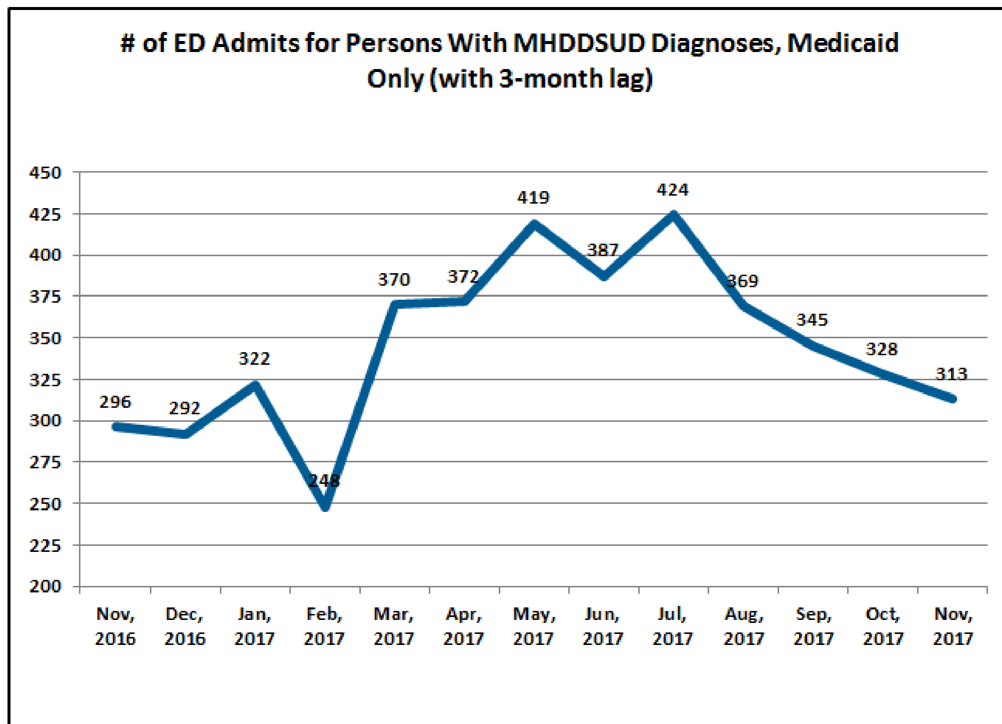
p. 33 Inpatient Rapid Readmission

Quality Assurance Activity: Use of emergency and crisis services and hospital ED's

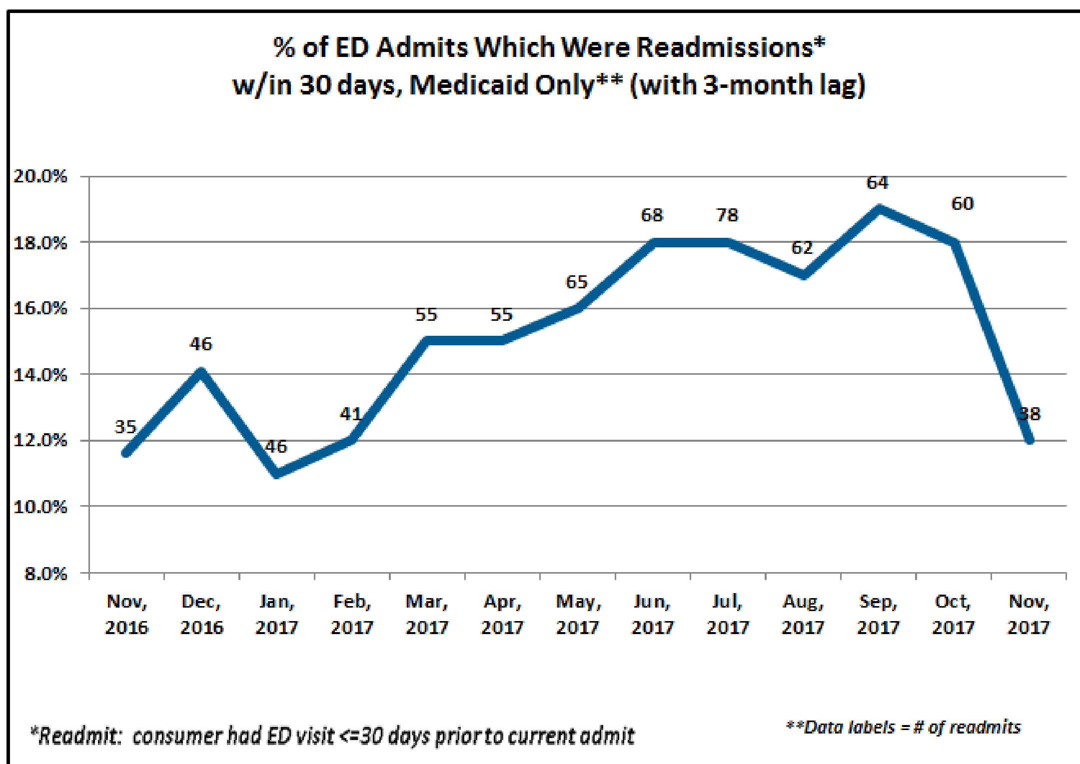
Lead staff: Steven Kozicki, MS, ASQ-CMQ/OE - Quality Management Director

Planned monitoring period (renewable): Jul-2017 to Jun-2018

Performance notes: As shown below, the number of emergency department (ED) admits for Vaya's Medicaid members trended upwards through most of the first half of calendar year 2017, followed by a steady downward trend during the remainder of the year. This suggests there have been recent improvements in the effectiveness of systems in place to divert members from the ED to alternative interventions.



For Medicaid members, the percentage of ED admits that were readmissions within 30 days trended upwards through most of calendar year 2017, and showed a steep decline near the end of the year. The isolated nature of the latter data point makes it difficult to draw reliable conclusions.



Recommendations: Identify the specific factors that have contributed to the downward trend in ED admissions and share this information with key departments and stakeholders. Consider setting a benchmark for the rate of ED readmissions within 30 days and assessing performance in relation to the benchmark.

Updated by Charley Barry *on* 5/10/2018

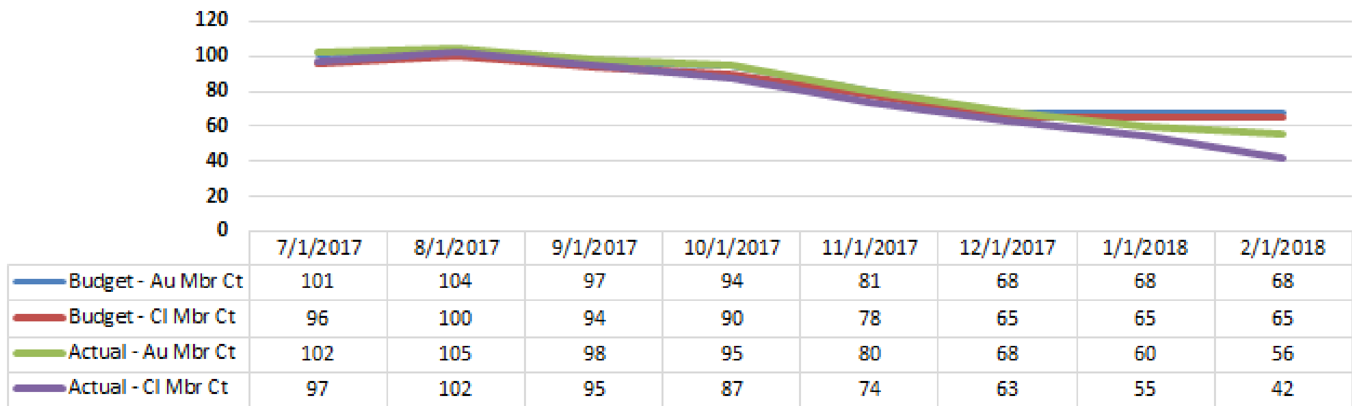
Related QI Activities: none

Quality Assurance Activity: Service patterns and costs for high cost / high risk individuals

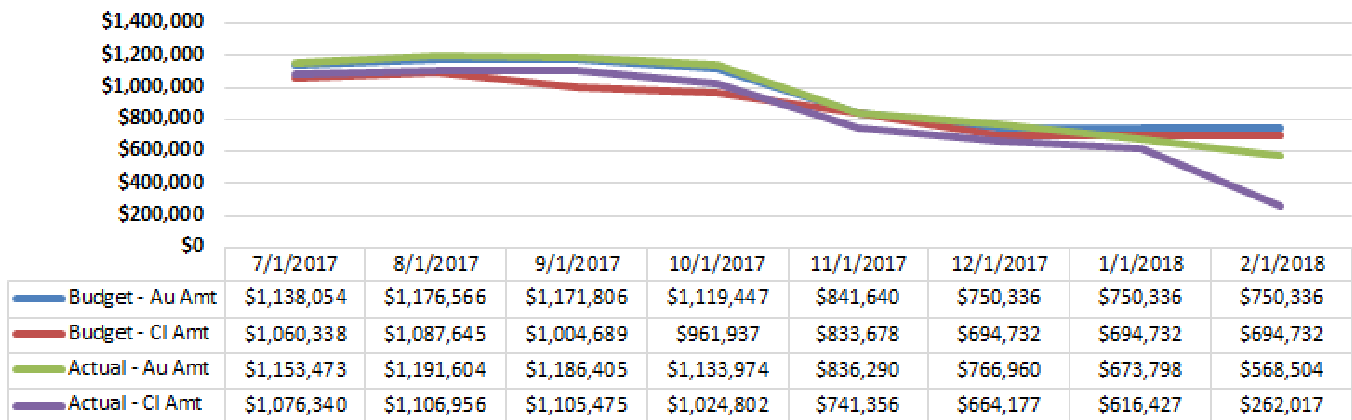
Lead staff: Maggie Farrington, MA - Utilization Management Director

Planned monitoring period (renewable): Jul-2017 to Jun-2018

Performance notes: In relation to service patterns and costs for high cost/high risk individuals, Vaya's primary focus has continued to be on Psychiatric Residential Treatment Facility (PRTF) services. The graph below shows the eight-month trends in expenditures for PRTF services and the number of members receiving PRTF services. The data indicates that Vaya has been very successful in adhering to the budgeted amount for this service, and that Vaya has been able to significantly reduce the utilization of this high-cost service.



	7/1/2017	8/1/2017	9/1/2017	10/1/2017	11/1/2017	12/1/2017	1/1/2018	2/1/2018
Budget - Au Mbr Ct	101	104	97	94	81	68	68	68
Budget - CI Mbr Ct	96	100	94	90	78	65	65	65
Actual - Au Mbr Ct	102	105	98	95	80	68	60	56
Actual - CI Mbr Ct	97	102	95	87	74	63	55	42



	7/1/2017	8/1/2017	9/1/2017	10/1/2017	11/1/2017	12/1/2017	1/1/2018	2/1/2018
Budget - Au Amt	$1,138,054	$1,176,566	$1,171,806	$1,119,447	$841,640	$750,336	$750,336	$750,336
Budget - CI Amt	$1,060,338	$1,087,645	$1,004,689	$961,937	$833,678	$694,732	$694,732	$694,732
Actual - Au Amt	$1,153,473	$1,191,604	$1,186,405	$1,133,974	$836,290	$766,960	$673,798	$568,504
Actual - CI Amt	$1,076,340	$1,106,956	$1,105,475	$1,024,802	$741,356	$664,177	$616,427	$262,017

Recommendations: Identify the factors that have contributed to the reduction in PRTF utilization and share this information with key departments and providers. Consider establishing a benchmark for PRTF utilization for purposes of future performance comparisons.

Updated by Charley Barry *on* 5/10/2018

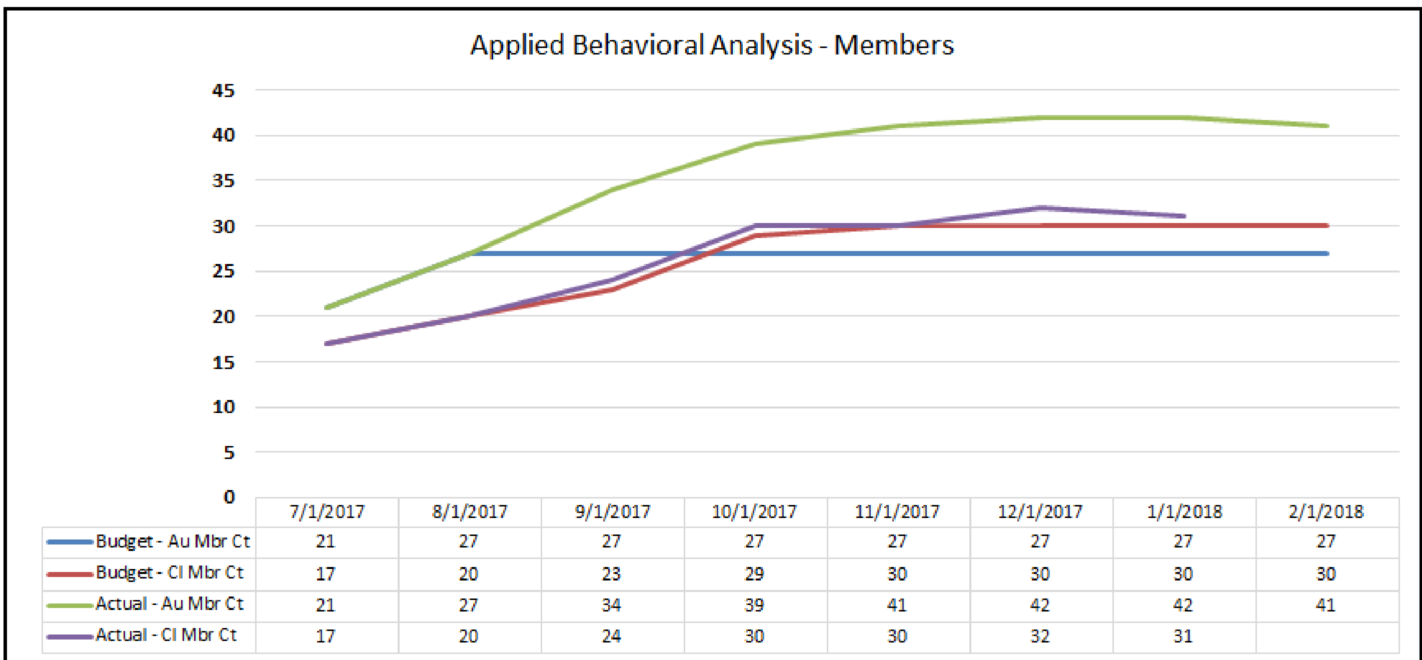
Related QI Activities:

Quality Assurance Activity: Use of evidence-based practices

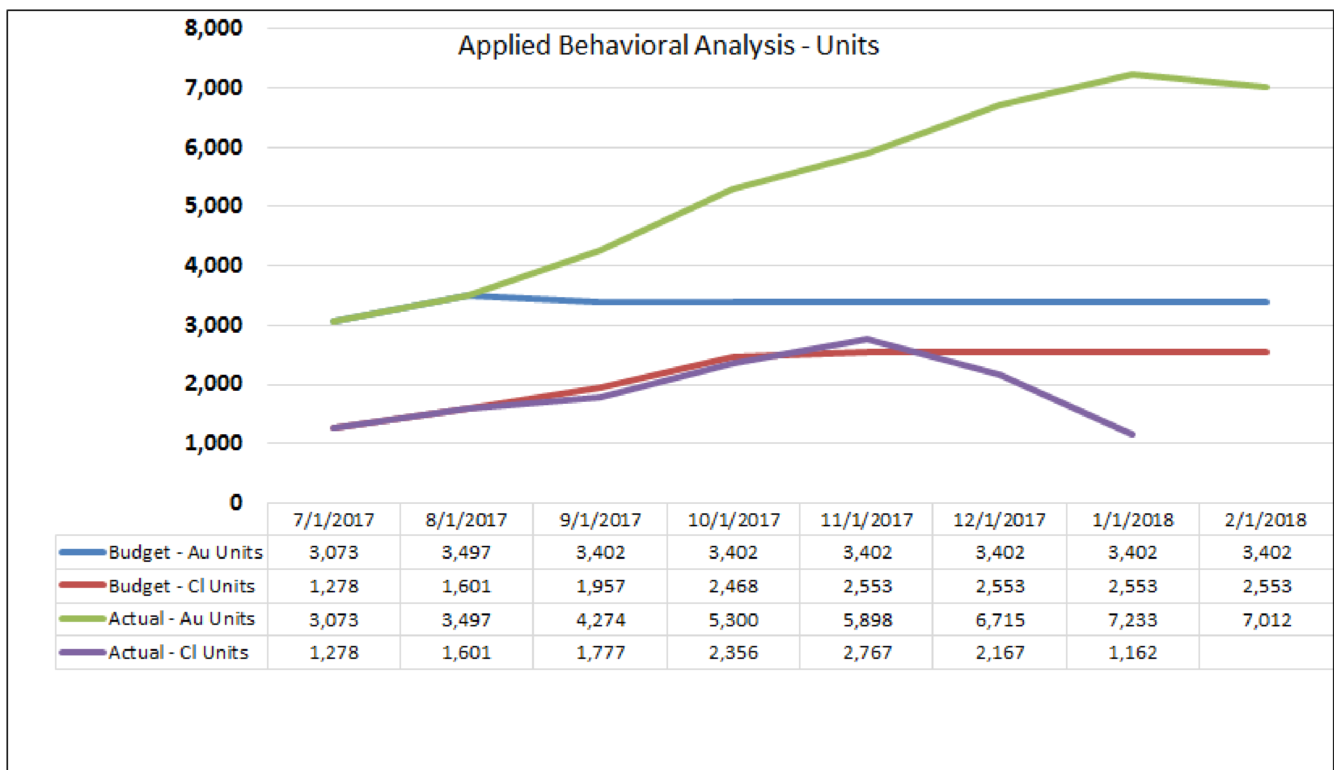
Lead staff: Maggie Farrington, MA - Utilization Management Director

Planned monitoring period (renewable): Jul-2017 to Jun-2018

Performance notes: Vaya's review and analysis of the utilization of evidence-based practices has focused on the utilization of Applied Behavioral Analysis (ABA) for members with Autism Spectrum Disorder. Since the inception of this service in July 2017, Vaya has budgeted for 27 members to receive this service. Based on claims data as shown below, this target was achieved within three months and utilization has remained at or above the target. Based on the actual authorizations, the number of members receiving this service appears to have leveled off at or a little above 30 members.



