Passport Health Plan

The Passport Work Plan reflects ongoing progress of QI activities throughout the year. It captures the yearly planned activities and objectives for improving:
- Quality of clinical care.

Project Name	Standard	Key Objectives/Initiatives	Requirement/Planned Activity	Performance Target/Goal	Lead Staff	Reporting	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Committee Approval	Status (On Target, At Risk)	Barriers to Meeting Goal
							x Due; X Complete														
Quality Program Structure																					
2018 QI Program Evaluation Report (includes all indicators for the present year.)	**QI1B**	The Program Evaluation Report is written annually to evaluate the results of QI initiatives in measurable terms trended over time and compared with performance objectives as defined in the QI work plan.	Evaluation includes: • A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service • Trending of measures to assess performance in the quality and safety of clinical care and quality of safety • Analysis and evaluation of the overall effectiveness of the QI program, including progress toward influencing network-wide safe clinical practices	**For all goals not met:** • QI must conduct a root cause or barrier analysis to identify the underlying reasons. • Analysis must include organizational staff that has direct experience with the processes that have presented barriers to improvement. **Evaluation Summary must include and address:** • Overall effectiveness • Adequacy of resources • Committee structure • Practitioner participation • Leadership involvement • Determination of whether to restructure or change the program	Director of Quality	Annually					2019 Done										QMMC	On Target	Claims run out data
2019 Quartery QI Work Plan **Q1 Q2 Q3 Q4**	**QI1A; DMS Report 17**	The QI Work Plan reflects ongoing activities and progress on QI activities throughout the year. It addresses program structure, quality of service, quality of clinical care, patient safety, member service and communication, network adequacy and performance improvement. The work plan captures the timeframe and frequency of activities, responsible parties and monitoring of issues. To maintain visibility into the performance and trends of major programs across the organization.	**Work Plan must address:** • Yearly planned QI activities and objectives for improving: – Quality of clinical care. – Safety of clinical care. – Quality of service. – Members' experience. • Time frame for each activity's completion. • Staff members responsible for each activity. • Monitoring of previously identified issues. • Evaluation of the QI program Quarterly The departments: • Monitor Work Plan Requirements and report significant findings to Quality and QMMC • Annually, monitor Performance Improvement Measures (HEDIS) and develop interventions for identified barriers and opportunities • Quarterly, collect data and monitor Performance and Process Indicators for trends and significant findings. Report data and findings to Quality and QMMC • Develop Interventions to address barriers and opportunities to address Performance and Process Indicators.	**Quarterly and Annual Requirements** • All requirements must be met and reported to Quality S by the 22nd of the month following the end of the quarter • Participate in Work Plan Quality Meetings • Present significant findings to the Quality Medical Management Committee	Accreditation Manager; Business Owners	Monthly monitoring, Quarterly reporting	2019 Q1 Done			2019 Q2 Done			2019 Q3			2019 Q4			QMMC	On Target	
Quality Program Description - 2019 Scope - Due Dec 2019	**QI1A**	The QI Program Description will be annually reviewed and updated according to national and state standards and guidelines with an emphasis on the QI program scope, goals, objectives and structure. This document will clearly outline how the QI program is organized and how it uses its resources to meet program objectives. This will include functional areas and their responsibility and the reporting relationship between the QI Department and the Quality Committee (QC).	**Annually** **Program must include:** • Program Structure • BH aspects of the program • How patient safety is addressed • How designated physician is involved • How BH practitioner is involved • Oversight of QI functions by QC • Annual work plan • Objectives for serving a culturally and linguistically diverse membership • Objectives for serving members with complex health needs • Incorporate recommendations from the QI Program Evaluation	• All requirements must be met • Reviewed and updated annually • Submitted to the Quality Committee and Advisory Council	Accreditation Manager	Annually			x			x								QMMC	Complete	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V
10	**Quality Committee**	**QI2A**	Quality Committee acts and plans the organization-wide QI Program; Inclusion of participating physicians with geographic and specialty representation	Committee functions include: • Recommends policy decisions • Analyzes and evaluates the results of QI activities • Ensures practitioner participation in the QI program through planning, design, implementation or review • Identifies needed actions • Ensures follow-up, as needed	Objective: • Committee demonstrates activities and the participation of required members by presenting clear and accurate records of minutes	Director of Quality	Quarterly			x			x			x				x	QMMC		
11	**NCQA Accreditation**	**N/A**	Implement constant readiness model; Ensure compliance with NCQA standards	Submit to NCQA: • Documented Process and Materials at the beginning of the lookback period 6/1/2018 • Provide Reports during the lookback period: 6/1/-2018 - 6/1/2020 • Preform regular chart audits beginning Mar 2018 • Close all gaps identified in last survey prior to LBP	Objective: • Score annual mock audit at 45/50 • Improve on scores from 2017 survey	Accreditation Manager	Ongoing	x	x	x	x	x	x	x	x	x	x	x	x	QMMC		• New processes are needed • Updated analysis training required for all departments • Implementation of PHM model
12	**Quality of Service**																					
13	**2019 CAHPS (Consumer Assessment of Healthcare Providers and Systems) Survey - Member Satisfaction Annual Eval to QMAC Dec 2019**	**N/A**	The Plan annually requests members to provide feedback on their experience with healthcare. Feedback covers areas regarding their healthcare services and health plan experience.	Annual collection of CAHPS survey by vendor underway in 1st quarter.	• Improve member satisfaction survey results to meet and/or exceed the 2018 Quality Compass® 90th Percentile for Adult and Child surveys by 12/31/19. • Improve DMS annual ranking for member satisfaction by 2%.	Director of Quality	Annually					x								QMMC		
14	**Analysis of Member Experience - Member Satisfaction Annual Eval to QMAC Dec 2019**	**QI4C, D**	The Plan monitors member satisfaction with its services and identifies areas of potential improvement. To assess member satisfaction with its services, The Plan annually evaluates member complaint and appeals and CAHPS survey results.	Aggregate member complaints and appeals by reason, showing rates related to: • Quality of Care • Access • Attitude and Service • Billing and Financial Issues • Quality and Practitioner Office Site. • Billing and Financial Issues • CAHPS 2019	Goals: Evidence of monitoring includes: • Quarterly reporting from all departments to establish opportunities for improvement. • Root-cause analysis provided to identify opportunities for improvement. • Annual reporting to the QMMC	Member Services Manager/UM Director	Annually												x		QMAC		
15	**Member Service Telephone Accessibility Standards - Member Satisfaction Annual Eval to QMAC Dec 2019**	**QI4A**	The organization has standards for timely access to Member Services. Organizations typically set telephone standards for the percentage of members' complaints concerning access to Member Services.	• Collect member average speed of answer • Collect member abandonment rate	• Meet or exceed ASA of 30 seconds goal. • Meet or exceed AR of 5% goal. • Improve ASA to meet and/or exceed the 2018 Quality Compass® 90th Percentile by 12/31/19. • Process 95% of Level I inquiries within 48 hours • Process 95% of Level II inquiries within 21 days • Improve member satisfaction with customer service as measured via CAHPS to meet and/or exceed the 2018 Quality Compass® 90th Percentile by 12/31/2019	Member Services Director	Quarterly Monitoring Annual report				x		x			x			x	QMAC		
16	**Monitoring Satisfaction with the Utilization Management Process - Member Satisfaction Annual Eval to QMAC Dec 2019**	**QI4G**	The Plan continually assesses member and practitioner satisfaction with its Utilization Management process to identify areas in need of improvement.	Components of the process: • Collecting and analyzing data on member and practitioner satisfaction to identify improvement opportunities • Taking action designed to improve member and practitioner satisfaction based on assessment of the data	Goals: • Practitioners: 90% of the surveyed providers will indicate a high level of satisfaction with the UM program by answering each of the Provider UM Satisfaction questions from the Delegate. • Practitioners: Establish baseline data for satisfaction with the UM process through the Provider Satisfaction Survey (2019)	Director of Quality/Provider Relations Manager/UR RN Manager	Annually								x						QMMC		
17	**Monitoring Satisfaction with Complex Case Management**	**PHM5F**	Passport annually evaluates satisfaction with its complex case management services to identify opportunities to improve member satisfaction and measures effectiveness of the actions.	Satisfaction data is collected through the following methods: • Obtaining feedback from members • Analyzing member complaints	Goals: For activities delegated to an NCQA accredited CM organization - Certificate of accreditation may be presented in lieu of activities and goals.	Managing Director of Clinical Operations	Annually												x	QC		

