QUALITY MANAGEMENT PROGRAM EVALUATION

FY 2019-2020

VAYAHEALTH

Section 1: Introduction to the QM Program

It is the policy of Vaya Health ("Vaya"), to maintain a quality management (QM) program which focuses on using objective and systematic measures to effectively monitor and evaluate services delivered to Vaya health plan members and conduct quality improvement activities (Core 17) and operational improvement activities that enable Vaya to improve member outcomes and promote member safety while efficiently managing operational resources.

Vaya is committed to implementing a robust QM program that ensures:

- the accessibility of services;
- a comprehensive and well-qualified provider network, and
- a comprehensive array of clinically appropriate mental health, substance use disorder, and intellectual/developmental disabilities (IDD) services that meet or exceed objective quality standards regardless of the setting.

More detail about the QM Program is set forth in the Annual QM Program Description.

Section 2: Major QM Program Accomplishments

Tracking and Reporting (monitoring)

Tracking and reporting of performance measures have been centralized with a dedicated team of individuals whose focus is to provide ongoing monitoring and to ensure that trends, anomalies and opportunities for improvement are identified on a regular basis.

Quality Improvement

Defined and Standardized New Improvement Process: Based on the Plan, Do, Study, Act (PDSA) continuous improvement methodology the organization defined and socialized a new more user-friendly yet systematic process for making improvements.

Mid-Course Tollgates: To ensure ongoing alignment and effectiveness of inflight quality work – and support the decision making and evaluation role of the Quality Improvement Committee – a series of well-defined tollgates (Success Criterion and Approvals) were designed into the process.

Standardized tools/templates: To facilitate movement through the Success Criterion and Approvals by the QIA owner or lead a set of standardized tools and templates were created. These job aids are closely aligned with the Success Criterion and Approvals and support owner and/or leads in leading cross-functional project teams and driving the quality improvement work.

This standardized user-friendly improvement process – along with the well- defined tollgates and standardized tools – has established a well-designed infrastructure critical in the success of Quality Improvement at Vaya. This includes:

1. Drive successful completion of focused and measurable quality improvement activities.
2. Advancing the capability of leaders and staff in evaluating and closing gaps in performance.

Frontline Improvements: In 2019, Vaya conducted a pilot program to teach frontline employees' continuous improvement. 135 staff expressed interest in the program and Vaya conducted 2 pilot classes of 12 participants each. Each participant completed a "Just Do It" project to improve their work and/or the work of their team. Not only was initial interest strong but the level of engagement and enthusiasm about making improvements grew as the class progressed. Projects included:

1. Decreasing error rate in reconsideration review (Utilization Management)
2. Rate of first call resolution (Claims)
3. Number of days in Transition Planning (TCLI)
4. Rate of credentialing application pended (Provider Network)
5. Rate of self-review forms completed accurate, complete and on time (Care Coordination)

Section 3: Tracking, Reporting (Monitoring)

The Performance Reporting Team (PRT) within the Business Integrity Department was formed in August 2018 and was assigned responsibility for the collection, submission, analysis and reporting of performance data and for responding to requests for specific data needs from both internal and external stakeholders. Three categories of performance measures were compiled and submitted by the PRT: Administrative Function Indicators, submitted monthly; Performance Measures, submitted quarterly; and Critical Performance Indicators, a subset of the Performance Measures, submitted quarterly. Additional reporting requirements were outlined by Attachment K of Vaya's NC Medicaid contract and included effectiveness of care measures, access/availability measures and use of services measures.

The PRT supported the QM program by providing performance and survey data for use in Quality Improvement Projects, Quality Improvement Activities and Quality Assurance Activities and by monitoring performance measures and administrative function indicators for anomalies and adherence to external and/or internal benchmarks.

The PRT analyzed the data collected in the LME/MCO Monthly Monitoring Report and summarized patterns and trends in the Core Performance Measures, which were presented to the Executive Leadership Team monthly and to the Board of Directors Regulatory Compliance and Quality Committee (RCQC). The presentation included data from the LME/MCO Performance Summary (MCO Comparison) and included input from the Regulatory Compliance Team (RCT), for the Compliance Log, and other Departments as needed.

Section 4: Quality Improvement Activities and Operational Improvement Activities

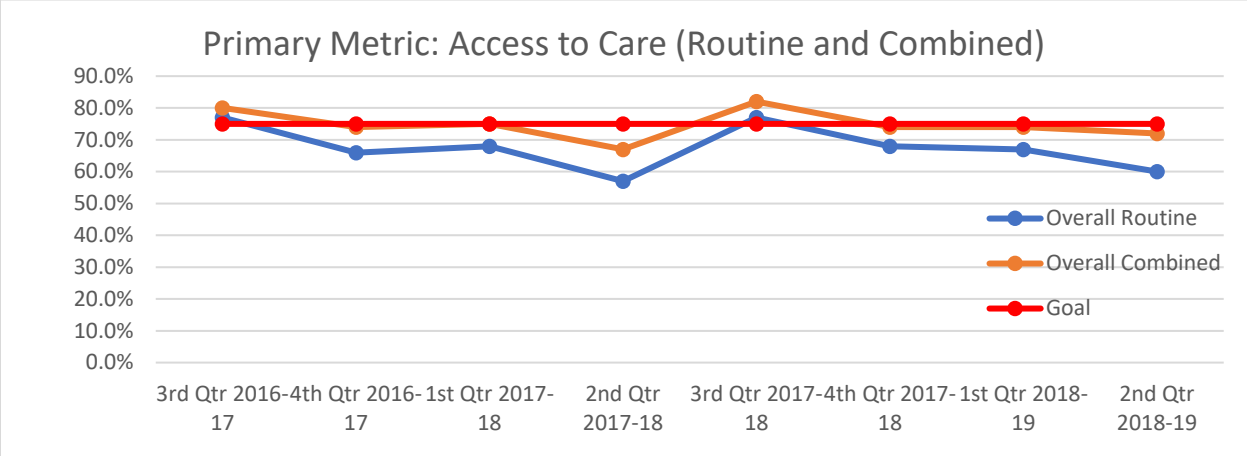
A. Current Inflight QIAs

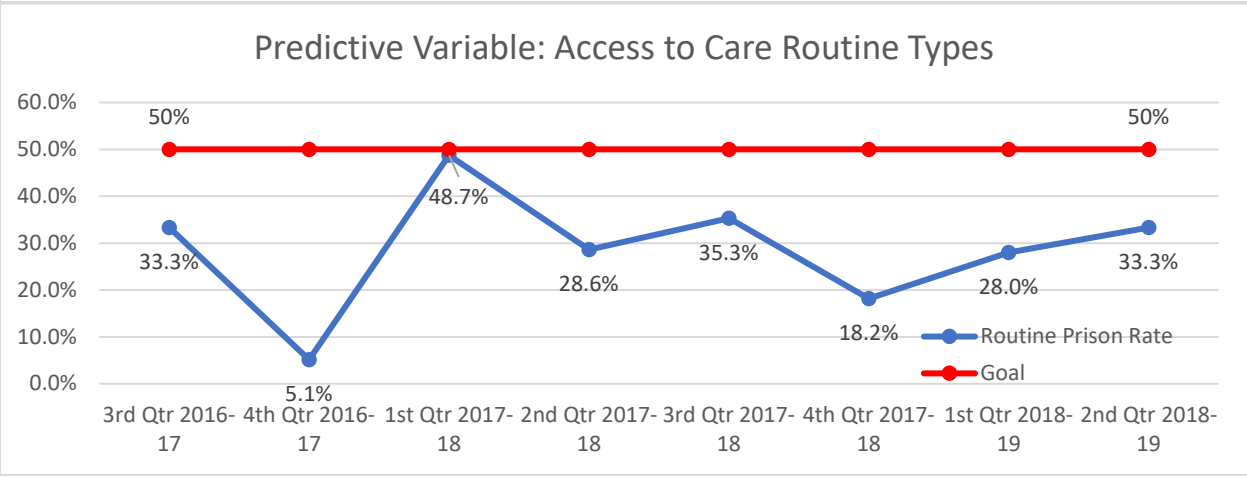
Activity #1

Activity Title: Increase Rate of Routine Care within 14 days of Call for Service
Objective: Access and Availability of Care
Measure (Quantifiable):

- Primary Metric: Increase the rate of Routine Calls receiving a service within 14 days from 67% to 75% by June 30, 2019.
- Predictive Variable: Increase the rate of individuals who receive a service within 14 days of being released from prison from 29% to 50% by June 30, 2019

Data Source: Outpatient Claims, Call log
Collection Data Cycle: Quarterly **Analysis Data Cycle:** Quarterly
Start date: 3/20/2019 **End date (projected):** 6/30/2019
Data:





Summary of Findings/Learnings:
During 6 of the last 8 quarters (3rd quarter 16-17 to 2nd quarter 18-19), Vaya fell below the state benchmark of 75% for Non-Medicaid Routine calls requesting services who received a service within 14 days. During all 8 quarters:

- Non-Medicaid Routine Calls receiving a timely service quarterly averaged as 68%.
- 24% (287/1175) of all the routine calls were from Prison Social workers.
- 27% (80/287) of those attended their appointment.
- All other routine calls attend appointments 80% of the time.