In terms of the authorized units of ABA budgeted versus the actual units authorized, the number of actual units has rapidly and significantly exceeded the number of units budgeted. The downward trend for actual claims in December and January is due to the lag in claims data; based on authorizations, it appears that once the claims data has matured, these months will show a continuing upward trend that goes well above the budgeted claims units. Thus it appears that Vaya has adhered fairly closely to the budget for the number of members, but the number of units being utilized per member is significantly greater than expected.



	7/1/2017	8/1/2017	9/1/2017	10/1/2017	11/1/2017	12/1/2017	1/1/2018	2/1/2018
Budget - Au Units	3,073	3,497	3,402	3,402	3,402	3,402	3,402	3,402
Budget - CI Units	1,278	1,601	1,957	2,468	2,553	2,553	2,553	2,553
Actual - Au Units	3,073	3,497	4,274	5,300	5,898	6,715	7,233	7,012
Actual - CI Units	1,278	1,601	1,777	2,356	2,767	2,167	1,162	

Recommendations: The roll-out of the ABA service has been successful in terms of rapid utilization of the available budget, and it appears that the utilization of this service has the potential to be significantly higher, especially in terms of the number of units per member receiving the service. Consider tracking the penetration rate and other measures of access to this service as part of the Service Availability QA Activity.

Updated by Charley Barry *on* 5/11/2018

Related QI Activities:

p. 39 Clinical Best Practices for Autism Spectrum Disorder Members

---

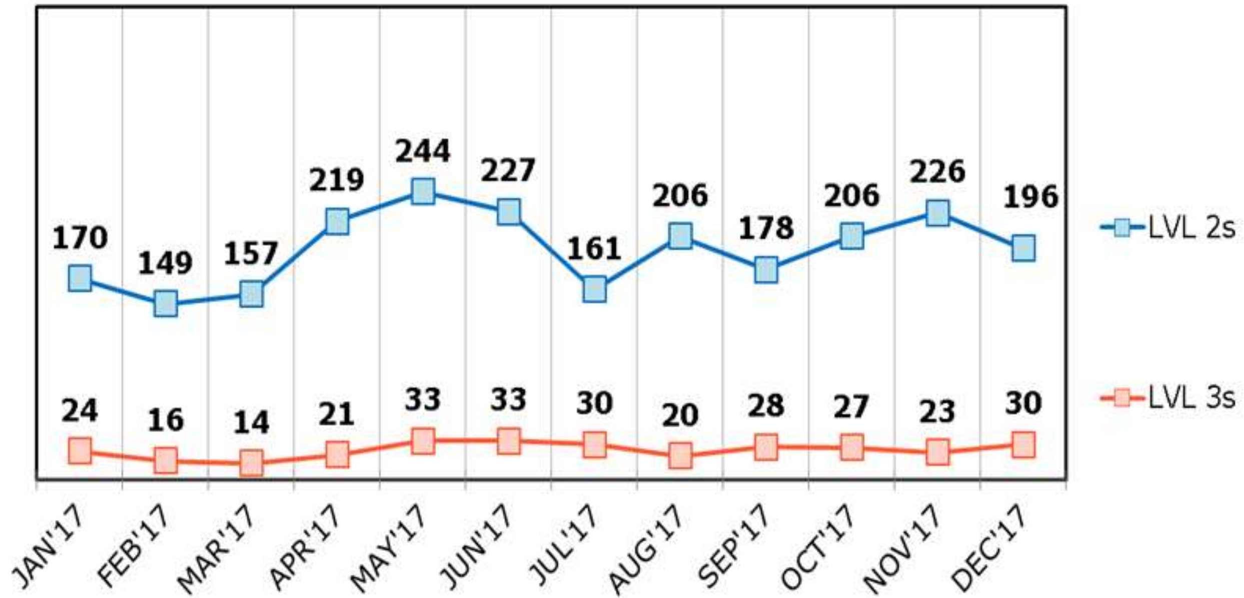
Quality Assurance Activity: Trends and patterns in incidents

Lead staff: Angela Lewis-Myers, MA - Healthcare Data Integration Manager

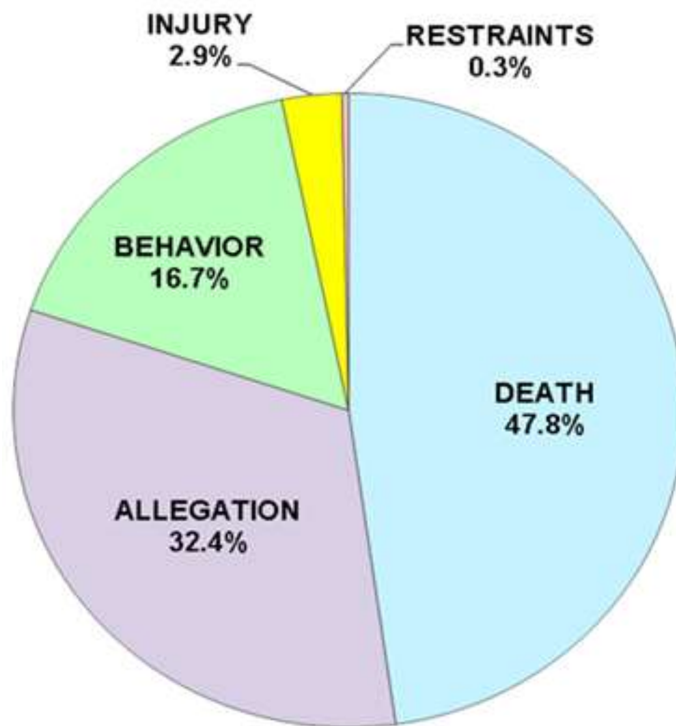
Planned monitoring period (renewable): Jul-2017 to Jun-2018

Performance notes: Incidents are reviewed in a timely manner and all level 3 incidents or incidents of concern are brought to the Critical Incident Review Committee at least monthly to be addressed. Currently, the Incident Reporting Team (IRT) is creating benchmarks based on other MCO incident levels to better determine if intervention is needed.

Chart 1 shows the number of level 2 and level 3 incidents reviewed each month of calendar year 2017. The Incident Report Team reviewed an average of 237 incidents per month.



Of all incidents received during this reporting period, **11%** were Level III or deaths which were reviewed by



Recommendations: April 2018 implementation of an electronic case management platform, EthicsPoint, will enable improved reporting of timeliness, outcomes, and prevention. It is recommended that a targeted analysis of enhanced services and residential service providers be conducted. Providers that are significantly different than their peers will be reviewed and any needed assistance or plans of correction will be implemented.

Updated by Angela Lewis-Myers *on* 5/8/2018

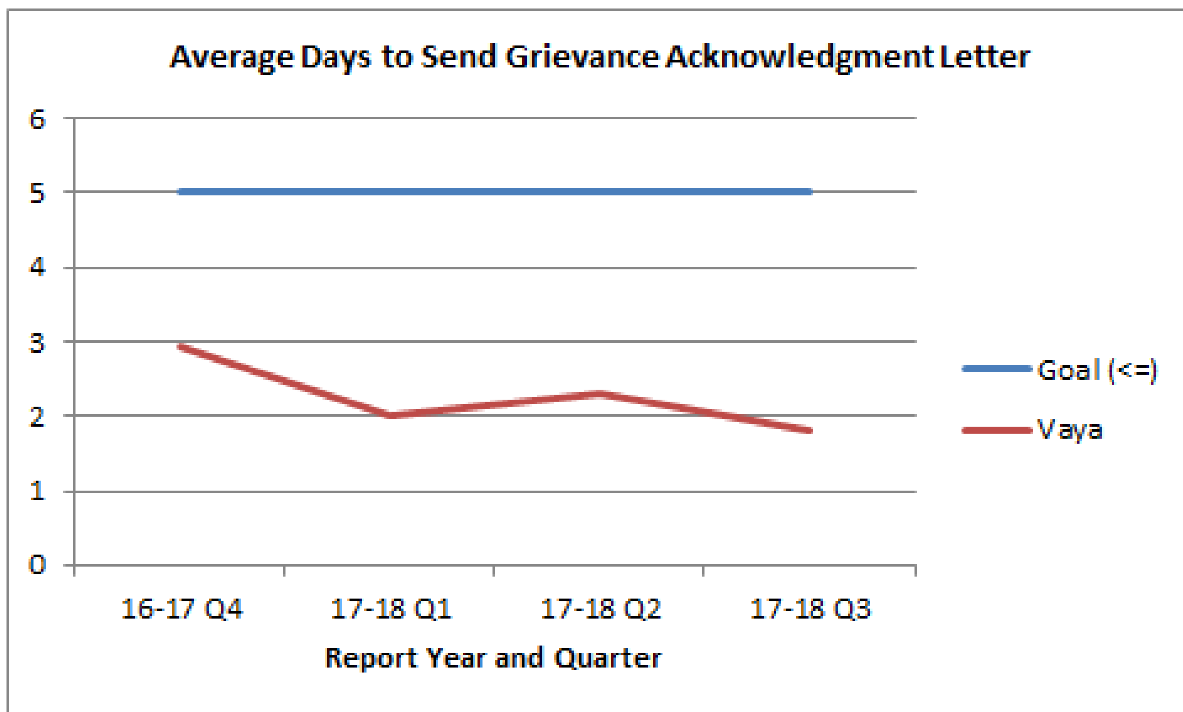
Related QI Activities: none

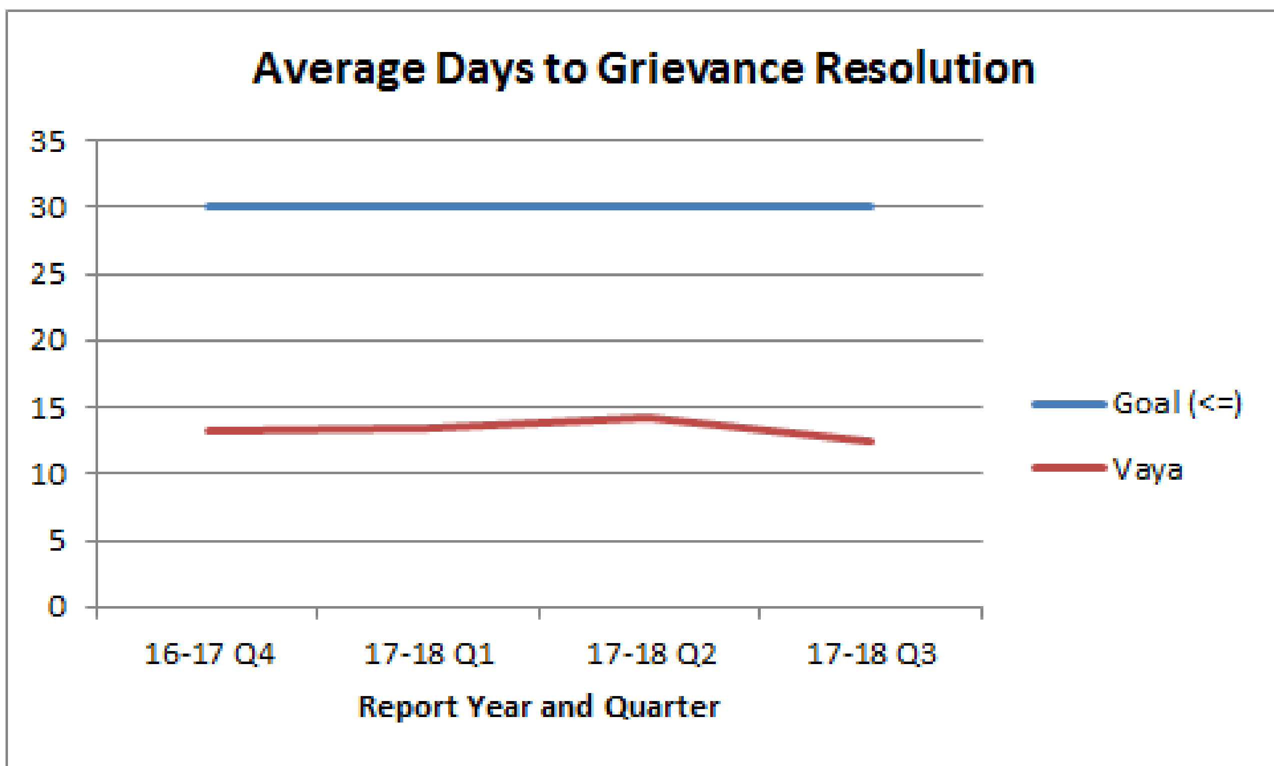
Quality Assurance Activity: Grievance response and resolution

Lead staff: Stephanie Hopfinger, BS - Grievance Specialist Lead

Planned monitoring period (renewable): Jul-2017 to Jun-2018

Performance notes: The Grievance Team strives to resolve each grievance within 30 days from the date of receipt. In Quarter 3, 2017 (Jan-Mar), the Grievance Team's average response to a grievance was 1.82 days and days to resolution was 12.42 days.





Recommendations: Continue to monitor to ensure compliance.

Updated by Stephanie Hopfinger *on* 5/9/2018

Related QI Activities: none

Quality Assurance Activity: Conduct of calls

Lead staff: Karla Mensah, MBA - Customer Services Senior Director

Planned monitoring period (renewable): Jul-2017 to Jun-2018

Performance notes: January 2018 - 3894 calls

- 96.56% were answered within 30 seconds (State requirement is 95%)
- 8 seconds - Speed of answer
- % of Calls Abandoned - 1.5% (State requirement is <5%)

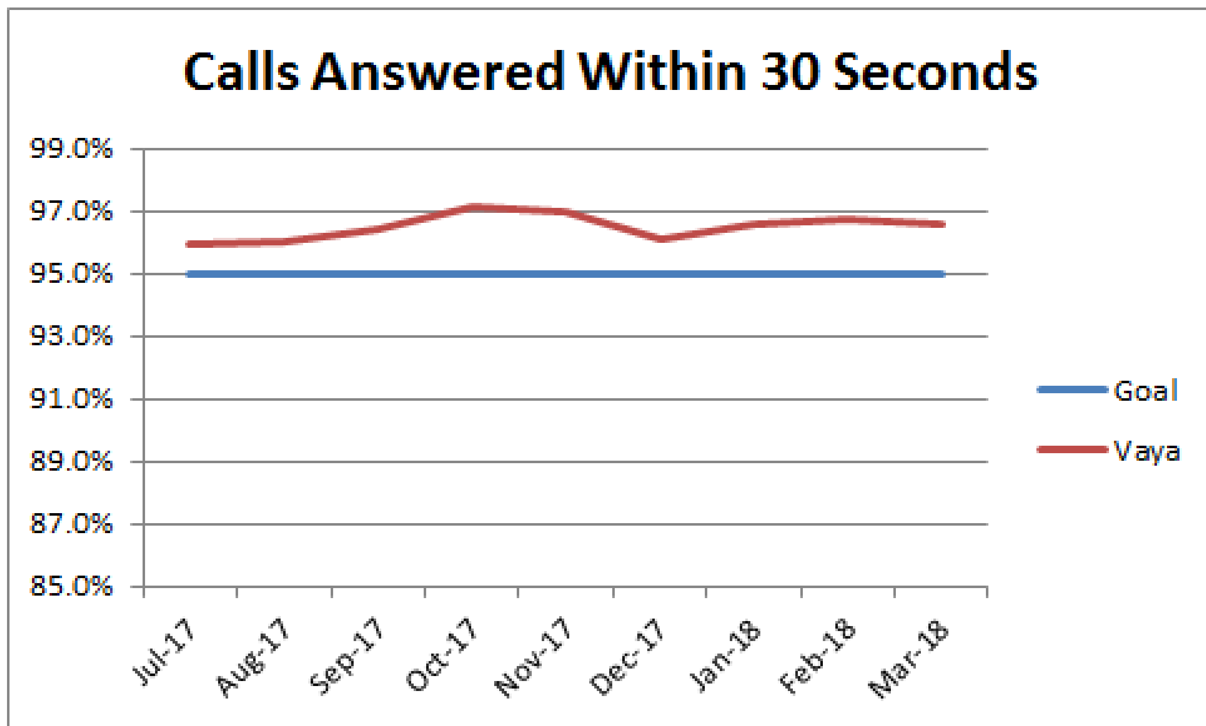
February 2018 - 3417 Calls

- 96.69% answered within 30 seconds
- 8 seconds - Speed of answer
- % of Calls Abandoned - 3.1% (State requirement is <5%)

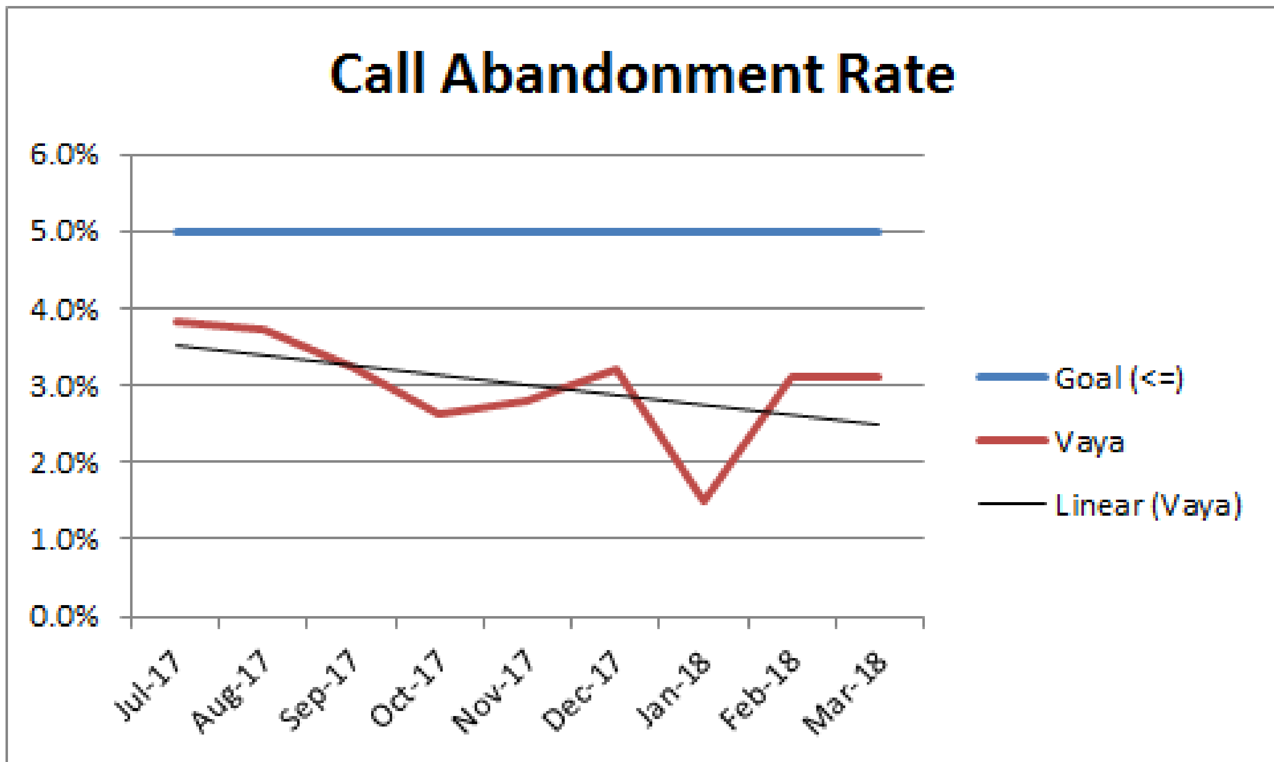
March 2018 - 3629 Calls

- 96.56% answered within 30 seconds
- 8 seconds - Speed of answer
- % of Calls Abandoned - 3.1% (State requirement is <5%)

Supervisor routine and random review of calls and call logs indicates that calls were customer-friendly and handled appropriately.



The Call Center consistently meets the <5% abandonment rate for calls each month. During the year an increase in abandoned calls was noted due to 211 calls, and in February and March due to the Kiosks with MindKare. Once discovered, Vaya no longer considered calls from these sources valid for this measure because they could not physically be answered.



Recommendations: Supervisors continue to monitor calls and call logs, providing individual staff feedback.

A Quality Assurance Survey is available for all non-emergent calls. Staff are required to administer five surveys per week.

Updated by Karla Mensah *on* 5/9/2018

Related QI Activities: none

Quality Assurance Activity: Service authorization processes

Lead staff: Maggie Farrington, MA - Utilization Management Director

Planned monitoring period (renewable): Jul-2017 to Jun-2018

Performance notes: Inter-Rater Reliability (IRR)

The Utilization Management Department Business Process "138- Inter-Rater Reliability Business Process" was reviewed and revised on 7/15/17. At least quarterly, the Mental Health/Substance Use (MH/SU) and the Intellectual /Developmental Disabilities (I/DD) UM Managers create IRR scenarios to give to each team member to complete using real or fictitious cases. Each IRR administration must include at least three scenarios and have only one correct response; all three may be selected to focus on the same administrative or clinical topic. Each disability-specific team shall achieve an IRR rating of no less than 90% at each administration and as a six-month average score. If this is not achieved, the Manager of the team will provide training to the individual staff and administer another round of IRR (similar topic) to him/her until the desired score is achieved.

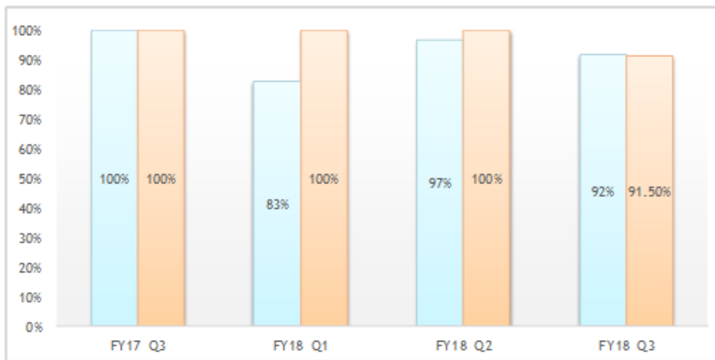
FY17 Q3 (April-June 2017), MH/SU scored 100% and IDD scored 100%.
FY18 Q1 (July-Sept) MH/SU scored 100% and IDD scored 83%.

- IDD UM Manager reviewed the case scenario with team for technical assistance, training and guidance. The 4 (of 10) staff that scored below expected completed reviews monthly until composite score was 90% or above.

FY18 Q2 (Oct-Dec) MH/SU scored 100% and IDD scored 97%.
FY18 Q3 (Jan-March) MH/SU scored 91.5% and IDD scored 92%.

- Lower scores on both teams in Q3 attributed to implementation of multiple new in lieu of and alternate services used to train staff in this review.

UM Quarterly Inter-Rater Reliability



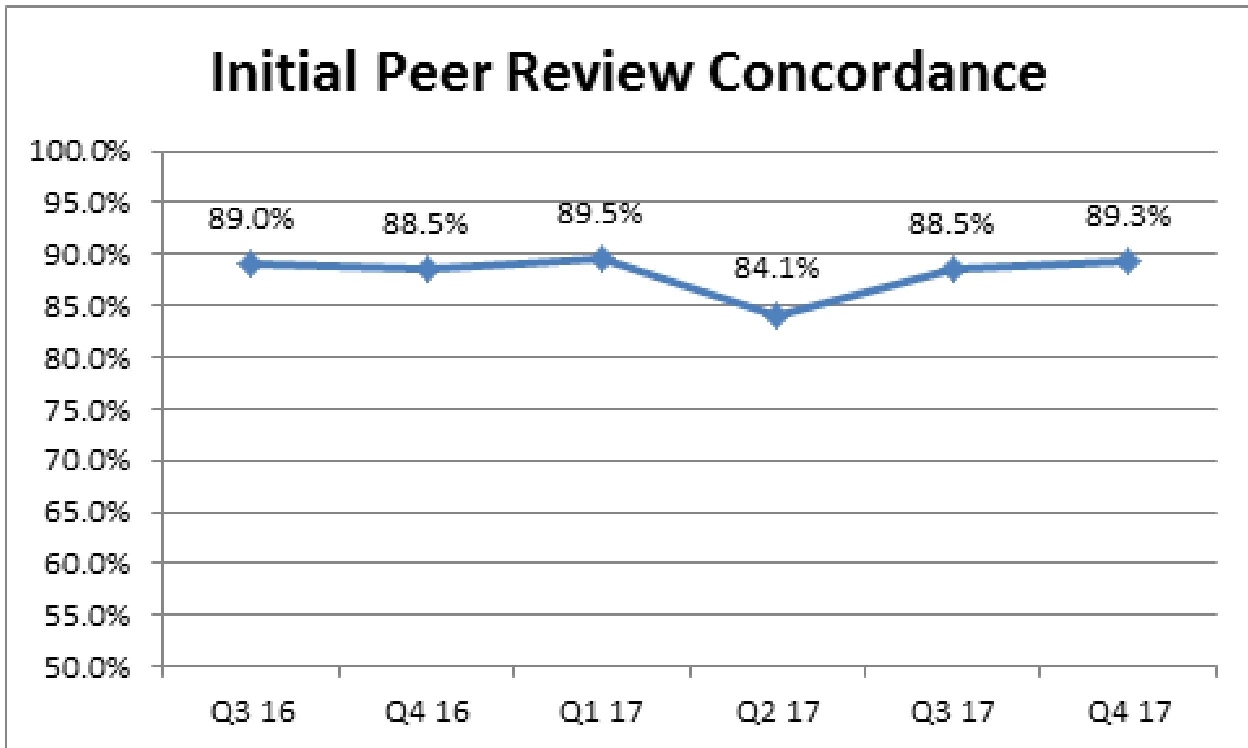
NOTES:
*90% combined expectation. The decrease in FY18 Q4 is largely due to development and implementation of several new in lieu of service definitions.

UM TEAM	FY17 Q3	FY18 Q1	FY18 Q2	FY18 Q3
IDD Team	100%	83%	97%	92%
MH/SU Team	100%	100%	100%	91.50%
Combined	100%	91.50%	98.50%	91.75%

**FY17 Q4 Missing due to transition of departmental staff

Peer Review Concordance

Initial Peer Review Concordance increased from 88.5% in Q3 2017 (July-September 2017) to 89.3% in Q4 (October-December 2017). Vaya has now established 80% as the standard for Initial Peer Review Concordance. Over the last four quarters, Initial Peer Review Concordance has averaged 87.9%.



Recommendations: Inter-Rater Reliability

Quarterly IRR scores will continue to be used in individual and group supervision between manager and clinician/QP to improve technical knowledge, competencies and consistency of reviews and authorization decisions.

Peer Review Concordance

Monitor Initial Peer Review Concordance against the 80% standard.

Updated by Maggie Farrington *on* 5/9/2018

Related QI Activities: none

Quality Assurance Activity: Member satisfaction

Lead staff: Steven Kozicki, MS, ASQ-CMQ/OE - Quality Management Director

Planned monitoring period (renewable): Jul-2017 to Jun-2018

Performance notes: The two primary sources for measures pertaining to member satisfaction are: the Experience of Care and Health Outcomes (ECHO) survey administered by DataStat, Inc. on behalf of DMA, and the Perception of Care Survey that is administered by the LME-MCOs (including Vaya) under the oversight of DMHDDSAS. Both surveys are administered annually; the 2017 ECHO survey was administered between August and November 2017, while the 2017 Perception of Care Survey was administered between May and June of 2017.

The ECHO survey for adults (18 and older) comparisons with previous results and with the statewide average were largely not statistically significant due to the small sample size. However, one item for the adult members regarding improvement in their ability to deal with daily problems compared to one year ago (question 31 in the survey) showed a statistically significant drop of 21.7 percentage points from 69.0% to 47.2%. This result was statistically significantly lower than the overall 2017 state average of 61.3%.

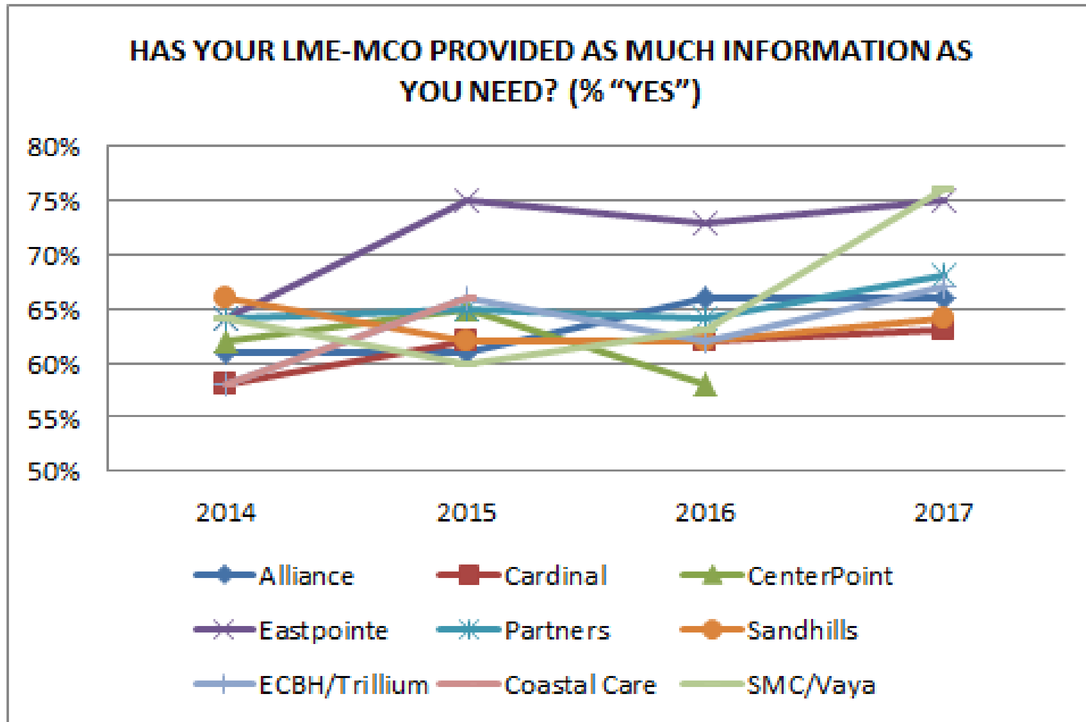
The analysis by DataStat suggested that two items should have top priority for further study due to low scores and a high correlation between scores on these items and overall satisfaction: getting urgent treatment as soon as needed (question 5), and delays in treatment while waiting for plan approval (question 39). This suggests that perceived delays in access to care may be a significant issue for Vaya's adult members; however, the number of respondents for these two items was very small (26 and 16, respectively).