During those 6 quarters where Vaya fell below state requirements:

- Non-Medicaid Routine Calls receiving a timely service quarterly averaged as 64%
- 30% (255/860) of all the routine calls were from Prison Social workers
- 27% (69/255) of those attended their appointment.
- All the other routine calls attend appointments 80% of the time.

During the 2 quarters that Vaya achieved the benchmark, the number of prisoner releases were less than half of other quarters. On average there are 35 calls a month regarding prison releases. In these two quarters there were 15 and 17 respectively.

Recommendations/Next Steps:
Determine and develop interventions to address root cause(s) for released prisoners not attending their appointments.
Measure Owner: Karla Mensah, MBA, CCCM Sr. Director of Member Services
Associated with any other QIAs or measure: Access to Care Report

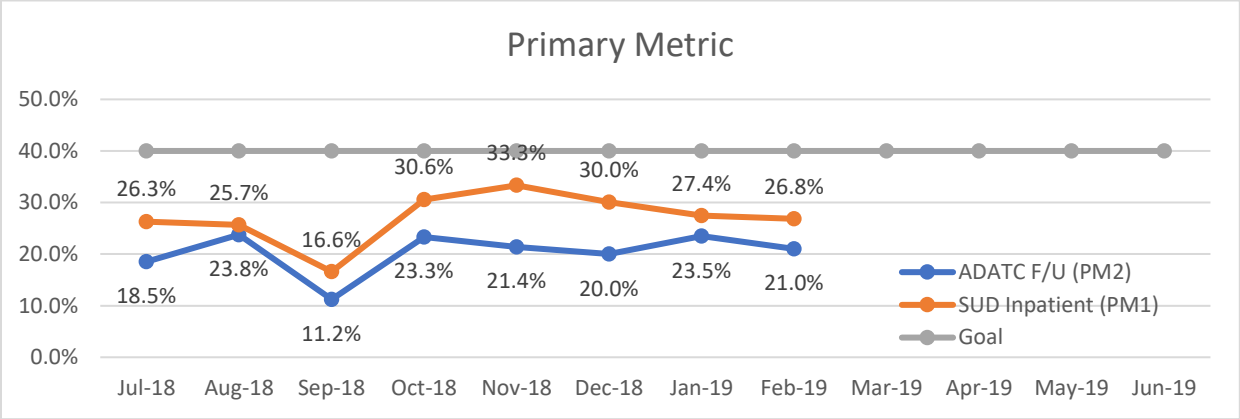
Activity #2
Activity Title: Increase Follow up Rate after ADATC Discharge
Objective: Safety of Clinical Care
Measure (Quantifiable):

- Primary Metric 1: For all non-Medicaid discharges from substance use inpatient services, increase the 1-7 day follow-up rate from 30% to 40%.
- Primary Metric 2: For all non-Medicaid discharges from ADATC, increase the 1-7 day follow-up rate from 20% to 40%.
- Predictive Variable 1: For those discharged from ADATC and enrolled in the ADATC VIP program, increase the follow-up after discharge rate from 20% to 50% by June 30, 2019.
- Predictive Variable 2: For those discharged and opted-in for Care Coordination, increase the follow-up after discharge rate from 20% to 50% by June 30, 2019.

Data Source: Inpatient and Outpatient Claims, Call Logs, Care Coordination Electronic Health Record
Collection Data Cycle: Monthly **Analysis Data Cycle:** Monthly
Start date: 2/4/2019 **End date (projected):** 6/30/2019
Data:

PM 1	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
SUD Discharges	232	230	217	229	237	203	215	220
Follow ups	61	59	36	70	79	61	59	59
Rate	26.3%	25.7%	16.6%	30.6%	33.3%	30.0%	27.4%	26.8%

PM 2	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
ADATC Discharges	108	101	98	103	117	90	98	100
Follow ups	20	24	11	24	25	18	23	21
Rate	18.5%	23.8%	11.2%	23.3%	21.4%	20.0%	23.5%	21.0%

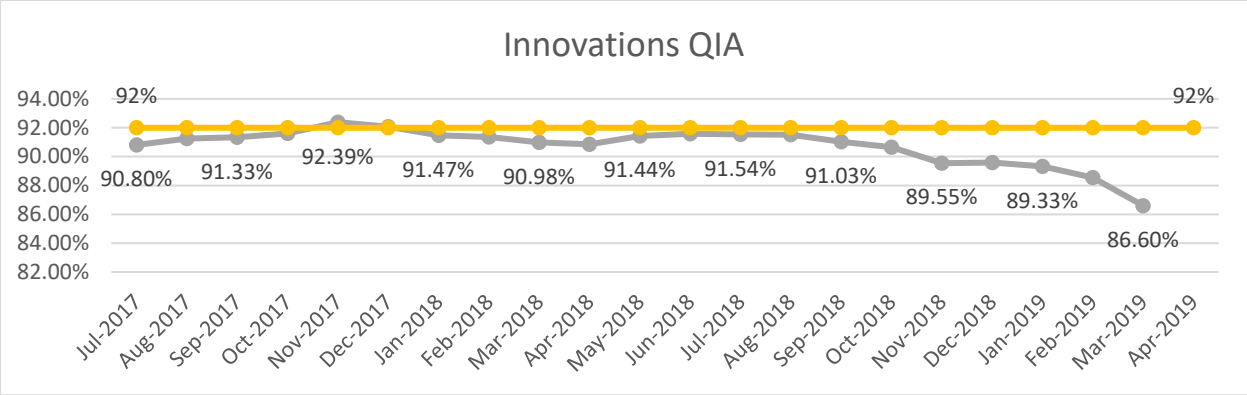


Summary of Findings/Learnings:
Most of the state-funded SUD discharges that make up the Primary Metric 1 are being discharged from ADATC. Of those being discharged from ADATC roughly 20% have a follow up within the allotted time frame. Interventions designed to improve this rate in other populations do not seem to have the same effect on state-funded SUD discharges. This QIA was developed specifically for this population to meet their needs. The ADATC VIP program focuses on person centered appointments and social determinants.
Recommendations/Next Steps:
Continue to review and monitor the process and make any adjustments or changes as needed. Monitor the progress and outcomes of the intervention to ensure progress.
Measure Owner: Donald Reuss, Sr. Director Provider Network, MS, NCC
Associated with any other QIAs or measure: 1-7 day follow up

Activity #3
Activity Title: Innovations Members receiving an Annual Primary Care Service
Objective: Access and Availability of Care
Measure (Quantifiable):

- Primary Metric: Increase the rate of Innovations Members receiving an annual Primary Care service to 92% by June 30, 2019. The Super Measure (Medicaid Only) is a subset of this QIP.