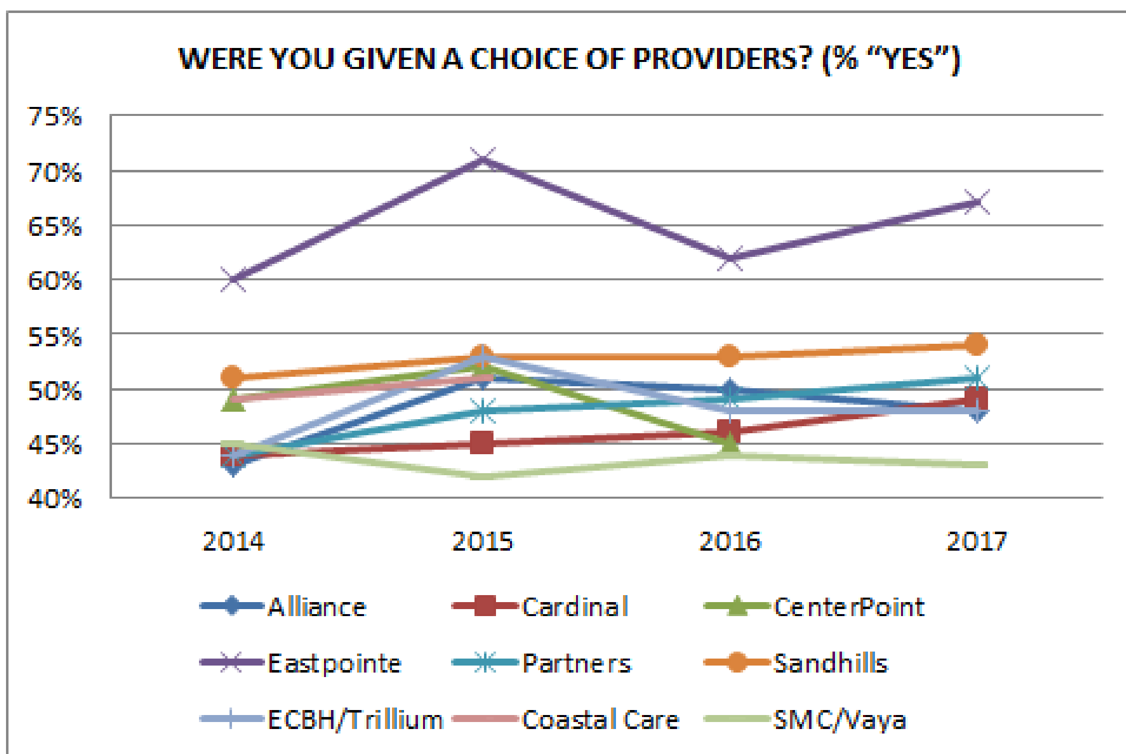
The 2017 ECHO survey for children (ages 12 to 17) also generally did not yield statistically significant comparisons with previous performance or statewide performance. Based on scores, sample size, and the correlation of items with overall satisfaction, the highest priority area for further study appeared to be perceived improvement in ability to deal with daily problems, social situations, symptoms, and accomplishing things compared to a year ago; however, Vaya's scores were very similar to the rest of the state in this regard.

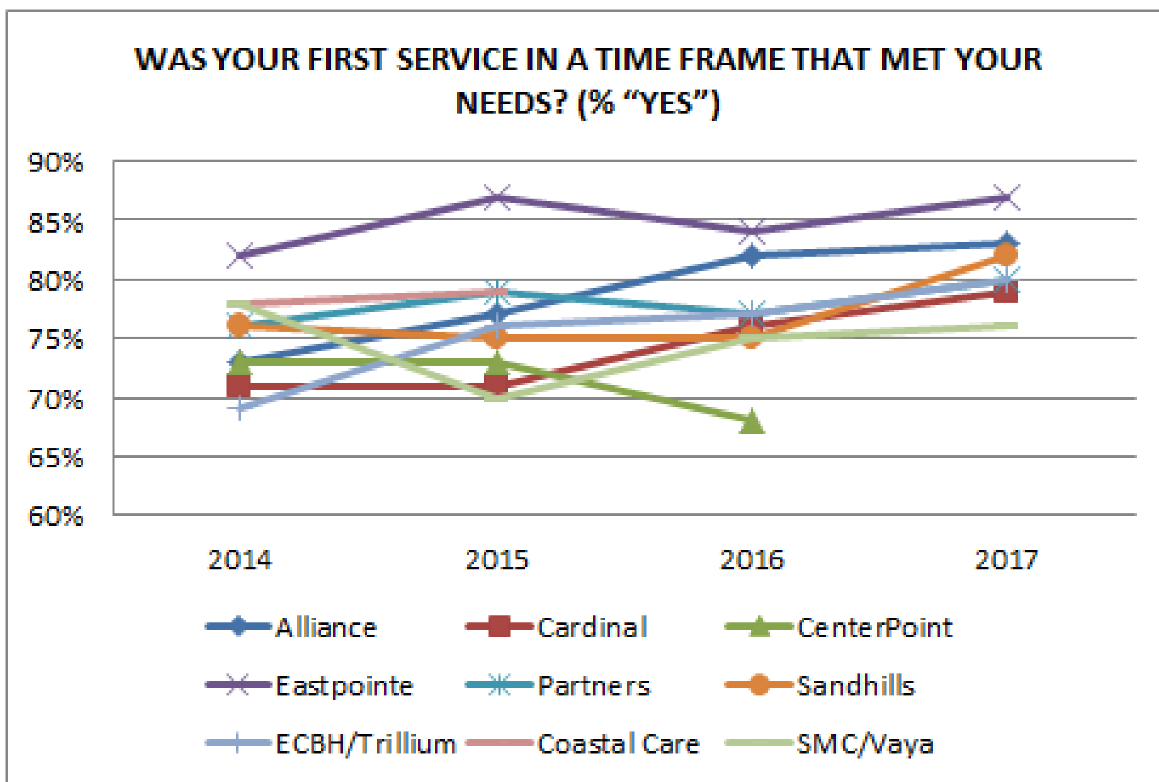
The Perception of Care Survey includes a set of questions that address member perceptions about LME-MCO and provider access, outreach, and responsiveness. Trends for these LME-MCO Network questions for the four-year period from 2014 to 2017 indicate multiple needs for study and improvement, as the Vaya trendline frequently is at or near the bottom relative to the other LME-MCOs. As shown in the first graph below, one notable exception is members' perceptions of Vaya providing as much information as needed, which has trended from a 60% positive response in 2015 (lowest in the state) to 76% in 2017 (highest in the state). All of the other results for the LME-MCO Network questions suggest areas in need of improvement, including the following:

- Receiving a Consumer Handbook within 14 days of starting services

- Knowing how to make a complaint with the LME-MCO
- Being given a choice of providers (see second graph below)
- Receiving your first service in a timeframe that met your needs (see third graph below)
- Getting the help you need to apply for benefits







Recommendations: Members' perceptions of their ability to deal with daily problems and challenges appears to be an area where improvement is needed. This may correlate with the NC-TOPPS results showing a marked decline in the percentage of members receiving Assertive Community Treatment Team services who perceive a reduction in their symptoms as a result of treatment. Further studies are needed focusing on the effectiveness of treatment in reducing symptoms and increasing members' perceptions that their ability to cope with the problems of daily living has improved.

The Perception of Care Survey results for the LME-MCO Network questions suggest that Vaya should examine its current processes for addressing the related requirements and implement process changes to improve member satisfaction with these functions.

Updated by Charley Barry *on* 5/11/2018

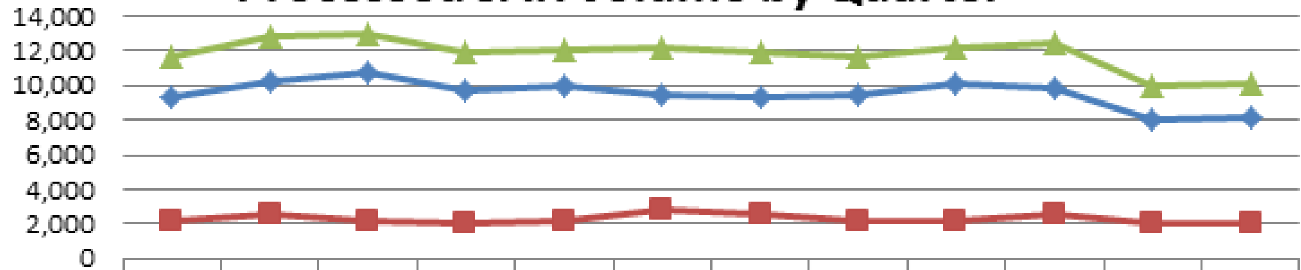
Related QI Activities: none

Quality Assurance Activity: Trends in denials and appeals

Lead staff: Stephen Puckett, HSP-P - Member Appeals Director

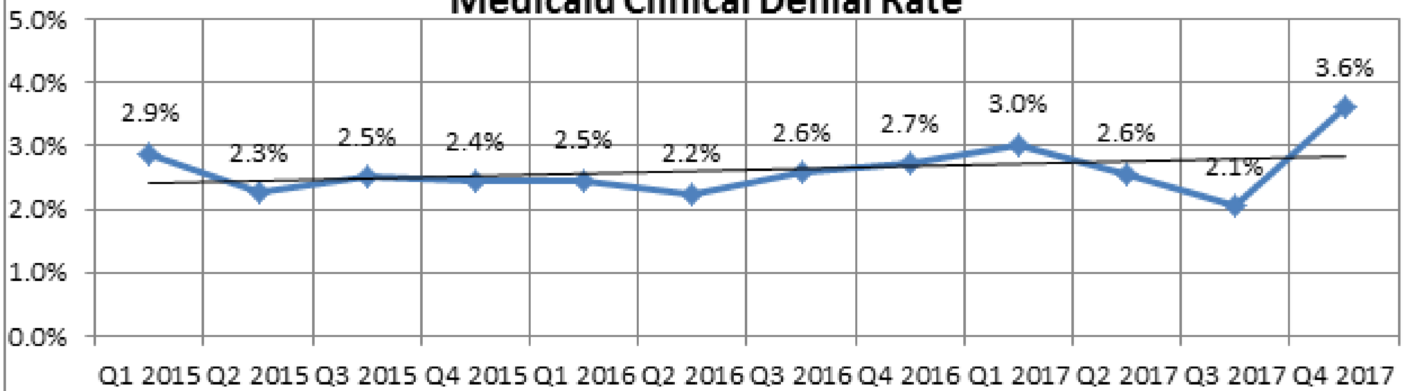
Planned monitoring period (renewable): Jul-2017 to Jun-2018

Performance notes: Service Authorization Request (SAR) Volume. In Q3 and Q4 2017 the SAR volume for Medicaid and State-Funded services dropped about 18% due to fewer services requiring prior authorization as of 7/1/2017. (Reporting for this activity is based on the calendar year, e.g., "Q1 2017" is January-March 2017.)

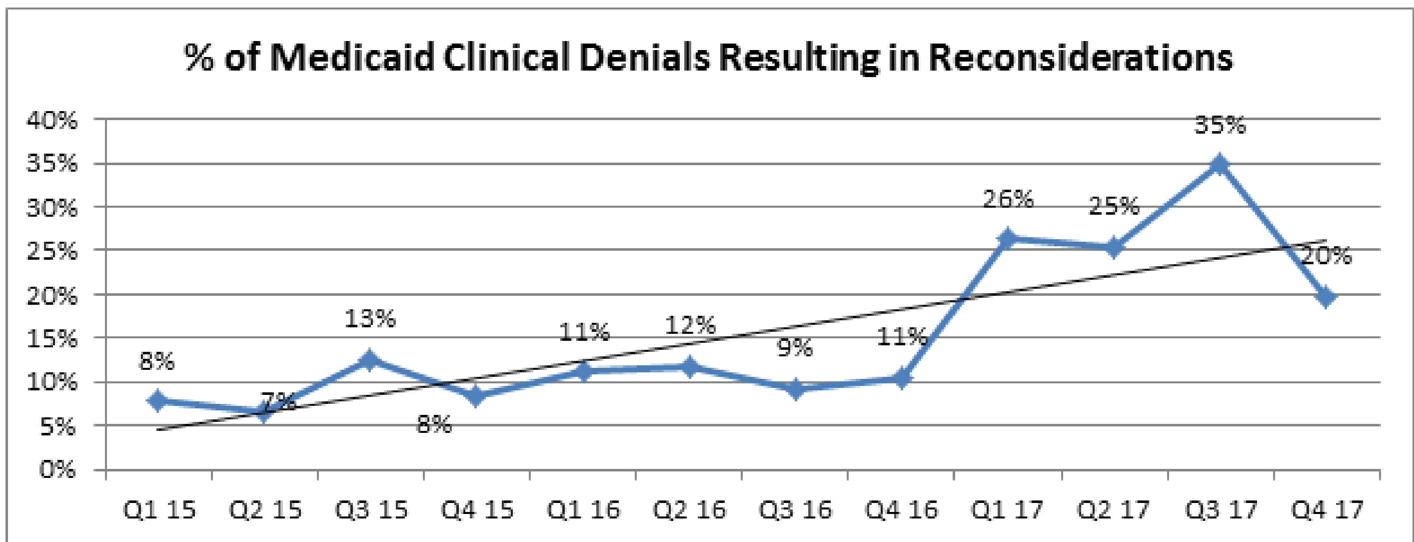


	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017
Series1	9,377	10,283	10,764	9,754	9,911	9,382	9,304	9,422	10,032	9795	7980	8,102
Series2	2,226	2,525	2,162	2,104	2,171	2,773	2,574	2,194	2,185	2577	2047	1994
Series3	11,603	12,808	12,926	11,858	12,082	12,155	11,878	11,616	12,217	12,372	10,027	10,096

<u>Clinical Denial Rate</u>. In Q4 2017, the Medicaid clinical denial rate increased dramatically from 2.1% in Q3 to 3.6%, a 71% increase. Ninety percent of this increase was due to increased denials of PRTF service (from 18 in Q3 to 134 in Q4). This increase was attributed to increased Utilization Management focus on PRTF service, particularly cases with longer lengths of stay. Secondarily, Applied Behavioral Analysis (ABA) denials increased from 0 in Q3 to 17 in Q4, due mainly to requests from two providers that did not meet EPSDT criteria. (A referral was made to Provider Network for technical assistance to these providers.) Although fewer State-Funded SARs are submitted, a similar trend in increased clinical denials occurred in Q4 with 46 denials after having only 17 in Q3. Seventy-nine percent of this increase was due to one service, Personal Assistance, with most denials due to requests for individuals found to not meet the NC criteria for having a Developmental Disability.



Rate of Appeals. The number of Medicaid Clinical Appeals rose slightly from 54 in Q3 to 59 in Q4. However, the rate at which Medicaid Clinical Denials were appealed dropped significantly from 35% in Q3 to 20% in Q4. This drop in the appeal rate was attributed to the Q4 denials of PRTF service (134 of 292). Only 9% of PRTF denials were appealed. This low rate is typical for PRTFs which often submit new SARs requesting continued stay which lessens the need or motivation for parents/guardians to appeal denials. The Q3 appeal rate for State-Funded Clinical Denials was 29% (5 of 17 denials appealed) but dropped to 9% (3 of 35 denials appealed) in Q4. The reason for this change is less clear than the change for the Medicaid appeal rate, but the smaller number of State-Funded SAR's denials and appeals means that relatively small absolute numbers result in larger percentages.



Recommendations: 1. Continue quarterly tracking and monitoring of SAR volume, denial rate and appeal rate for Medicaid and State-Funded services.
2. Where possible, identify and recommend actions such as provider technical assistance that may decrease the denial rates of services.

Updated by Katherine Roody *on* 5/9/2018

Related QI Activities: none

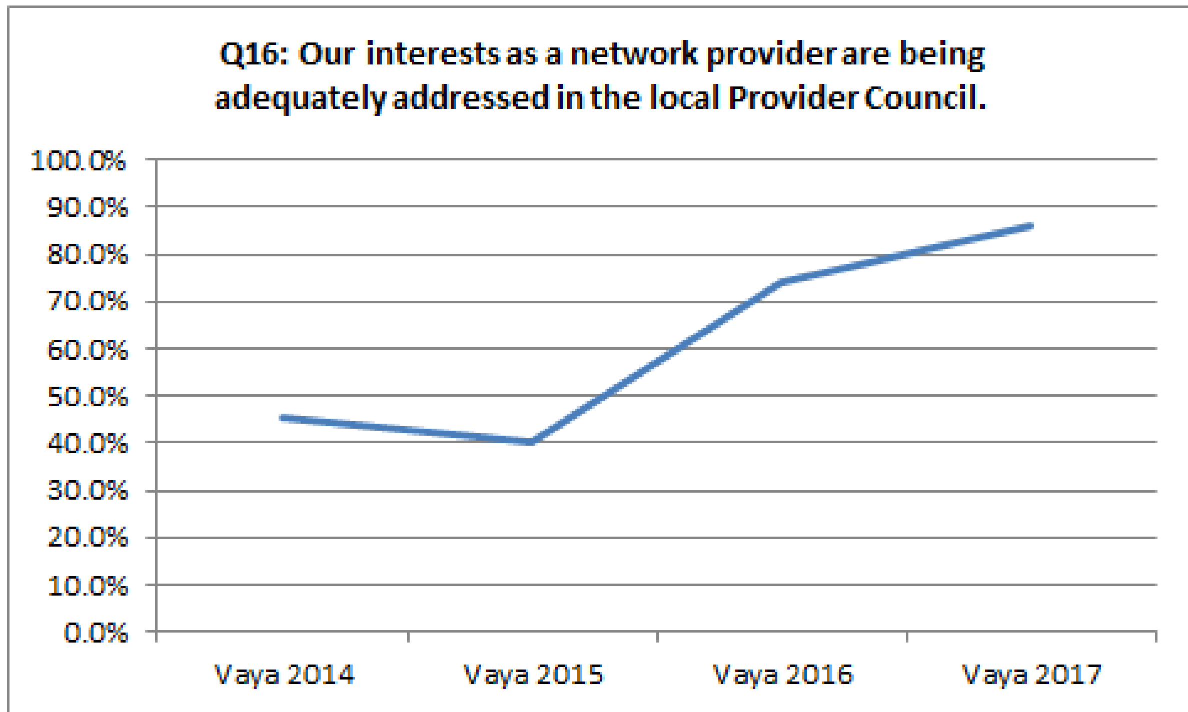
Quality Assurance Activity: Adequacy of LME/MCO supports for providers

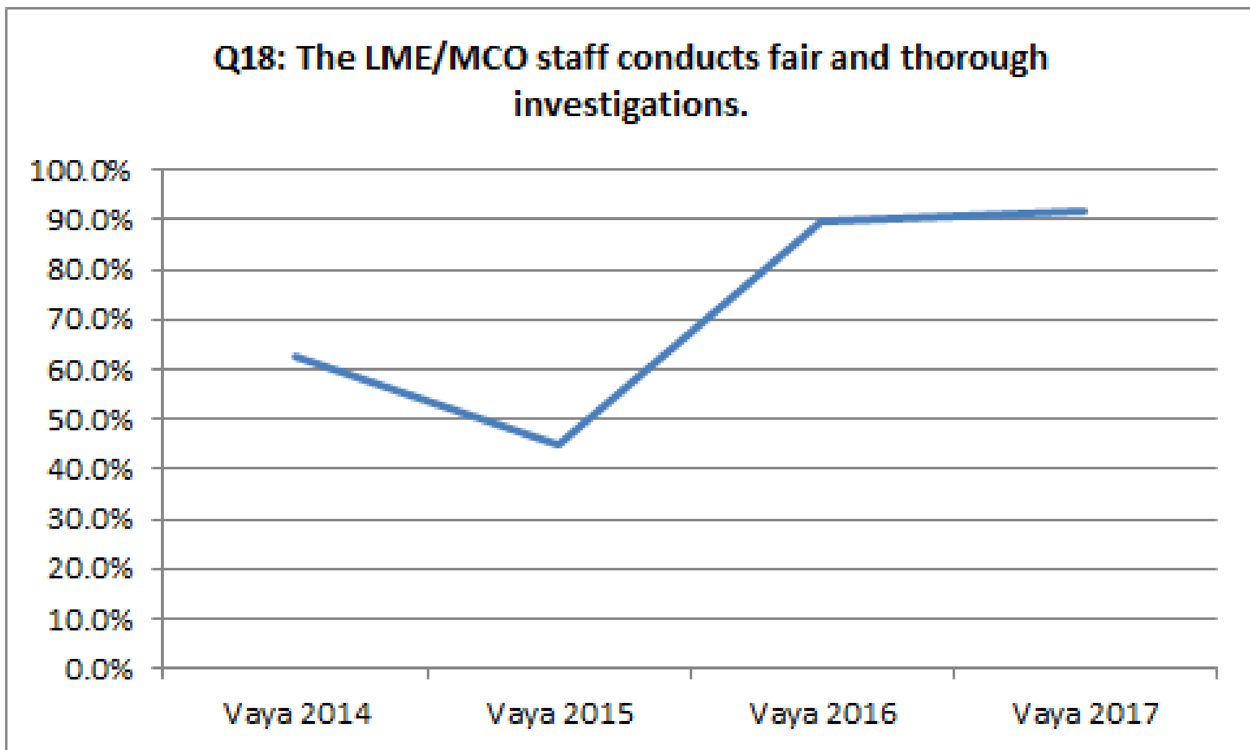
Lead staff: Donald Reuss, MA - Provider Network Operations Senior Director

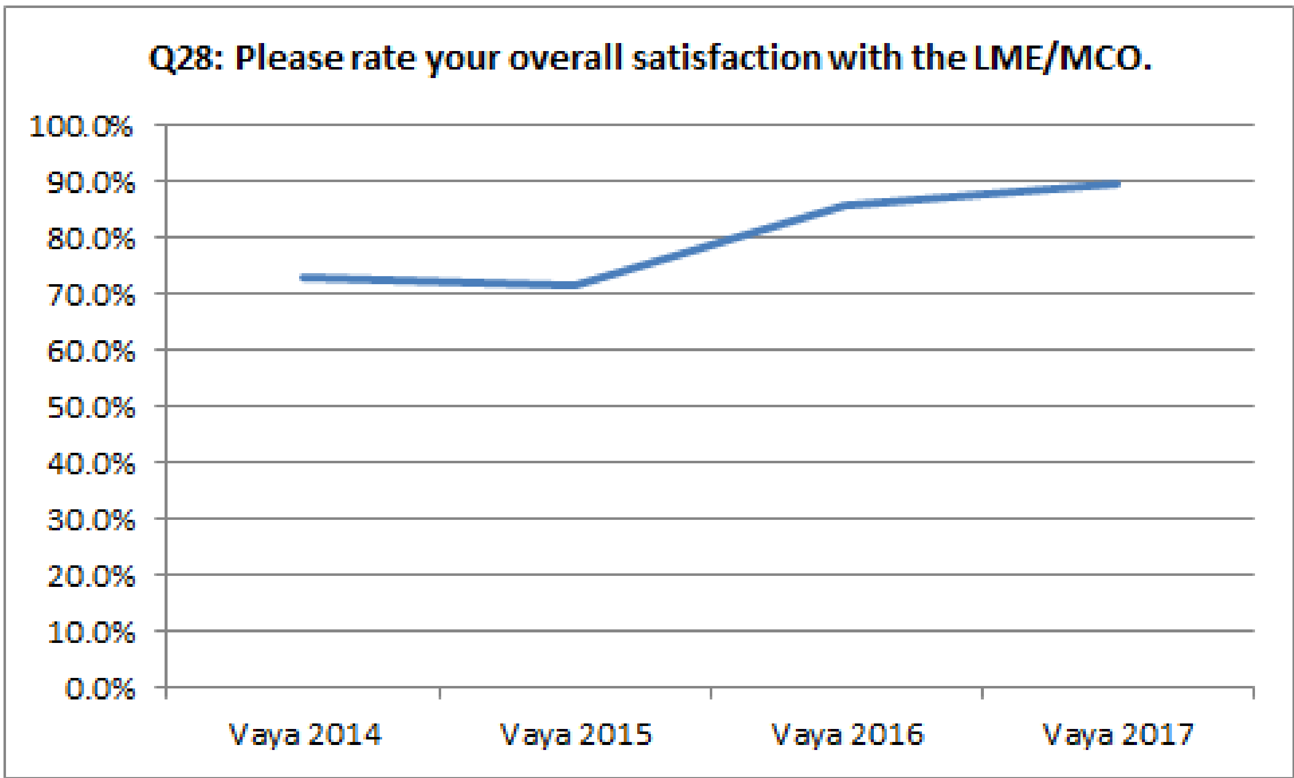
Planned monitoring period (renewable): Jul-2017 to Jun-2018

Performance notes: This quality assurance activity is measured annually through the Provider Satisfaction Survey (PSS), through ongoing and open communication with network providers, and through feedback from Vaya's Provider Advisory Council. Vaya continues to experience an upward trend (2015-2017). The graphs below show the four-year trend in the rate of positive responses for

three of the survey items, including overall satisfaction with the LME-MCO.







Recommendations: Vaya will continue to look for ways to better communicate with network providers as well as addressing provider concerns as raised by the Provider Advisory Council and/or individual providers.

Updated by Tommy Duncan *on* 5/9/2018

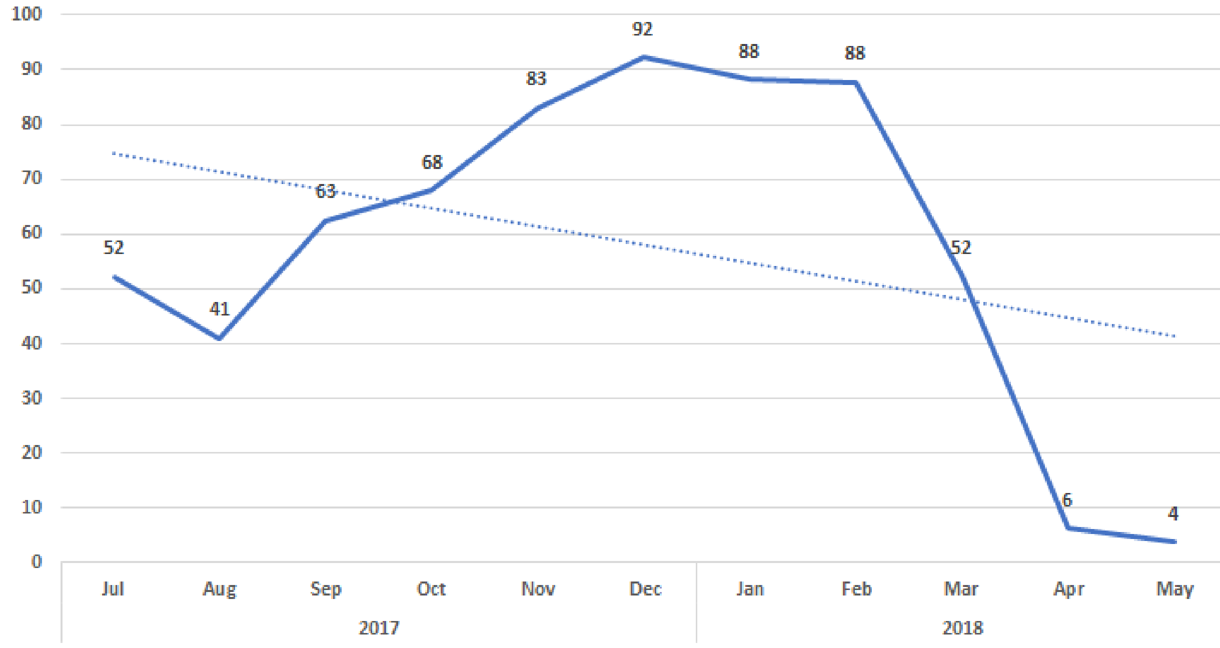
Related QI Activities: none

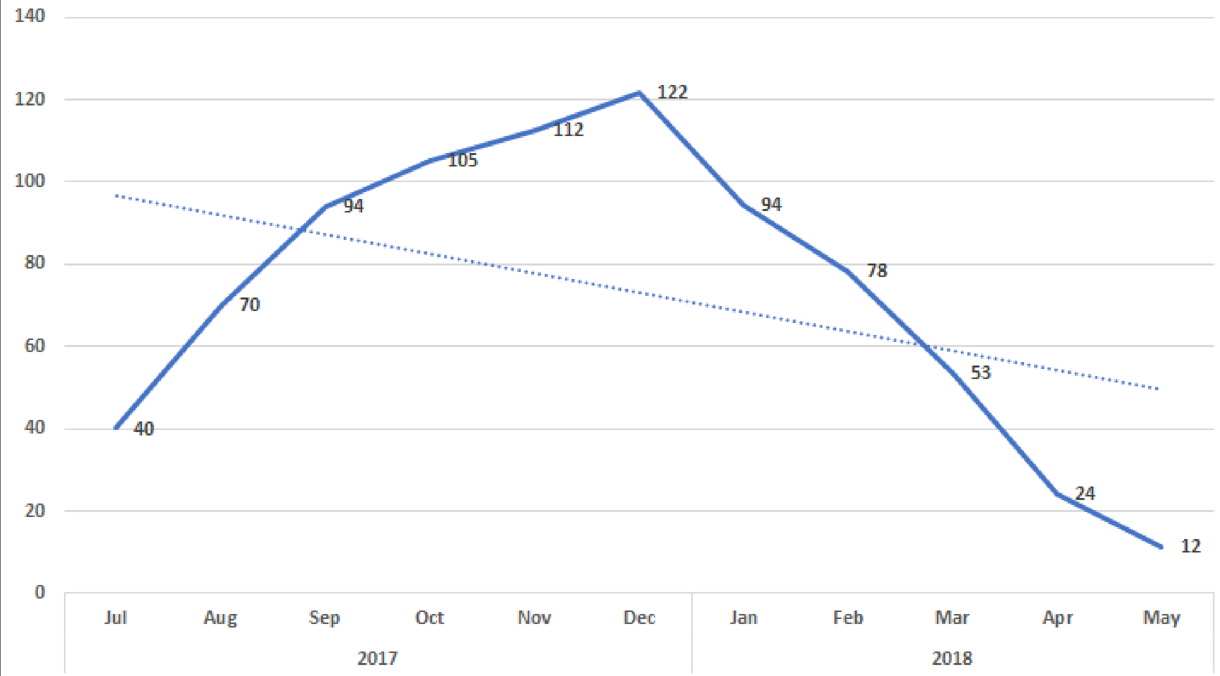
Quality Assurance Activity: Credentialing and recredentialing of providers

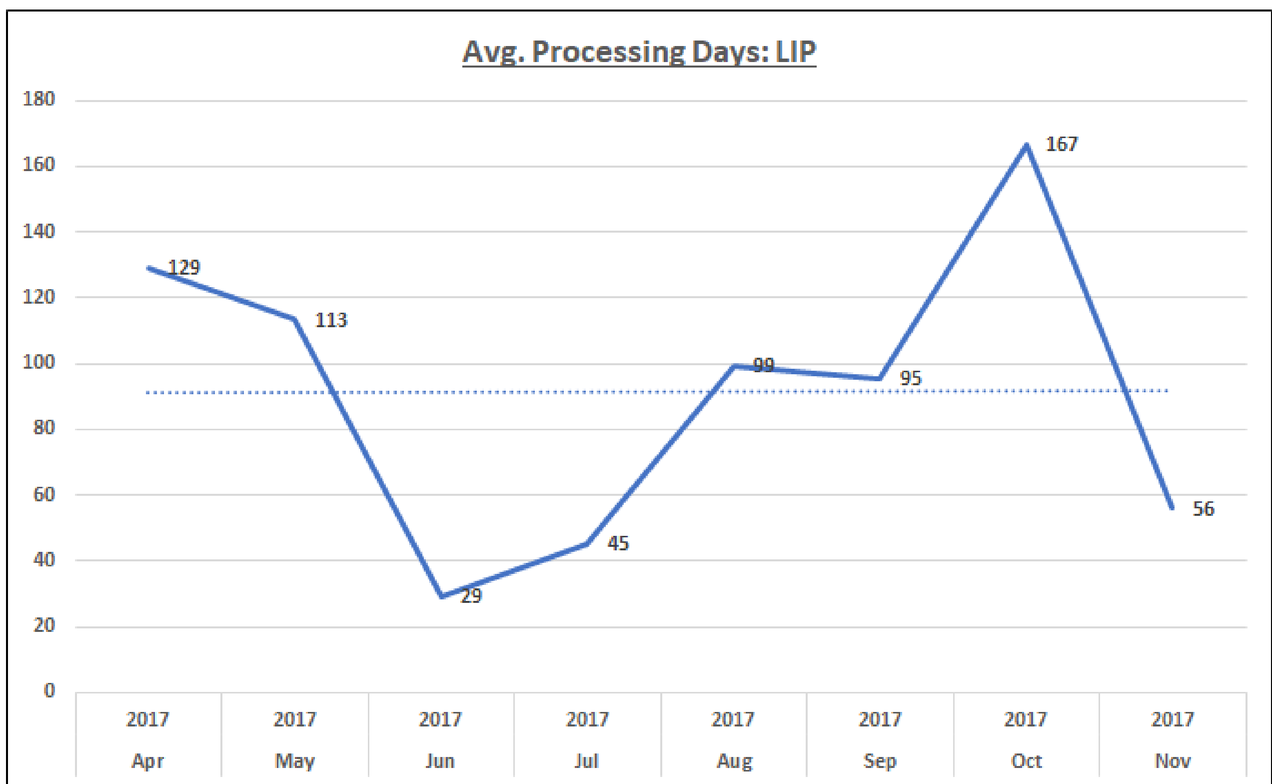
Lead staff: Andrew D'Onofrio, MPA - Provider Operations Director

Planned monitoring period (renewable): Jul-2017 to Jun-2018

Performance notes: Vaya's average processing time for all providers has increased since July 2017. Organizational changes and staffing restrictions (i.e. FMLA) starting in July 2017 contribute to this trend. Several process and organizational changes have led to improved timeframes.