Data Source: Behavioral Health Claims and Medical Claims
Collection Data Cycle: Monthly **Analysis Data Cycle:** Monthly
Start date: 9/19/2018 **End date (projected):** 1/1/2020
Data:



Summary of Findings/Learnings:

Intervention

a. Intervention #1: Added Care Coordination tasks to the administrative health record.
    i. Connect member to primary care.
    ii. Schedule primary care appointment.
    iii. Document outcomes of the primary care appointment.
b. Intervention #2: Develop and distribute educational material to members, family, behavioral health providers and primary care providers.
    i. Materials have been created and are awaiting final internal approval for dissemination.
    ii. Upon approval, materials will be distributed to the appropriate audience.
c. Intervention #3: Improve the task completion rate in the administrative health record for the following tasks (intervention is in discovery).
    i. Connect member to primary care.
    ii. Schedule primary care appointment.

Recommendations/Next Steps:

- Upon approval of the educational material (Intervention #2), distribute the material to the appropriate audience.
- Continue to develop the measure and implement interventions targeting the task completion rates.

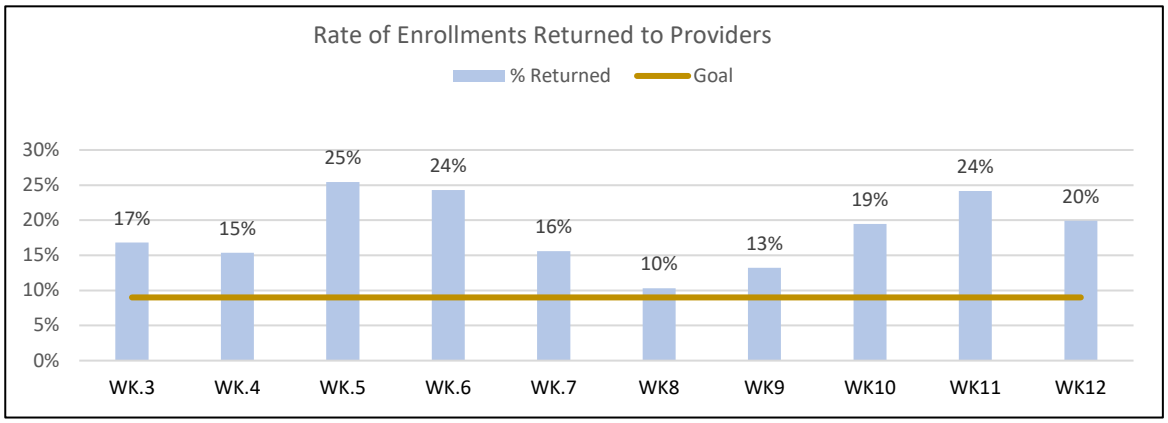
Measure Owner: Sara Wilson, Sr. Director of Care Coordination, LCSW
Associated with any other QIAs or measure: Innovations Annual Primary Care Super Measure

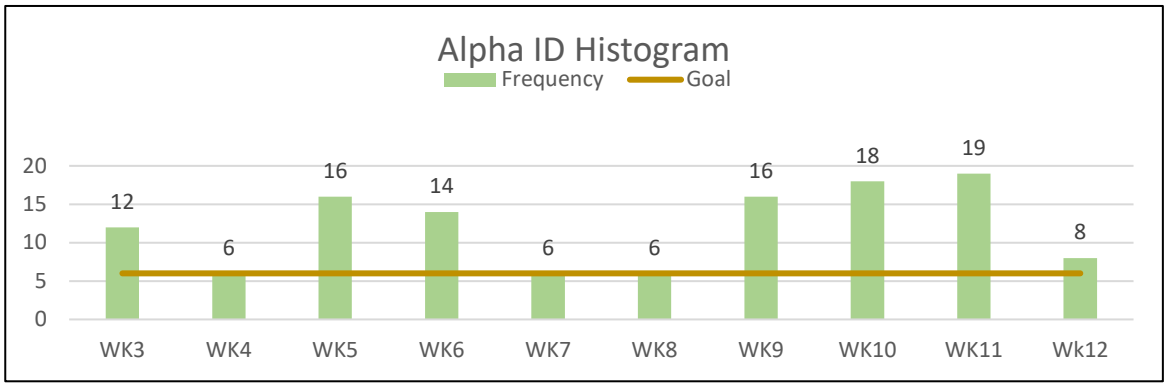
Activity #4
Activity Title: Reduce Rate of Enrollments Returned to Providers
Objective: Safety of Clinical Care
Measure (Quantifiable):

- Primary Metric: (Numerator) Number of enrollments returned to providers / (Denominator) Total number of enrollments submitted
- Predictive Variable: # returns to provider because of Alpha Issues

Data Source: Enrollment Specialists data collection
Collection Data Cycle: Daily **Analysis Data Cycle:** Weekly
Start date: 12/11/2018 **End date (projected):** 6/3/2019

Data:





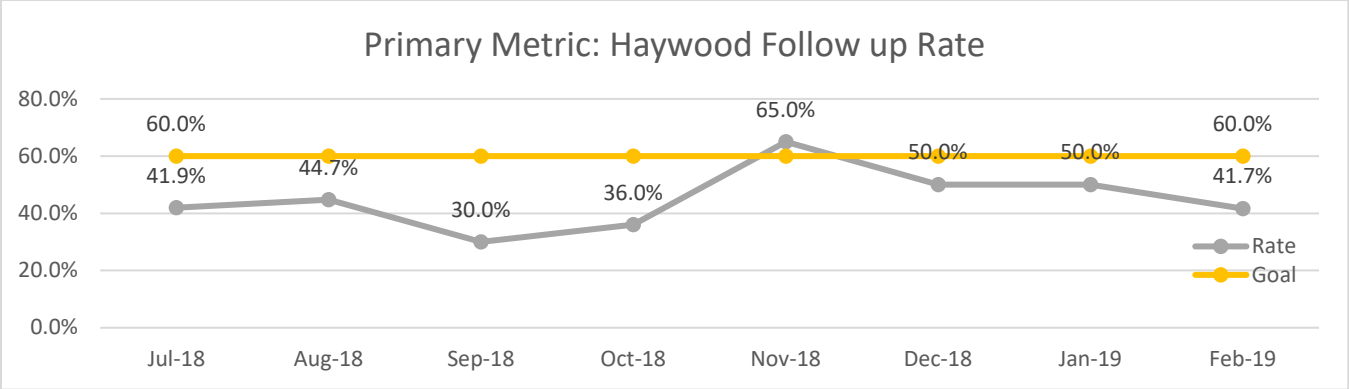
Summary of Findings/Learnings:
Of all returns to providers, 26% are due to Alpha ID issues. Issues with the member's name make up 55% of all the Alpha issues. Gathering Voice of the Customer from the providers revealed that if they had the capability of searching Alpha by the social security number, most if not all issues would be resolved.
Recommendations/Next Steps:
Research feasibility and legality of request to vendor (WellSky) for change in Alpha so that the provider can search via social security number.
Measure Owner: Lynnyona Evans, Sr Director Claims & Reimbursement, BS
Associated with any other QIAs or measure: N/A

Activity #5
Activity Title: Increase Follow-Up Rate After Haywood Discharge (Pilot)
Objective: Safety of Clinical Care
Measure (Quantifiable):

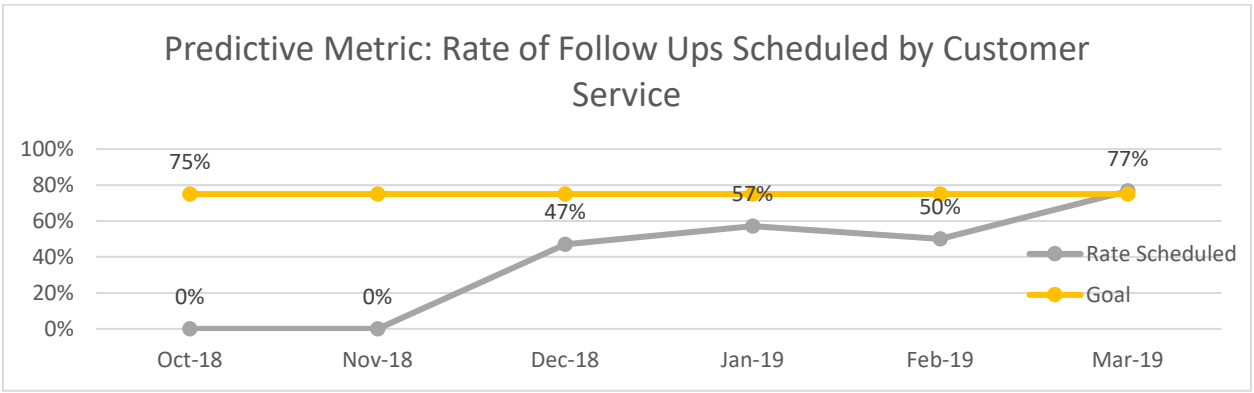
- Primary Metric: Increase the 1-7-day follow-up after discharge rate for Haywood from an average of 51% to 60% by August 31, 2019.
- Predictive Variable: Increase the rate in which Haywood schedules a follow-up after discharge appointments through Member Services from 10% to 75% by June 30, 2019.