Avg. Processing Days: Agency
100
90
80
70
60
50
40
30
20
10
0
52
41
63
68
83
92
88
88
52
6
4
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
2017
2018


Avg. Processing Days: LP
140
120
100
80
60
40
20
0
40
70
94
105
112
122
94
78
53
24
12
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
2017
2018



Recommendations: The Credentialing Team continues to track and monitor the performance data for providers. Credentialing will continue to look for implement process improvement interventions. These measures will continue to be monitored to determine if Quality Improvement Activities or Project is needed.

Updated by Andrew D'Onofrio *on* 7/9/2018

Related QI Activities: none

Quality Assurance Activity: Service availability

Lead staff: Donald Reuss, MA - Provider Network Operations Senior Director

Planned monitoring period (renewable): Jul-2017 to Jun-2018

Performance notes: Service availability is addressed annually through the Gaps Analysis process. Services deficiencies are reported to DMA and DMHDDSAS through the Exceptions Report process as part of the Annual Gaps Analysis. If exceptions are justified, they are approved by DMA and/or DMHDDSAS (respectively). Additionally, ongoing notification regarding gaps in network services are gained through the Service Gaps Referral Form and through stakeholder input.

Recommendations: For the 2018 Gaps Analysis report, the Network Development Plan will include Vaya's plans for improving service areas where required benchmarks for access and choice are not met. Service gaps notification of any type are currently reviewed by Provider Network leadership and staff as well as the Network and Services Management Committee.

Updated by Tommy Duncan *on* 5/9/2018

Related QI Activities: none

Quality Assurance Activity: Cultural competency and access to care for underserved groups

Lead staff: Donald Reuss, MA - Provider Network Operations Senior Director

Planned monitoring period (renewable): Jul-2017 to Jun-2018

Performance notes: The Provider Advisory Council has reviewed and approved Vaya's Cultural Competency Plan. Vaya is currently working in Phase 1: Awareness. Additionally, the Provider Advisory Council's disability specific subcommittees meet monthly to address the cultural needs and concerns of the IDD, SU, and MH populations.

Recommendations: The 2018 Gaps Analysis requires the inclusion of narratives regarding Vaya's efforts to ensure culturally appropriate services for all members. Vaya will be addressing cultural competence concerns as part of the 2018 Community Needs Assessment Survey. The survey results will be available after the survey closes on May 15, 2018, and will be used in Phase 2 of Vaya's Cultural Competency Plan.

Updated by Tommy Duncan *on* 5/9/2018

Related QI Activities:

p. 40 Assessment and Treatment of Mental Health Disorders in Innovations Beneficiaries

p. 36 Increase housing placements through the Transitions to Community Living Initiative

---

Quality Assurance Activity: Provider compliance with State Rules

Lead staff: Lisa Besses, LPC - Contract Performance Director

Planned monitoring period (renewable): Jul-2017 to Jun-2018

Performance notes: Contract Performance Specialists conduct bi-annual Routine Monitoring Reviews and Routine Post Payment Reviews as required of contracted network providers to ensure compliance with State rules.

Contract Performance Specialists conduct Focused Investigations to ensure compliance with all applicable rules and regulations.

Site Review Specialists conduct annual and emergency Health and Safety site reviews of unlicensed AFL homes within the Vaya network. In addition, member-specific site reviews are conducted of unlicensed AFLs when a new member moves in.

Recommendations: Continue to conduct Routine Monitoring, Routine Post Payment reviews and Focused Investigations as required to ensure compliance. Plan of Corrections (POC) and/or recommendations are issued for findings out of compliance. Referrals are made to the Special Investigations Unit (SIU) for any out of compliance findings that may require a payback. In reference to Unlicensed AFL reviews, POC's may be issued if corrections have not been made within 30 days of the Health and Safety Site review.

It is recommended that benchmarks for specific monitoring questions be established.

Updated by Angela Lewis-Myers *on* 5/8/2018

Related QI Activities: none

Quality Assurance Activity: Provider compliance with clinical practice guidelines

Lead staff: Patty Wilson, Ph.D., LPC, CI - Performance and Quality Improvement Senior Director

Planned monitoring period (renewable): Jul-2017 to Jun-2018

Performance notes: From the Vaya Approved Best Practice Guidelines, the following two were identified for monitoring this fiscal year:

- Supported Employment (SE) as promulgated by Substance Abuse and Mental Health Services Administration (SAMHSA)
- Best Practice Treatment of Opioid Dependence as promulgated by the National Institute of Drug Abuse (NIDA) - Opioid

Monitoring of adherence to the NIDA guidelines for Treatment of Opioid Dependence was conducted via the following:

- Quarterly Post Payment Review (PPR) of Outpatient Opioid Treatment services by the Contract Performance Unit PPR Clinicians
- DHSR Annual and Complaint Surveys
- Biannual Routine Post-Payment Review

Data from the above was used to assess six criteria for adherence to the clinical practice guidelines. Currently six of the seven clinics reviewed met all of the criteria; one clinic met 50% of the criteria and is implementing a Plan of Correction.

Recommendations: Continue to develop further reviews of adherence to clinical practice guidelines and track trends in the review results over time to inform Vaya's process for promulgating the guidelines and ensuring compliance.

Monitoring of adherence to the SAMHSA SE guidelines was not accomplished this fiscal year. Recommend it be accomplished in the coming fiscal year via the Service Authorization Request review process by the Utilization Management team.

Updated by Charley Barry *on* 5/11/2018

Related QI Activities:

p. 41 Fidelity of Supported Employment Services

Quality Assurance Activity: Provider compliance with LME/MCO contractual requirements

Lead staff: Patty Wilson, Ph.D., LPC, CI - Performance and Quality Improvement Senior Director

Planned monitoring period (renewable): Jul-2017 to Jun-2018

Performance notes: Vaya continues to move forward with implementation of Value Based Contracting (VBC) with its Provider Network, which was initiated with Comprehensive Care Centers. Monitoring of compliance with contractual requirements related to VBC was conducted in Spring 2018. The

Contract Performance Unit used a standardized workbook to review all elements of the Provider Contract Attachment F-Comprehensive Care Center Performance Requirement Addendum. Out of compliance findings or deficiencies required implementation of an approved Plan of Correction. Additional monitoring of provider contract compliance is conducted as an element of all provider investigations. During bi-annual Routine Post Payment Review providers must submit a copy of their Quality Management Program and evidence of implementation.

Recommendations:

- Continue annual monitoring of CCC performance requirements, including any new elements added.
- Continue monitoring for contract compliance as part of all investigations.
- Continue monitoring for Provider Quality Management Program compliance.

Updated by Patty Wilson *on* 5/17/2018

Related QI Activities: none

Quality Assurance Activity: Prevention, detection, and remediation of fraud, waste, and abuse

Lead staff: Brande Lamb, LPC, CI - Special Investigations Director

Planned monitoring period (renewable): Jul-2017 to Jun-2018

Performance notes: 1) Fraud prevention and detection: Data analytics utilizing FAMS and/or other data mining techniques occurred on a monthly basis. Other analytics including targeted service line and provider data mining were conducted on a quarterly, semi-annually and/or annual schedule. The Healthcare Data Integration Manager generated referrals on providers that appeared to be most unlike their peers and that may have been engaging in billing abuse or potentially fraudulent activities.

2) Remediation of occurrences; investigations were conducted in response to suspected fraud, waste, and abuse referrals and data mining referrals as noted above. Investigation Report of Findings (ROF) included Notice of Overpayments, Educational Warning Letters and/or Best Practice Recommendations as applicable.

Recommendations: Continue case supervision by Senior Director and Director. Continue process of all SIU team members acquiring a fraud investigator certification. Continue utilizing FAMS and/or other data mining techniques to cultivate case leads.

Updated by Angela Lewis-Myers *on* 5/8/2018

Related QI Activities: none

2017-2018 Quality Improvement Activities

Quality Improvement Activity: Inpatient Rapid Readmission

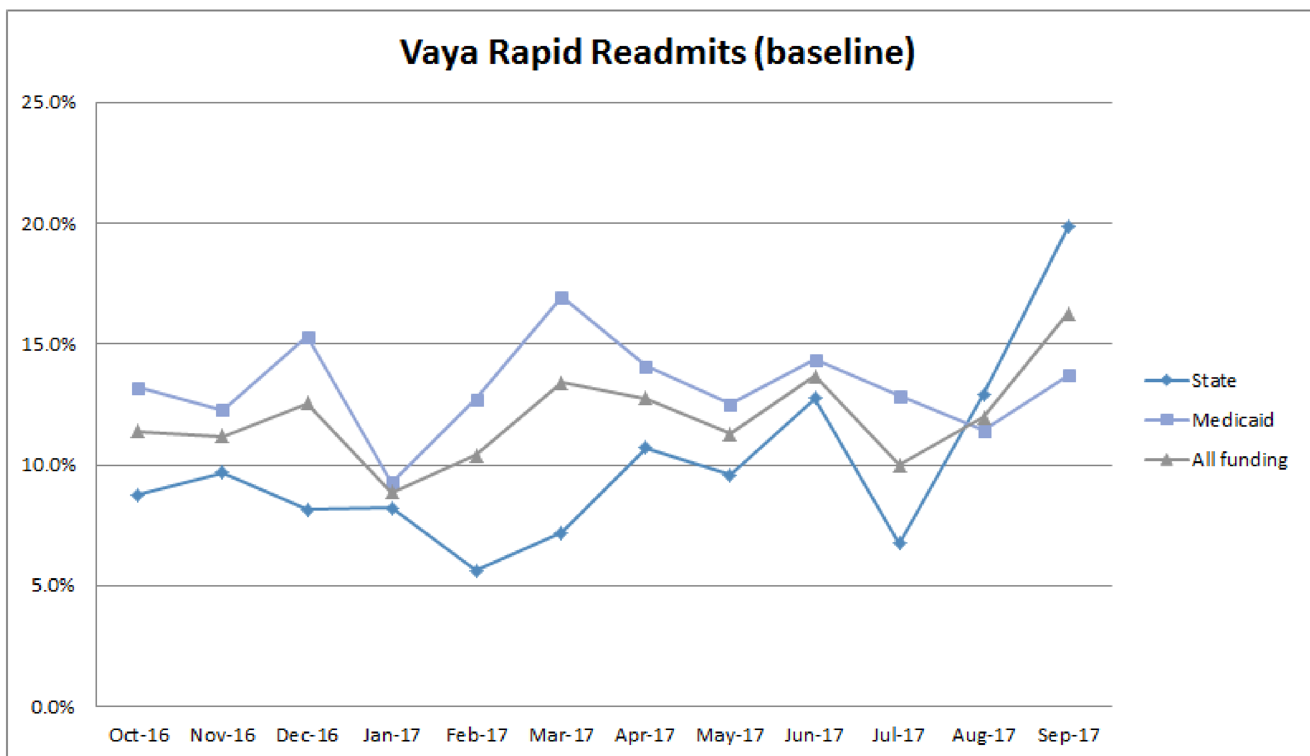
Performance Improvement Goal: The rate at which members are discharged from a Community Psychiatric Inpatient service and subsequently readmitted to a Community Psychiatric Inpatient service within 30 days will be at or below 11.4% (5% less than the baseline of 12%).

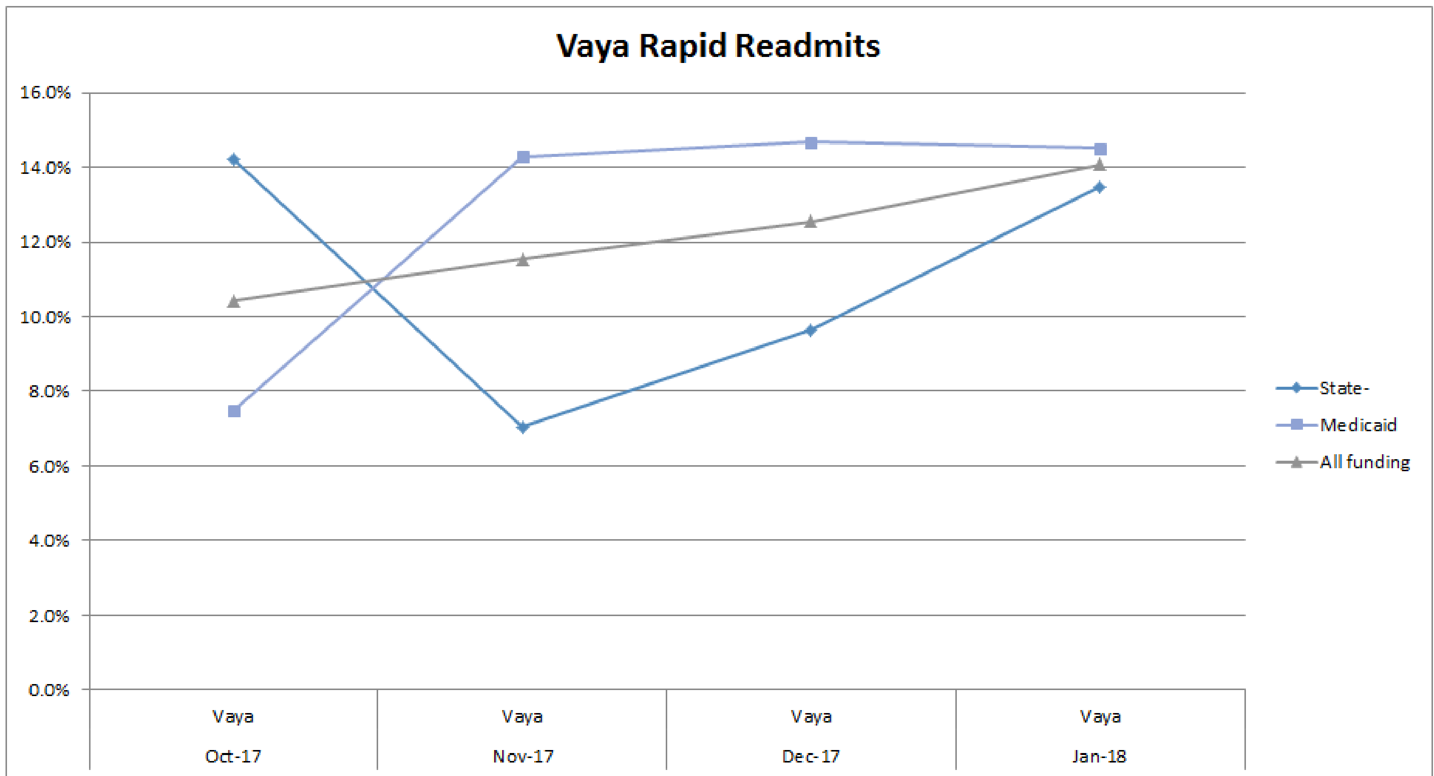
Lead staff: Barbara Bellamy, RN - Acute Response Team Manager

Implementation start date: Dec-2017 ***Projected completion date:*** Jul-2019

Status: In progress ***End date:*** n/a

Progress notes: The project team continues to assess effectiveness of interventions of Peer Bridger and Teach Back methodology. Additional root cause analysis is being conducted to determine additional potential interventions. Data for the period from October 2017 through January 2018 continues to show an overall upward trend.