Data Source: Inpatient and Outpatient Claims, Call Log
Collection Data Cycle: Monthly **Analysis Data Cycle:** Monthly
Start date: 8/6/2018 **End date (projected):** 8/31/2019
Data:

QM Program Evaluation



Overall	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Discharges	31	38	20	25	20	24	24	24
F/U	13	17	6	9	13	12	12	10
Rate	41.9%	44.7%	30.0%	36.0%	65.0%	50.0%	50.0%	41.7%
Goal	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%



	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Scheduled	0	0	8	16	16	23
Discharges	22	20	17	28	32	30
Rate Scheduled	0%	0%	47%	57%	50%	77%
Goal	75%	75%	75%	75%	75%	75%

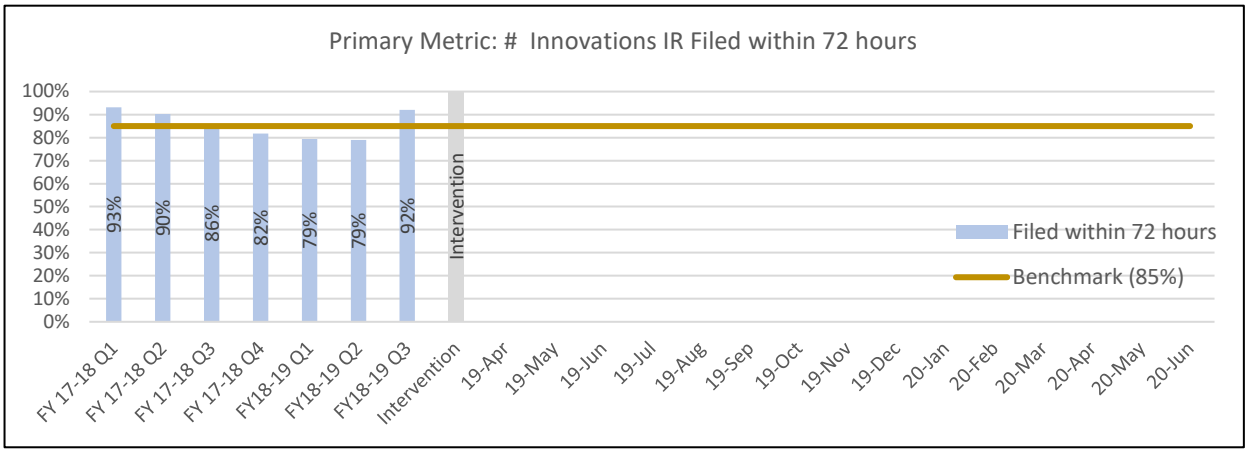
Summary of Findings/Learnings:
When appointments are scheduled through Member Services, reminder calls can be provided to members, and if appointments are not made it is easier to reschedule those appointments in a timely manner. Member Services can also assist with removing barriers or obstacles or connecting the member to resources that may prevent the member from attending the appointment.
Recommendations/Next Steps:
Continue to monitor the progress and outcomes of the intervention.
Measure Owner: Karla Mensah, MBA, CCCM Sr. Director of Member Services
Associated with any other QIAs or measure: 1-7 day follow up after discharge

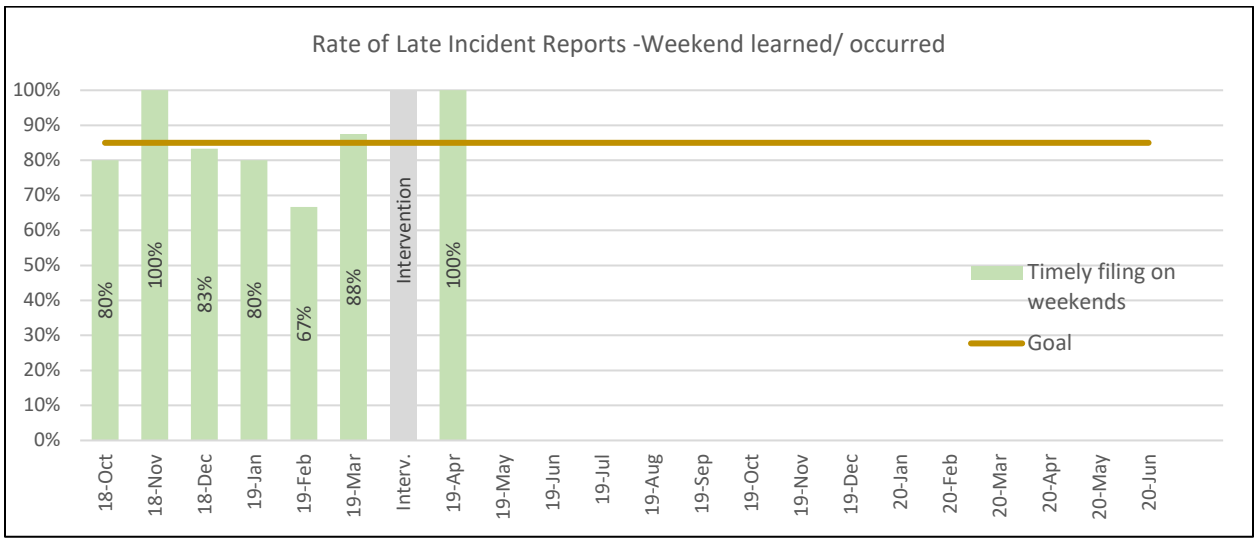
Activity #6

Activity Title: Increase Rate of Innovations Incident Report Timely Filing
Objective: Safety of Clinical Care
Measure (Quantifiable):

- Primary Metric: Increase the rate of Innovations Incident Reports filed within 72 hours from 83% to 85%.
- Predictive Variable: Increase the rate of filed Innovations Incident Reports involving incidents that occur on the weekend from to 83% to 85%.

Data Source: IRIS
Primary Metric Collection Data Cycle: Monthly
Primary Metric: Analysis Data Cycle: Quarterly
Predictive Metric: Collection Data Cycle: Weekly
Predictive Metric: Analysis Data Cycle: Monthly
Start date: 2/4/2019
End date (projected): 10/1/2019
Data:





Summary of Findings/Learnings:
Most of the late filings are from incidents that occur on the weekends. It was determined that a QIA conducted in 2018 was successful in raising the rate of on-time submittals but was not formally documented and

standardized. A new process that outlines clearly defined expectations is being developed, implemented and disseminated to Incident Report Specialists and contracted providers.

Recommendations/Next Steps:

Conduct Voice of the Customer to find out why incident reports are filed late when they occur on the weekend.

Measure Owner: Stephanie Hilbert, IRT Supervisor, MBA, QP

Associated with any other QIAs or measure: N/A

Activity #7

Activity Title: Decrease Number of New and Resubmitted Incident Reports in Queue

Objective: Safety of Clinical Care

Measure (Quantifiable):

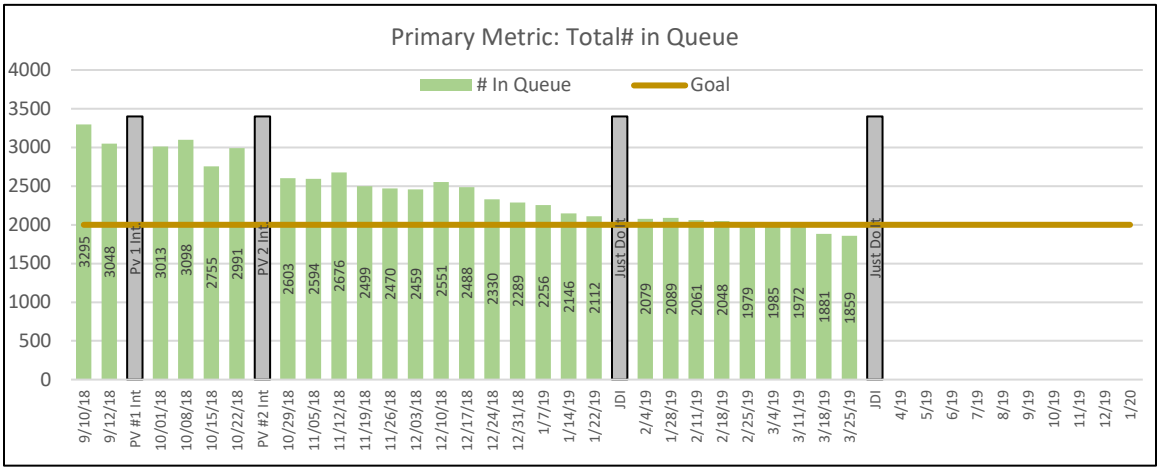
- Primary Metric: Decrease the total number of Incident Reports in Que from 3295 to less than 2000
- Predictive Variable: Reduce the number of New and Resubmitted Incident Reports in Queue from 1259 to less than 300

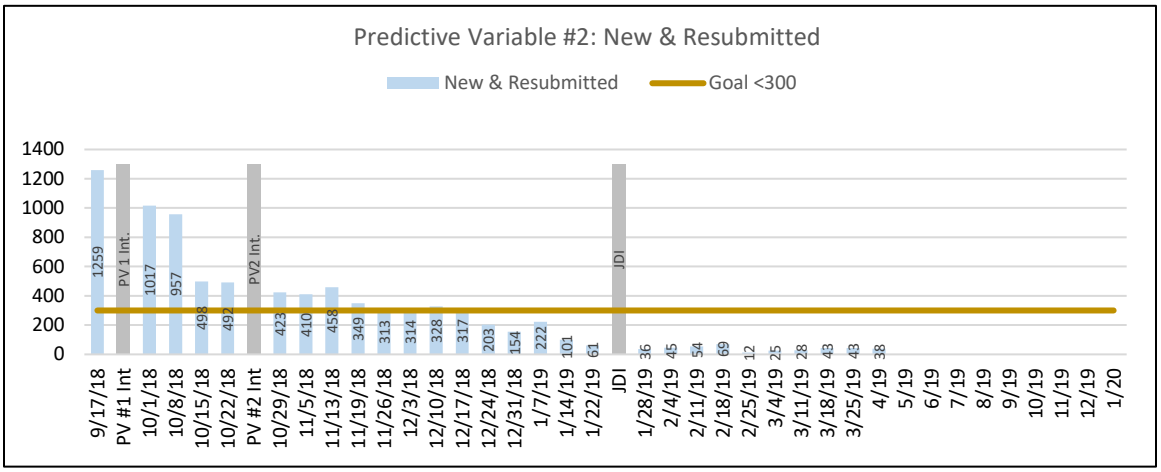
Data Source: IRIS

Collection Data Cycle: Weekly **Analysis Data Cycle:** Weekly

Start date: 8/6/2018 **End date (projected):** 3/1/2019

Data:





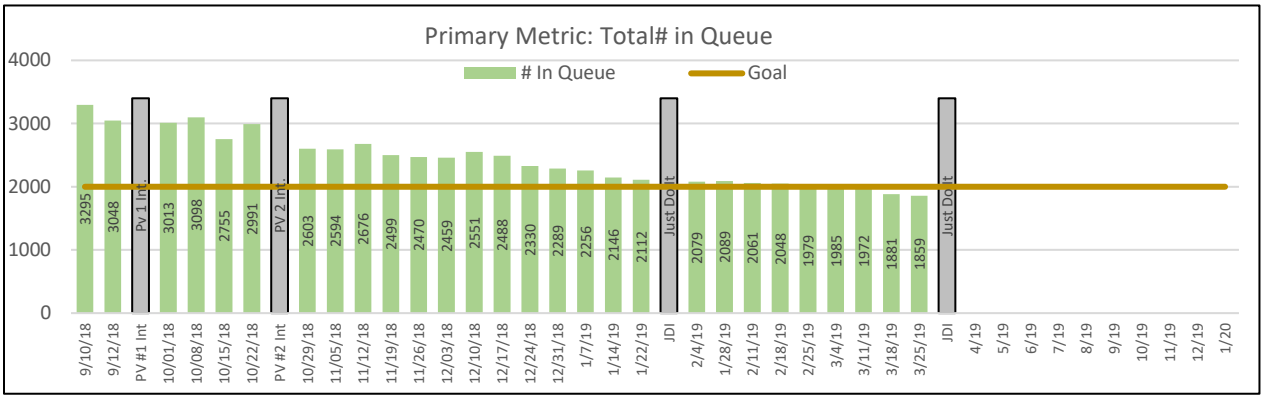
Summary of Findings/Learnings:
The Incident Report Team needed to develop and implement a clear process for managing and scheduling the daily work of Incident Report Specialists. Implementing a process for managing and scheduling work defined expectations and provided structure to their daily work thus increasing efficiency.
Recommendations/Next Steps:
Monitor number of new and resubmitted incidents in queue for 12 months to ensure sustaining improvement
Measure Owner: Stephanie Hilbert, IRT Supervisor, MBA, QP
Associated with any other QIAs or measure: Affects "Increase Number of Incident Reports Reviewed Per Week"

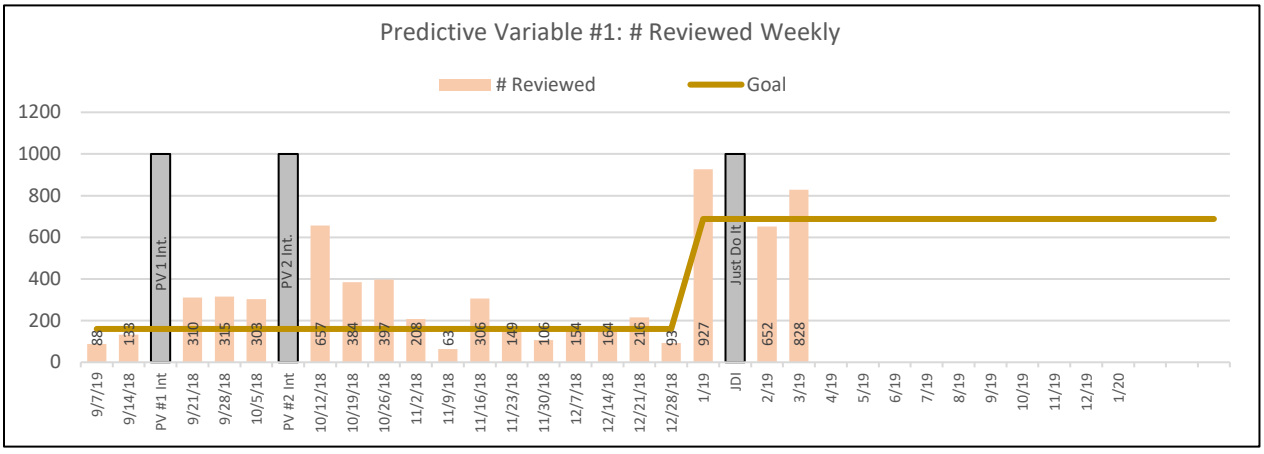
Activity #8

Activity Title: Increase Number of Incident Reports Reviewed Per Week
Objective: Safety of Clinical Care
Measure (Quantifiable):

- Primary Metric: Decrease the total number of Incident Reports in Queue from 3295 to less than 2000
- Predictive Variable: Increase the number of incident Reports reviewed per week from 110 to 160 (688/per month).