Recommendations: Continue current interventions of Teach Back method and Peer Bridger model. Additional interventions are being explored for the discovery phase.

Per recommendation of CMO, project team reviewed discharge summaries sent to primary care physicians. Data collected by Acute Response Care Coordinators indicates that Haywood is the only hospital consistently sending discharge summaries to primary care physicians. Mission Hospital sends discharge summaries only to physicians who are in the Mission network. This could be a contributing factor to the low readmission rates at Haywood and should be considered as a future intervention.

Note: This QI Activity is a Vaya Quality Improvement Project (QIP). A detailed report for this QIP is included in the Appendices to the 2018 Quality Management Program Description.

Updated by Lynn English *on* 4/20/2018

Quality Improvement Activity: Improve Timeliness of Transitions to Community Living Initiative Quality of Life Survey Completion

Performance Improvement Goal: Vaya TCLI staff will administer and submit the QOL surveys in a timely manner for a minimum of 80% of the required surveys.

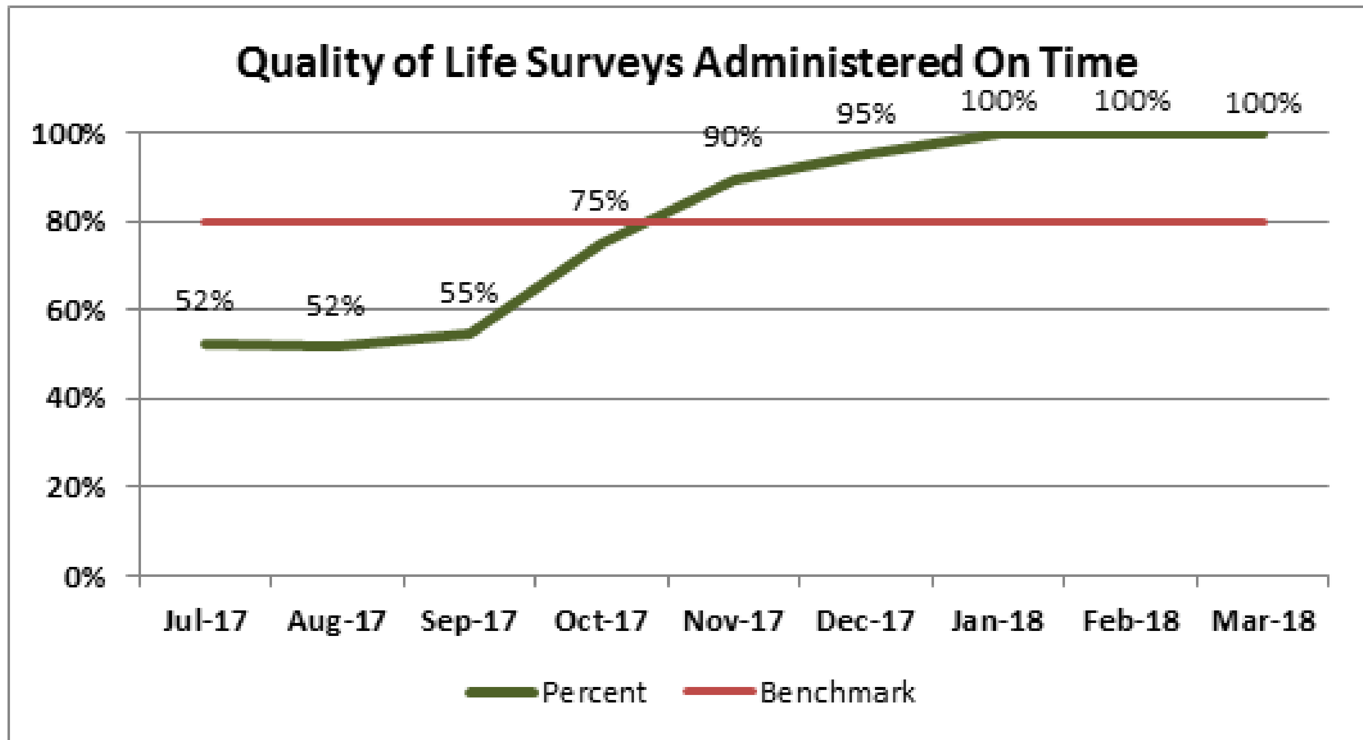
Lead staff: Kelsie Clark, MA - Transition Manager

Implementation start date: Oct-2017 ***Projected completion date:*** Jun-2018

Status: Completed - goal achieved ***End date:*** Mar-2018

Progress notes: Since the implementation of the interventions, the TCLI team has had a steady increase in the completion rates of Quality of Life Surveys. In October 2017, the TCLI team was able to achieve a

75% completion rate. Each month since then has shown an increase from the month prior. For November, 89.5% of surveys were completed within required time frames. For December, 95% were timely. As of the most recent verified data, the TCLI team was able to ensure that 100% of the surveys were timely for January and February, 2018. The team is confident the established procedures will continue this trend. An automated tool designed to track, monitor, and remind staff of required time frames is still in development with MIS. The current procedures seem to be both effective and sustainable for TCLI staff. While the Year to Date average of 74.6% is still below the target of 80%, a continuation of the current trend should resolve this.



Recommendations: Continue the interventions in place as they appear to be working. The automated tool will take the place of the current manual processes. As the project goal has been met or exceeded for four consecutive months, it is recommended that this QIP be closed and that it be moved into the monitoring phase to ensure continued success.

Note: This QI Activity is a Vaya Quality Improvement Project (QIP). A detailed report for this QIP is included in the Appendices to the 2018 Quality Management Program Description.

Updated by Steven Kozicki *on* 4/24/2018

Quality Improvement Activity: Integrated Care (Access to Primary & Preventive Care) for Innovations Waiver Participants

Performance Improvement Goal: The percentage of all active Innovations recipients that have received a primary care service within the previous 12 months for ages 3-6 and ages 20 and over, or within the previous 24 months for ages 7-19, will be at least 92%.

Lead staff: John Frazier, MSW - Care Coordination Manager

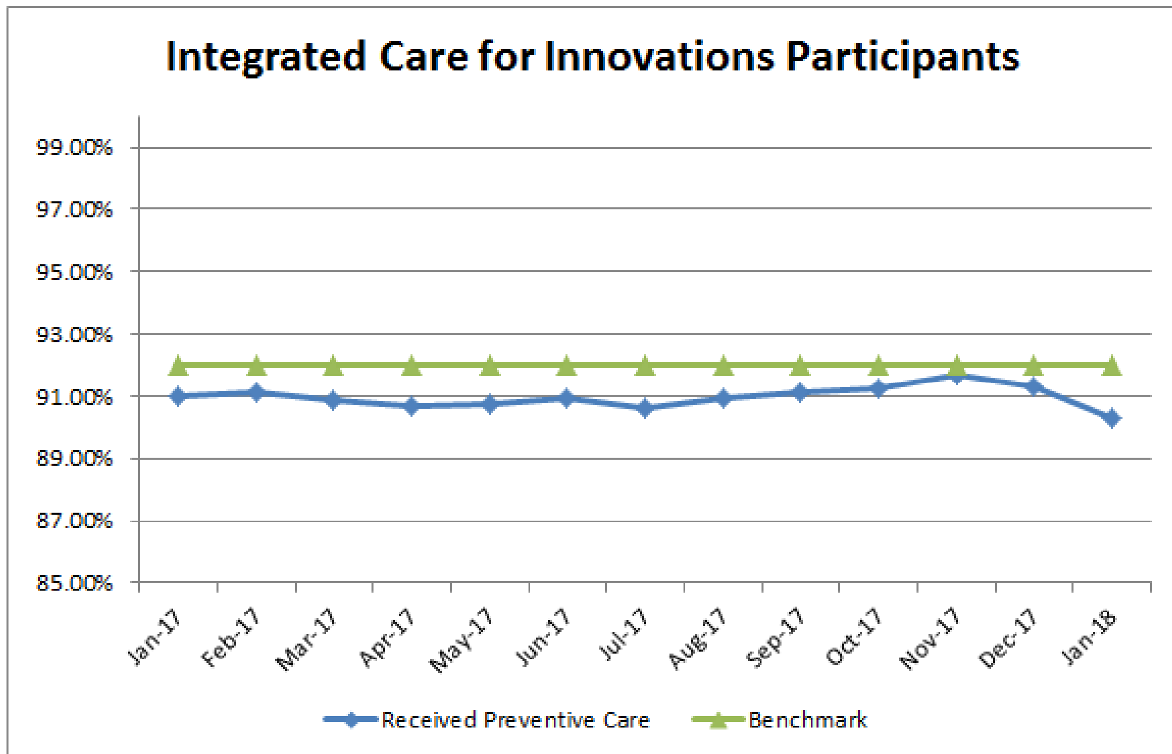
Implementation start date: Dec-2017 ***Projected completion date:*** Aug-2018

Status: In progress ***End date:*** n/a

Progress notes: Performance continues to fall just below the goal of 92%. The last four reported months show a downward trend, but this is due to the claims lag.

Educational materials about integrated care have been developed for Vaya staff, providers, primary care physicians, members and guardians. Based on the recommendation of QIC, the Assistant Medical Director has collaborated in development and review of these materials.

Value Based Contracting has a similar goal for providers which could positively impact performance. Value Based Contracting related to integrated care is expected to begin on July 1, 2018.



Recommendations: Project team will complete and distribute educational materials. Project team will continue to identify potential barriers and solutions/interventions.

Note: The state has established a "Supermeasure" for integrated care for Innovations participants that represents a subset of the target population for this project. The Supermeasure data indicates that Vaya exceeded this project's 92% benchmark for the 3 months of data provided.

Note: This QI Activity is a Vaya Quality Improvement Project (QIP). A detailed report for this QIP is included in the Appendices to the 2018 Quality Management Program Description.

Updated by Lynn English *on* 4/20/2018

Quality Improvement Activity: Increase housing placements through the Transitions to Community Living Initiative

Performance Improvement Goal: The monthly rate at which qualifying individuals with persistent mental illness or substance use disorders are transitioned out of congregate living situations and into community-based supportive housing will be 6.67 or higher, i.e., at least 80

individuals will be transitioned per year.

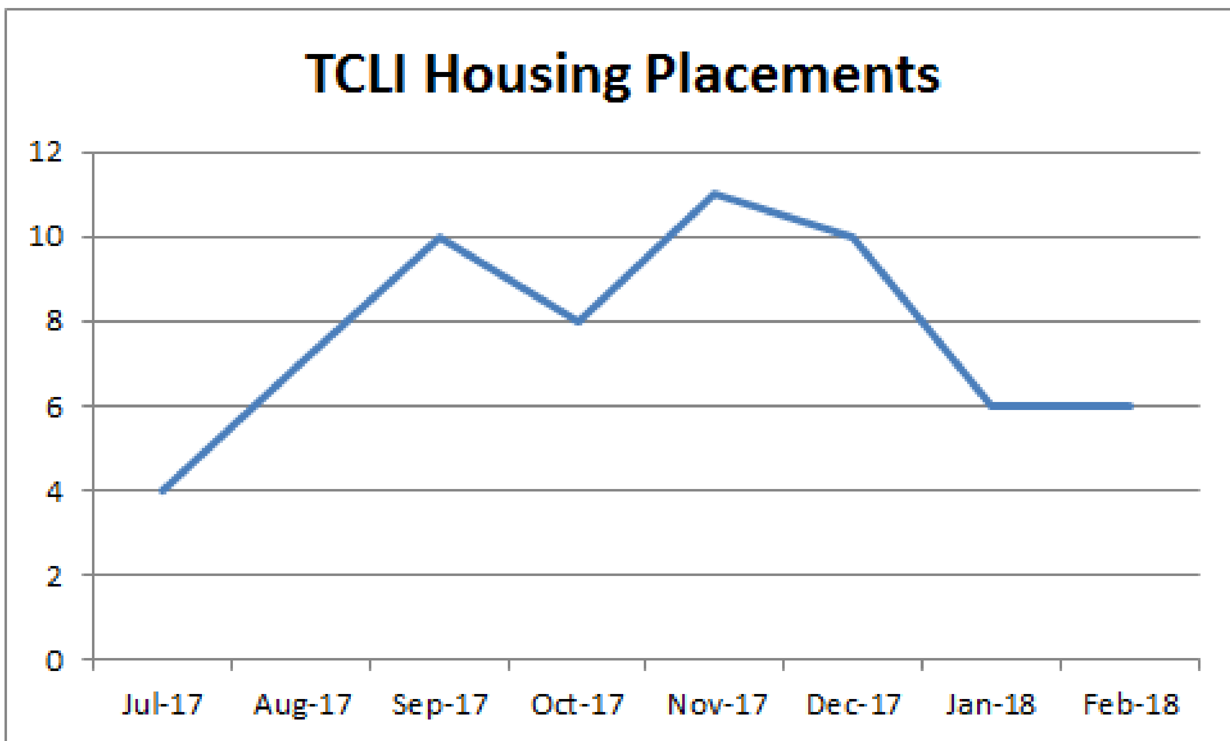
Lead staff: Kelsie Clark, MA - Transition Manager

Implementation start date: Jan-2018 ***Projected completion date:*** Jul-2018

Status: In progress ***End date:*** n/a

Progress notes: Data for the four-month period from September 2017 through December 2017 showed a significant increase in the rate of placements even though this was prior to formal implementation of the project interventions. To date the monthly rate is 7.17, which is above the project goal of 6.67. While recent numbers have increased substantially, much of the increase came from staff efforts to revisit participants that had previously been unable or unwilling to consider moving out of congregate living settings. While these efforts have resulted in higher numbers housed, this is a limited pool of individuals and these efforts are not expected to result in sustained improvement. There will be a need to find more participants meeting the specific criteria for the program, which is anticipated to be a barrier. An automated tool designed to track, monitor, and remind staff of required time frames is still in development with MIS.

Post-intervention data for January and February 2018 appears to reflect this with a placement rate of 6 per month. Overall, Vaya's current monthly average is 7.75 with a total of 62 moves in the current fiscal year.



Recommendations: Continue the current project interventions. The automated tool will take the place of the current manual processes. Continue to analyze data to determine the effectiveness of the interventions and identify barriers, and to develop further interventions as indicated.

Note: This QI Activity is a Vaya Quality Improvement Project (QIP). A detailed report for this QIP is included in the Appendices to the 2018 Quality Management Program Description.

Updated by Steven Kozicki *on* 4/24/2018

Quality Improvement Activity: RN Care Coordinator Utilization

Performance Improvement Goal: Utilize RN Care Coordinator to support integrated care.

Lead staff: Nancy McClintock, MSW, RN - Care Coordination RN Manager

Implementation start date: Jul-2014 ***Projected completion date:*** Feb-2018

Status: Completed - goal achieved ***End date:*** Mar-2018

Progress notes: The Care Coordination (CC) leadership team developed strategies to utilize RNs to enhance integrated care across Vaya Health. These strategies included the Health Risk Assessment (HRA) and Complex Care Coordination Teams (C3T) in each region. The primary barrier was the inconsistency of CCs using the HRA. This barrier was addressed by creating a methodology and reporting to allow managers to track the completion of the HRA in the Clinical Docs tab of AlphaMCS.

With the implementation of the Incedo system, RNs conduct medication reviews and make referrals for pharmacist review as needed.

RN CCs implemented interventions to support population management including patient and family education for multi-morbid health conditions, coordination with Primary Care offices and support of other medical interventions.

Recommendations: Goal has been achieved. This QI Activity is closed due to the establishment of work flows in Incedo.