Data Source: IRIS
Primary Metric Collection Data Cycle: Weekly **Primary Metric Analysis Data Cycle:** Weekly
Predictive Metric Collection Data Cycle: Daily **Predictive Metric Analysis Data Cycle:** Weekly
Start date: 8/6/2018 **End date (projected):** 3/1/2019
Data:





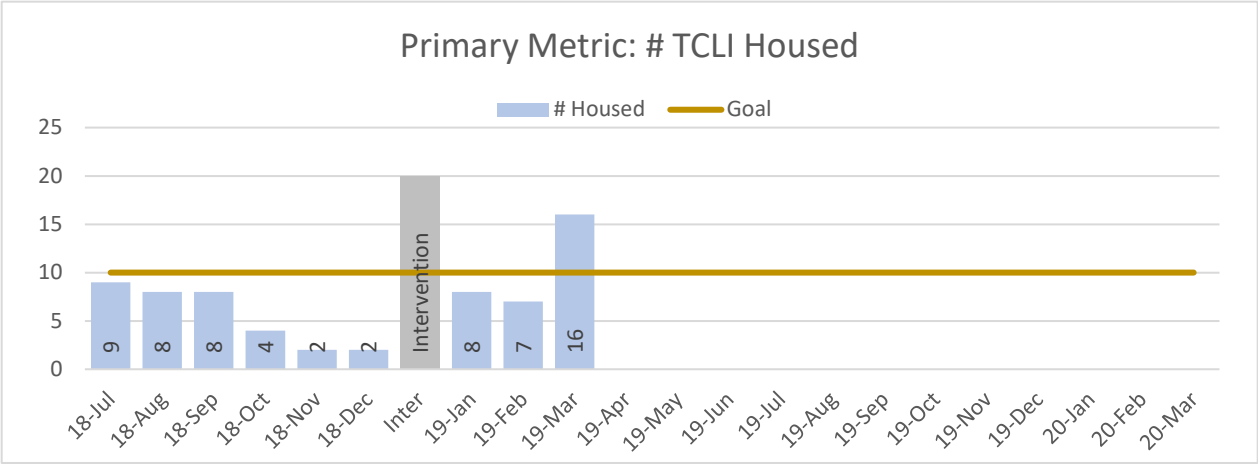
Summary of Findings/Learnings:
There was a duplicative step in the process that was unnecessary. Reducing this step enabled the Incident Report Specialists to be able to review more reports per week.
Recommendations/Next Steps:
Monitor productivity for 12 months to ensure sustaining of improvement
Measure Owner: Stephanie Hilbert, IRT Supervisor, MBA, QP
Associated with any other QIAs or measure: Affects QIA "Decrease Number of New & Resubmitted in Queue"

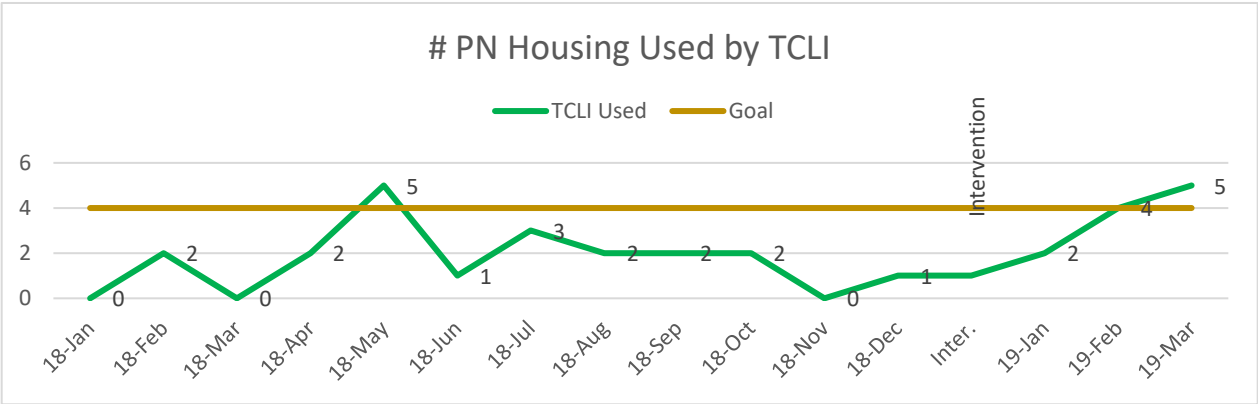
Activity #9

Activity Title: Increase PN Housing Used By TCLI
Objective: Safety of Clinical Care
Measure (Quantifiable):

- Primary Metric: Increase the number of members housed through TCLI Housed per month from 8 to 10
- Predictive Variable: Increase the number PN Housing Units Used by TCLI per month from 2 to 4

Data Source: TCLI Database, CLIVe Housing Report & Housing Supports, TCLI Reports
Collection Data Cycle: Monthly **Analysis Data Cycle:** Monthly
Start date: 10/19/2018 **End date (projected):** 6/30/2019
Data:





Summary of Findings/Learnings:
There was a lack of an effective way to manage the housing inventory and clearly identify the needs of the members. Creating a process that included a centrally located inventory spreadsheet has improved

communication and clearly defined the needs of both departments. This has enabled housing to find more viable housing and TCLI to be able to place more members.

Recommendations/Next Steps:

Monitor progress and keep increasing goal so that TCLI is using more and more of the units supplied by PN Housing

Measure Owner: Kelsie Clark, TCLI Manager, MA, QP

Associated with any other QIAs or measure: No

B. Closed QIAs:

Closed Activity #1

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

Objective: Safety of Clinical Care

Measure (Quantifiable):

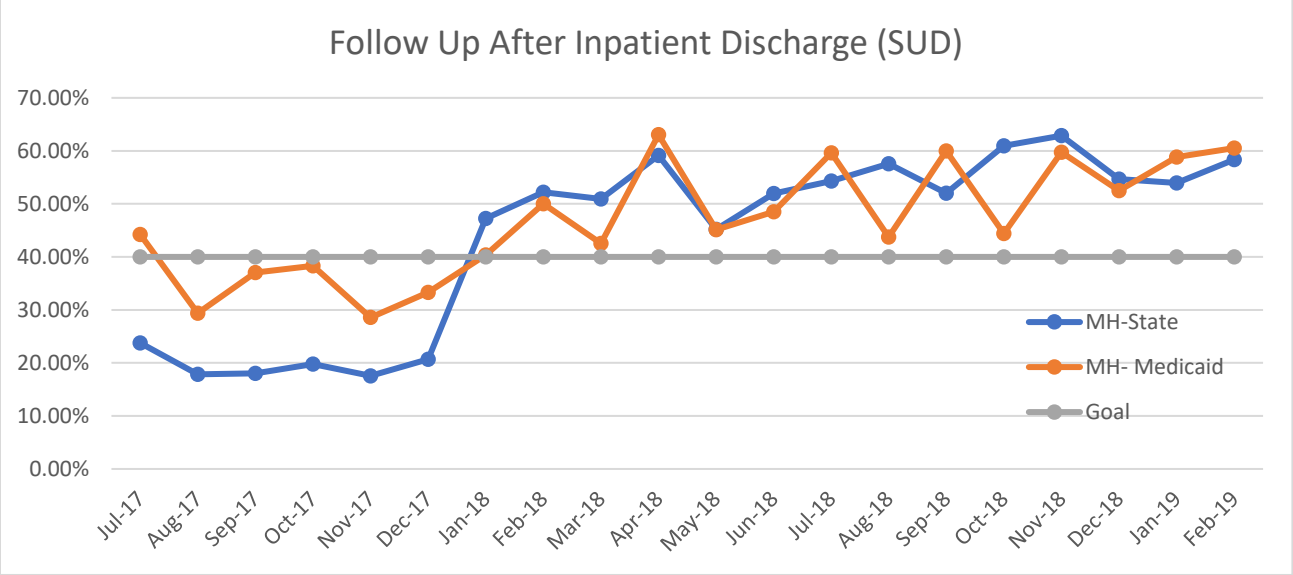
- Increase the rate of Medicaid and state-funded members who are seen by an outpatient provider within 0-7 days of discharge from an inpatient substance use facility to above 40%.