Updated by Jennifer Flint *on* 3/26/2018

Quality Improvement Activity: Complex Care Coordination Competencies

Performance Improvement Goal: Enhance Complex Care Coordination skills of CC staff by developing and implementing CC Academy training, Whole Person Care Training and other training opportunities.

Lead staff: Rhonda Cox, HSP-PA - Chief Population Health Officer

Implementation start date: Jan-2015 ***Projected completion date:*** Dec-2017

Status: Completed - goal achieved ***End date:*** Aug-2017

Progress notes: All of Care Coordination (CC) has attended the first and second rounds of the CC Academy. The department continues to find ways to educate CC staff on best practices and national standards of whole person care. CC Academy II was held in the summer of 2017. Newly hired CCs will attend CC Academy I.

Recommendations: There is an established relationship between Vaya CC and MAHEC to continue the development and delivery of the CC Academy. This goal is complete and the CC and Vaya teams will continue this work.

Updated by Sara Wilson *on* 8/8/2017

Quality Improvement Activity: Clinical Best Practices for Children and Youth in Crisis

Performance Improvement Goal: Increase availability and utilization of clinical best practices for children and youth In crisis.

Lead staff: Maggie Farrington, MA - Utilization Management Director

Implementation start date: Jul-2015 ***Projected completion date:*** Jun-2018

Status: Completed - goal achieved ***End date:*** Apr-2018

Progress notes: Child Facility Based Crisis Center (Family Preservation Services) is on schedule to open June/July 2018 to serve 16 youth at any given time.

Eliada Homes opened Assessment and Evaluation Center on 3/26/18 to provide 30-day intensive evaluation of treatment needs for up to nine youth ages 11-17 that are at risk of out of home placement.

Implementation of newly approved In Lieu of Service Definition:

- Transitional Youth Services effective 1/1/18;
- High Fidelity Wraparound effective 5/1/18; and
- Enhanced Therapeutic Foster Care scheduled start in Fall 2018.

Closer monitoring of and clinical review/peer review of youth in PRTF level of care implemented in October 2017, with the goal to reduce clinically inappropriate admissions. Youth with lengths of stay beyond three months and no discharge plan or step-down plan identified will be clinically staffed with Medical Director, Associate Medical Director and Care Coordination. The expectation of PRTF being a short-term service and education regarding all available services for high risk youth (including existing services and new In Lieu of Services) has been communicated with all stakeholders.

Recommendations: This goal has been achieved. UM will continue collaboration with Provider Network Development regarding children and youth in crisis.

Updated by Maggie Farrington *on* 4/16/2018

Quality Improvement Activity: Clinical Best Practices for Autism Spectrum Disorder Members

Performance Improvement Goal: Increase availability and utilization of clinical best practices for Autism Spectrum Disorder members.

Lead staff: David Boyd, MBA - Network Management Coordinator

Implementation start date: Mar-2016 ***Projected completion date:*** Jul-2018

Status: Completed - goal achieved ***End date:*** Mar-2018

Progress notes: Four providers have active programs for members with Autism Spectrum Disorder. Provider Network is currently evaluating provider capacity and network need in rural areas.

Recommendations: This goal has been achieved. Provider Network will continue to monitor and add additional programs in underserved, rural areas of our catchment.

Updated by Tommy Duncan *on* 3/23/2018

Quality Improvement Activity: Assessment and Treatment of Mental Health Disorders in Innovations Beneficiaries

Performance Improvement Goal: a) Ensure that no fewer than 80% of Innovations beneficiaries with documented evidence of a MH disorder have received a MH assessment within the past 2 years. b) Ensure that no fewer than 75% of Innovations beneficiaries with documented evidence of a MH disorder have received a MH service within the past 2 years. (This is a QI Project.)

Lead staff: Rachael Smith, LPC - IDD Utilization Management Manager

Implementation start date: Feb-2015 ***Projected completion date:*** Jun-2017

Status: Discontinued - other ***End date:*** Sep-2017

Progress notes: Project results were compiled in June 2017 for the second year of post-intervention data. The results indicate that 30% of Innovations recipients with evidence of a mental health disorder received a mental health assessment in the previous two-year period. This is an improvement compared to the baseline (2015) and 2016 results, but still below the project goal of 80%.

2017 results indicate that 63% of these recipients received a mental health intervention within the previous two years. This is an improvement compared to the previous results but also below the goal of 75%.

Recommendations: The project results indicate some success. However, the improvement has been slow and suggests that expectations for rapid improvement in this measure are not realistic.

The project was discontinued due to the resource-intensive nature of the data collection relative to the improvement. Interventions will continue as they appear to be effective.

Updated by Charley Barry *on* 8/29/2017

Quality Improvement Activity: Timely Submission of Incident Reports

Performance Improvement Goal: The rate of timely submission of incident reports by providers will be 85% or better.

Lead staff: Angela Lewis-Myers, MA - Healthcare Data Integration Manager

Implementation start date: Jun-2015 ***Projected completion date:*** Jul-2017

Status: Completed - goal achieved ***End date:*** Sep-2017

Progress notes: Vaya's rate of timeliness is at 91%. All innovation providers were sent letters in January 2017 as a reminder of the expectations for timely incident reporting. A refresher training that addressed timeliness of incident reports was provided in spring of 2017. In July of 2017, incident report specialists identified five providers that were out of compliance. Technical assistance referrals were made to the Investigation Oversight Committee. The Contract Performance team followed up with these providers and issued Plans of Correction as needed. Additional non-compliance by providers who have received technical assistance will result in Investigation referrals.

Recommendations: This goal has been achieved. Timeliness rates will be monitored to ensure improvement is sustained.

Updated by Angela Lewis-Myers *on* 9/20/2017

Quality Improvement Activity: Fidelity of Supported Employment Services

Performance Improvement Goal: Ensure fidelity of service by all state-funded Supported Employment providers by the beginning of state FY 2017.

Lead staff: Sarah Lancaster, BS - Housing and Employment Manager

Implementation start date: Jan-2016 **Projected completion date:** Apr-2018

Status: Completed - goal achieved **End date:** Mar-2018

Progress notes: All three current Supported Employment providers meet fidelity (RHA, FPS, Meridian). Each provider is being paid for the services based on their fidelity score. Vaya has received an allocation letter from the state to fund development of an additional program in an underserved area of our northern region (FPS is currently serving this region but does not have a physical presence in this area). Daymark has been identified as the provider for this new program. Vaya anticipates this program going live by June 30, 2018.

Recommendations: This goal has been achieved.

Updated by Tommy Duncan *on* 3/23/2018

Quality Improvement Activity: Follow-Up After Discharge from Inpatient Mental Health Treatment

Performance Improvement Goal: The rate at which Vaya Medicaid and state-funded members are seen by an outpatient mental health provider within seven days of discharge from an inpatient mental health facility will be at least 40%.

Lead staff: Steven Kozicki, MS, ASQ-CMQ/OE - Quality Management Director

Implementation start date: Dec-2017 **Projected completion date:** Sep-2018

Status: In progress **End date:** n/a

Progress notes: Estimates of the rate of members' engagement with the Peer Bridger service (per providers' reports) following discharge range from 65% to 99.9%, a substantial increase relative to the baseline of 20% to 30% and well above the project goal of 40%. However, due to the lag in claims data, verification of these initial results will not be possible until approximately July 2018. Nevertheless, the estimates for engagement with the Peer Bridger service are very encouraging and suggest that this intervention, now that it has been expanded to include nearly all of the target facilities, may be adequate to achieve the project goal.

Recommendations: Continue implementation of the Peer Bridger service. Continue the development of real-time indicators for engagement with the Peer Bridger service and with qualifying services in general.

Continue monitoring and implementing solutions regarding claims processes through NC-TRACKS approval.

Note: This QI Activity is a Vaya Quality Improvement Project (QIP). A detailed report for this QIP is included in the Appendices to the 2018 Quality Management Program Description.

Updated by Steven Kozicki *on* 4/24/2018

Quality Improvement Activity: Follow-Up After Discharge from Inpatient Substance Use Disorder Treatment

Performance Improvement Goal: The rate at which Vaya Medicaid and state-funded members are seen by an outpatient substance use disorder treatment provider within seven days of discharge from an inpatient substance use disorder treatment facility will be at least 40%.

Lead staff: Steven Kozicki, MS, ASQ-CMQ/OE - Quality Management Director

Implementation start date: Dec-2017 ***Projected completion date:*** Sep-2018

Status: In progress ***End date:*** n/a

Progress notes: Estimates of the rate of members' engagement with the Peer Bridger service (per providers' reports) following discharge range from 65% to 99.9%, a substantial increase relative to the baseline of 20% to 30% and well above the project goal of 40%. However, due to the lag in claims data, verification of these initial results will not be possible until approximately July 2018. Nevertheless, the estimates for engagement with the Peer Bridger service are very encouraging and suggest that this intervention, now that it has been expanded to include nearly all of the target facilities, may be adequate to achieve the project goal.

Recommendations: Continue implementation of the Peer Bridger service. Continue the development of real-time indicators for engagement with the Peer Bridger service and with qualifying services in general.

Continue monitoring and implementing solutions regarding claims processes through NC-TRACKS approval.

Note: This QI Activity is a Vaya Quality Improvement Project (QIP). A detailed report for this QIP is included in the Appendices to the 2018 Quality Management Program Description.

Updated by Steven Kozicki *on* 4/24/2018

Adequacy of Resources, Training, Scope and Content

The focus of the QM Program this past year has been on internal processes which ultimately affect the services received by our members. Improving the efficiencies of these processes ensures overall organizational effectiveness in the management of service delivery. In addition, the QM Program promotes data driven decision making through the presentation of data and analysis of that data to inform decisions across the organization.

While there is an identified Quality Improvement Team at Vaya, the responsibility for quality improvement is shared across the organization with oversight provided by the Quality Improvement Committee (QIC). QIC includes Vaya staff, providers and community stakeholders. Over the past year Vaya has taken a more direct approach to Quality Management and Quality Improvement. Since the last QM Program Evaluation the entire team attended the American

Society of Quality (ASQ) World Conference in May of 2017. Quality Management Director, Steven Kozicki became a Certified Manager of Quality and Operational Excellence through ASQ. The Quality Improvement Advisory Team (QIAT) has begun training for various ASQ Certifications. All members of the Quality Management department are now members of ASQ. This affiliation provides the team access to quality management and improvement resources and training.

There is a continuing need across the organization to improve understanding of Quality Management and Quality Improvement principles and utilization of standard tools. Currently this is carried out by “Just in Time” training by the Quality Management department during Quality Improvement Committee, Quality Improvement Project Team meetings, Quality Assurance Team meetings, and specific trainings as requested. The team facilitated training on Root Cause Analysis (RCA) for the Contract Performance Unit as they worked to develop a Plan of Correction in response to the Annual Systems Review of Block Grants. A robust training project has been approved by Vaya’s Project Management Steering Committee, but due to resources, the project is on hold at this time. The ultimate goal of the project is to increase organizational knowledge of quality principles.

Quality Management Annual Workplan

2018-2019

Vaya Health 2018-2019 Quality Management Annual Work Plan

Performance Area	Start date	Completion date	Lead staff	Status
Service availability[1]	Jul-18	Jun-19	Donald Reuss Provider Network Operations Senior Director	Performance monitoring in progress
Cultural competency and access to care for underserved groups[1]	Jul-18	Jun-19	Donald Reuss Provider Network Operations Senior Director	Performance monitoring in progress
Timely access to care[1]	Jul-18	Jun-19	Karla Mensah Customer Services Senior Director	Performance monitoring in progress
Initiation and engagement with MHSU treatment[1]	Jul-18	Jun-19	Steven Kozicki Quality Management Director	Performance monitoring in progress
Integrated care and access to primary care (continuity of care, per DMA/DMH)[1]	Jul-18	Jun-19	Nina Vinson Clinical Informatics Director	Performance monitoring in progress
Use of state facilities and local hospitals[1]	Jul-18	Jun-19	Maggie Farrington Utilization Management Director	Performance monitoring in progress
Use of emergency and crisis services and hospital ED's[1]	Jul-18	Jun-19	Steven Kozicki Quality Management Director	Performance monitoring in progress
Service patterns and costs for high cost / high risk individuals[1]	Jul-18	Jun-19	Maggie Farrington Utilization Management Director	Performance monitoring in progress
Use of evidence-based practices[1]	Jul-18	Jun-19	Maggie Farrington Utilization Management Director	Performance monitoring in progress
Member outcomes[1]	Jul-18	Jun-19	Alison McCall Site Review Specialist	Performance monitoring in progress
Member satisfaction[1]	Jul-18	Jun-19	Steven Kozicki Quality Management Director	Performance monitoring in progress
Trends and patterns in grievances[1]	Jul-18	Jun-19	Stephanie Hopfinger Grievance Specialist Lead	Performance monitoring in progress
Trends and patterns in incidents[1]	Jul-18	Jun-19	Angela Lewis-Myers Healthcare Data Integration Manager	Performance monitoring in progress
Trends in denials and appeals[1]	Jul-18	Jun-19	Steve Puckett Director of Member Appeals	Performance monitoring in progress

[1]Performance measures associated with this Quality Assurance Activity are listed in the 2018 QM Program Description

[2]Performance Improvement Goal and other details are included in the 2017-2018 QI Program Evaluation

Vaya Health 2018-2019 Quality Management Annual Work Plan

Performance Area	Start date	Completion date	Lead staff	Status
Provider compliance with State Rules[1]	Jul-18	Jun-19	Lisa Besses Contract Performance Director	Performance monitoring in progress
Provider compliance with clinical practice guidelines[1]	Jul-18	Jun-19	Patty Wilson Performance and Quality Improvement Senior Director	Performance monitoring in progress
Provider compliance with LME/MCO contractual requirements[1]	Jul-18	Jun-19	Patty Wilson Performance and Quality Improvement Senior Director	Performance monitoring in progress
Incident response and reporting[1]	Jul-18	Jun-19	Angela Lewis-Myers Healthcare Data Integration Manager	Performance monitoring in progress
Prevention, detection, and remediation of fraud, waste, and abuse[1]	Jul-18	Jun-19	Brande Lamb Special Investigations Director	Performance monitoring in progress
Grievance response and resolution[1]	Jul-18	Jun-19	Stephanie Hopfinger Grievance Specialist Lead	Performance monitoring in progress
Adequacy of LME/MCO supports for providers[1]	Jul-18	Jun-19	Donald Reuss Provider Network Operations Senior Director	Performance monitoring in progress
Conduct of calls[1]	Jul-18	Jun-19	Karla Mensah Customer Services Senior Director	Performance monitoring in progress
Service authorization processes[1]	Jul-18	Jun-19	Maggie Farrington Utilization Management Director	Performance monitoring in progress
Credentialing and recredentialing of providers[1]	Jul-18	Jun-19	Andrew D'Onofrio Provider Operations Director	Performance monitoring in progress
Improve Timeliness of Transitions to Community Living Initiative Quality of Life Survey Completion[2]	Apr-2018	Mar-2019	Kelsie Clark Transition Manager	Post-QIP monitoring in progress
Inpatient Rapid Readmission[2]	Sep-2017	Jul-2019	Barbara Bellamy Acute Response Team Manager	Improve phase in progress (QIP)

[1] Performance measures associated with this Quality Assurance Activity are listed in the 2018 QM Program Description

[2] Performance Improvement Goal and other details are included in the 2017-2018 QI Program Evaluation

Vaya Health 2018-2019 Quality Management Annual Work Plan

Performance Area	Start date	Completion date	Lead staff	Status
Integrated Care (Access to Primary & Preventive Care) for Innovations Waiver Participants[2]	Sep-2017	Aug-2018	John Frazier Care Coordination Manager	Improve phase in progress (QIP)
Follow-Up After Discharge from Inpatient Mental Health Treatment[2]	Sep-2017	Sep-2018	Steven Kozicki Quality Management Director	Improve phase in progress (QIP)
Follow-Up After Discharge from Inpatient Substance Use Disorder Treatment[2]	Sep-2017	Dec-2018	Steven Kozicki Quality Management Director	Improve phase in progress (QIP)
Increase housing placements through the Transitions to Community Living Initiative[2]	Oct-2017	Jul-2018	Kelsie Clark Transition Manager	Improve phase in progress (QIP)

[1]Performance measures associated with this Quality Assurance Activity are listed in the 2018 QM Program Description

[2]Performance Improvement Goal and other details are included in the 2017-2018 QI Program Evaluation