Data Source: Inpatient and Outpatient Claims

Collection Data Cycle: Monthly **Analysis Data:** Cycle Monthly

Start date: 9/20/2017 **End date:** 11/28/2018

Data:



Summary of Findings/Learnings:

- Vaya was able to sustain the 40% benchmark consistently for both funding sources since January 2018. The downward trend in the most recent months is due to the claims lag. Those rates will continue to rise as claims are filed by providers.
- The data presented is from Vaya's claims system and not from NC Tracks. Although this measure mimics the Super Measure, it is not the state's data and does not determine if Vaya meets the state benchmark.

Recommendations:

- This QIP focuses on services that occur between the day of discharge (day 0) and the 7 days following the discharge. The goal of the QIP is to ensure members receive a qualifying service during that time to promote engagement in treatment.

- In October 2018 the State changed the definition of this measure to only count services that occur within day 1-7 after discharge, meaning services on the day of discharge (day 0) no longer count towards the benchmark. The interventions for this project focused on the day of discharge which aligns with best practice.
- Due to the sustained performance above the benchmark and the change in the state definition of this measure, QM recommends closing this QIP and investigating the possibility of a new project that aligns with the new state definition.

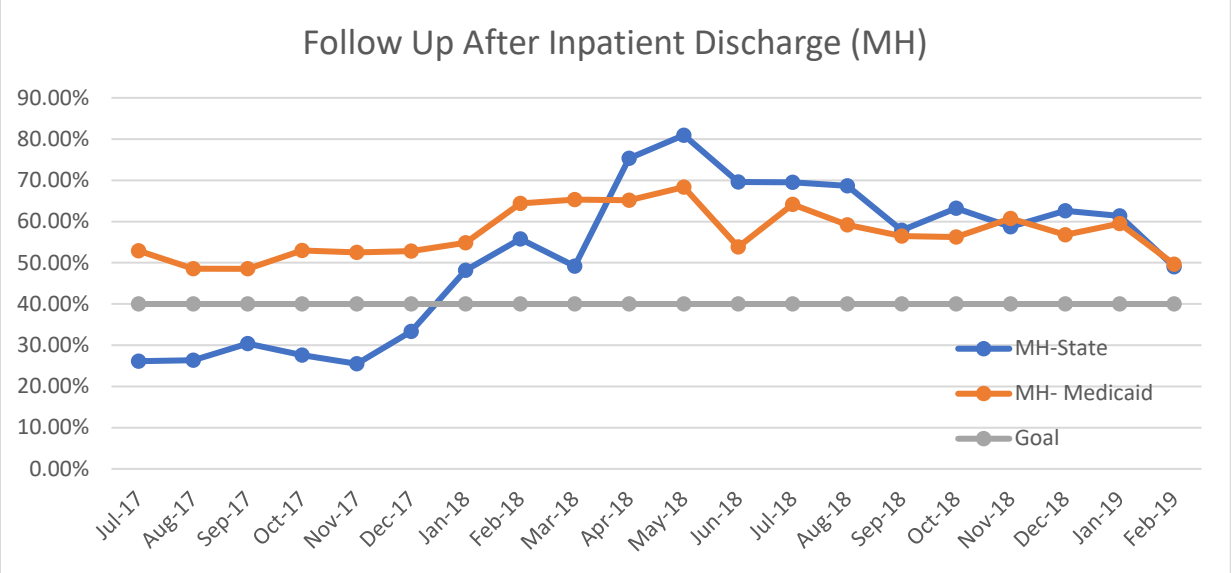
Measure Owner: Steven Kozicki, MS, ASQ-CMQ/OE - Quality Improvement Manager
Associated with any other QIAs or measure:

- 0-7 day Follow up After MH Discharge
- 1-7 day Follow up After MH Discharge
- 1-7 day Follow up After SUD Discharge

Closed Activity #2
Activity Title: Follow-Up After Discharge from Inpatient Mental Health
Objective: Safety of Clinical Care
Measure (Quantifiable):

- Increase the rate of Medicaid and state-funded members are seen by an outpatient provider within 0-7 days of discharge from an inpatient Mental Health facility to above 40%.

Data Source: Inpatient and Outpatient Claims
Collection Data Cycle: Monthly **Analysis Data Cycle:** Monthly
Start date: 9/20/2017 **End date:** 11/28/2018
Data:



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Measure Owner: Steven Kozicki, MS, ASQ-CMQ/OE - Quality Improvement Manager

Associated with any other QIAs or measure:

- 0-7 day Follow up After MH Discharge
- 1-7 day Follow up After MH Discharge
- 1-7 day Follow up After SUD Discharge

Closed Activity #3

Activity Title: Inpatient Rapid Readmission

Objective: Quality of Clinical Care

Measure (Quantifiable):

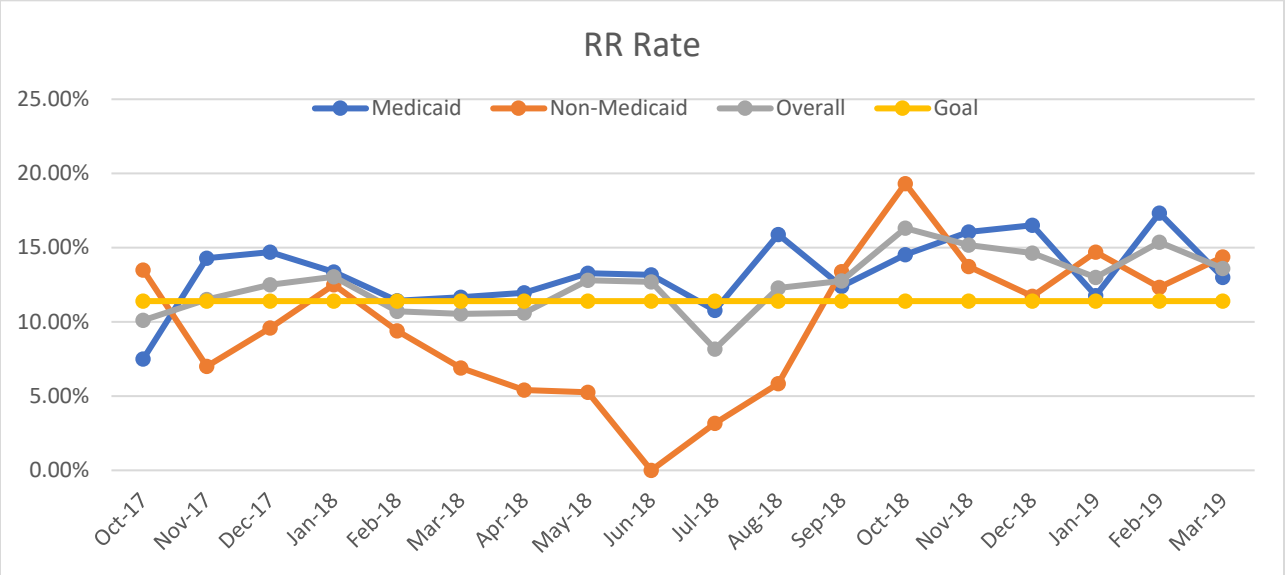
- Increase the rate of members discharged from a Community Psychiatric Inpatient service and subsequently readmitted to a Community Psychiatric Inpatient service within 30 days to be at or below 11.4%

Data Source: Inpatient Claims

Collection Data Cycle: Monthly **Analysis Data Cycle:** Monthly

Start date: 9/20/2017 **End date:** 1/23/2019

Data:



% of MH/SUD Admissions that were Readmissions within 30 days (Overall)				
Month	Medicaid	Non-Medicaid	Overall	Goal
Oct-17	7.50%	13.50%	10.10%	11.40%
Nov-17	14.30%	7.00%	11.50%	11.40%
Dec-17	14.70%	9.60%	12.50%	11.40%
Jan-18	13.37%	12.50%	13.04%	11.40%
Feb-18	11.42%	9.40%	10.71%	11.40%
Mar-18	11.66%	6.90%	10.54%	11.40%
Apr-18	11.97%	5.41%	10.61%	11.40%
May-18	13.27%	5.26%	12.80%	11.40%
Jun-18	13.17%	0.00%	12.70%	11.40%
Jul-18	10.79%	3.17%	8.17%	11.40%
Aug-18	15.88%	5.84%	12.30%	11.40%
Sep-18	12.40%	13.38%	12.76%	11.40%
Oct-18	14.53%	19.32%	16.31%	11.40%
Nov-18	16.06%	13.73%	15.17%	11.40%
Dec-18	16.52%	11.72%	14.63%	11.40%
Jan-19	11.76%	14.71%	12.99%	11.40%
Feb-19	17.33%	12.33%	15.36%	11.40%
Mar-19	13.00%	14.37%	13.60%	11.40%

Summary of Findings/Learnings:
The Rapid Readmission (RR) Workgroup identified many areas for process improvement but struggled to identify interventions that were measurable and specifically correlated with impacting the RR rate primary metric. Challenges included identifying and defining the problem(s), identifying the difference between interventions and process improvement strategies, and identifying the members who are likely to readmit so as to intervene and mitigate the readmission event. The most significant lesson learned is when identifying possible interventions, staff must understand and specify how the intervention will impact the primary metric AND how Vaya will measure the effectiveness. *Note: In October 2017, Vaya adopted new complex care management platform. This was a complicating factor regarding data collection as the data source and data reporting for all previous CC activities was designed in the previous Alpha system.*

Recommendations/Next Steps:
There were a variety of internal subgroups at Vaya working on the issues of high rates of inpatient and ED admissions, Rapid Readmission and Follow up after Discharge Super Measures. Due to concerns about duplication of work and lack of alignment across these efforts, ELT recommended discontinuing subgroups and establishing a new workgroup with ELT and Sr. Director level leadership to define, prioritize and plan ongoing efforts more clearly. Vaya will continue current Care Transitions daily practices including patient education techniques, ensuring information exchange between inpatient facility and outpatient provider and medical practice, enhancing member and team's crisis plan utilization, warm hand off to community care coordinator and Peer Bridger model interventions. Population Health and MIS continue to work on ability to monitor current operations and their effectiveness as delivered. Additional root cause analysis will be conducted in the new workgroup to determine additional micro and system level potential interventions, such as value based

contracting and collaboration with hospital systems and outpatient providers. The RR Workgroup recommends closing the current project due to lack of progress but with lessons learned.
Measure Owner: Sara Wilson, Sr. Director of Care Coordination, LCSW

Section 5: Quality Improvement "Just Do Its"

One key learning that was repeatedly reinforced is that not all gaps – or solutions – are the same. Some quality gaps have a clear and obvious cause that are easily addressed. Other gaps are more systematic with causes that are more ambiguous. Quality gaps with complex and unclear causes require a more systematic, rigorous, and resource intensive approach. To increase the number of small improvements, and avoid taxing resources unnecessarily, Vaya created "Just Do It" activities for situations where the solution/intervention is clear and specific, requiring limited assessment and few resources. The current inflight Just Do It consists of:

1. Decrease processing time for out-of-state and out-of-catchment incident reports

Section 6: Influencing Network Wide Safe Clinical Practices

Peer Review

Vaya's Utilization Management Department conducts Peer-to-Peer discussions with providers as a tool in determining the medical necessity of service authorization requests. These discussions include the review of Service Definitions, Clinical Practice Guidelines, and individuals' clinical information to identify safe and effective treatments. This process involves education and coaching of network providers to help them make clinically effective treatment decisions for Vaya members.

Provider Monitoring

Vaya's Network Performance and Integrity (NPI) Department conducts continuous and ongoing monitoring of the provider network to ensure services are provided as required and promote member safety. Monitoring come in two forms, routine and targeted. NPI also conducts all complaint investigations against providers. Investigations could encompass allegations of fraud, member safety, or service delivery concerns. This year, NPI began taking a longitudinal look into investigations results to better determine trends and patterns of providers to ensure services are provided in a safe and effective manner.

Assertive Community Treatment (ACT) Learning Community

Beginning in December 2018, ACT teams began conducting an ongoing Learning Community with Vaya's Provider Network Operations Department. The purpose of this collaborative learning forum is to identify issues critical to member care and engage efforts to improve that care. Since December 2018 the ACT Learning Community has been examining ED visit and inpatient admission data. This data represents the outcomes ACT teams are intended to impact. Several efforts were initiated to address problems highlighted by this data:

Effort #1: Divert members in crisis from the ED to Facility Based Crisis centers. This is being accomplished by FBC communicating bed availability to ACT team leads.

Effort #2: Follow-up after inpatient discharge. ACT teams are working to connect with members immediately after an inpatient discharge to ensure member reengagement in treatment and adherence to the crisis plan.

Effort #3: ACT teams are reinforcing education with members concerning crisis resources available for use prior to an ED visit

The ACT Learning Community has also been examining the separation rates of TCLI participants to identify reasons and potential associated efforts to prevent separations.

Psychiatric Residential Treatment Facilities (PRTFs)
Beginning in April 2019, various Vaya providers serving children began working with the PNO and UM Departments to brainstorm reasons some children have long length of stays in PRTFs. Although these efforts are in their infancy, these brainstormed reasons will then initiate problem solving efforts focused at decreasing length of stay at PRTF.

Section 7: QM Program Learning and Continuous Improvements

Learning and improvement is continuous and daily in Vaya's QM program. These range from small, immediate "tweaks" to systematic changes that require more time and effort. Below are current learnings associated will key QM program areas, along with potential recommendations.

Program Resources
We continually evaluate and test methods and strategies to use QM resources and subject matter experts more effectively. One strategy that has produced success is creating more self-sufficiency in people resources. This involves providing the right people with quality improvement knowledge and skill at its "point us use" – when the knowledge and skill is needed. We anticipate this will facilitate staff adopting some practical QM skills. To accomplish this Vaya created a series of user-friendly job aids to facilitate improvement work. We will continue to evaluate and test methods and strategies to use QM resources more effectively.

Structural Change
In July 2018 QIC was restructured into an Internal QIC (I-QIC) and Organizational QIC (O-QIC). This new structure has shown benefit in better managing many details of QIAs. It also provided Vaya QM staff the opportunity to work more closely with Vaya leaders and project owners/leads to mature our quality work. We will continue to not only evaluate potential structural changes but also define tactics to best leverage our current structure.

QIC Structure
Two key learnings arose in terms of leveraging the current QIC structure. One is the need to effectively integrate the various processes that comprise the QM program. QIC is a critical component in these processes and needs to be well-integrated into the program with well-designed roles/responsibilities and support tools. This entails tactics such as:

1. Focusing all components of the program on a common goal.
2. Clearly defining handoffs that optimize achievement of this common goal.

Second is clearly defining critical decisions points along the well-documented process. This includes proactively defining the decisions that need to be made. This was accomplished with routine tollgate or Success Criterion.

Practitioner/ Provider Participation
Practitioner/ provider participation in QIC has always been consistent. However, we have two opportunities to ensure their input generates greater value to the Vaya QM program. One is practitioner input during QIC. We continue to encourage this by clearly defining key elements of the QIAs that relate to providers such as member and provider impact, and then actively seeking their input about these elements. Second is partnering with providers for specific QIAs. With Medicaid Transformation, this cross-organizational partnership is becoming more critical. Over the past year we have successfully partnered with providers on the 7 Day Follow-up QIA, but we need to continuing working across organizational boundaries and involve providers with:

1. Problem Assessment
2. Intervention Definition
3. Intervention Implementation

Leadership Involvement

Vaya initiated – and will continue – building the capability of internal leadership to achieve and maintain improvements in member quality and operational efficiencies. This involves ongoing and real-time learning by use of primers and ongoing actionable discussion along with the creation of support tools and material to guide efforts.