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18	**Quality of Clinical Care**																					
19	**2019 Population Health Management Strategy Description**	**PHM1A**	The Population Health Management (PHM) Program Description will need to be in place until such time as Evolent Health is accredited for PHM.	**Annually** **Program must include:** • Four Focus Areas of Targeted Populations • Member Communication • Provider Support • Population Assessment Results • How members are informed about available PHM programs.	Annual Requirements • All requirements must be met • Reviewed and updated annually • Submitted to the Quality Committee and Advisory Council	Accreditation Manager	Annually							x						QMMC		
20	**Population Health Management Implementation**	**PHM2A** **PHM2B** **PHM2D** **PHM6A**	Incorporate analysis of data on social determinants of health into the annual population assessment Develop and implement a process to at least annually segment and stratify the entire enrolled population into subsets for targeted intervention based on their health needs	Activities for 2019 *2019 Population Health Management Strategy Description *Population Assessment - Incorporate social determinants of care (SDoH) Resource identification for SDC *Develop a plan and timeframe for completion of a comprehensive analysis of PHM strategy activities	Annual Requirements • All requirements must be met • Reviewed and updated annually • Submitted to the Quality Committee and Advisory Council	Accreditation Manager	Annually							x						QMMC		
21	**Complex Case Management: Assessment**	**PHM5C**	The Complex Case Management assessment provides services for its highest risk members with complex conditions and helps them access needed resources.	Assessment must consider and include the following: • Modify the case management assessment to reflect updated NCQA expectations for PHM 3D factors 3, 5, 6 and 10 • The Plan's covered population, not just members identified for complex case management	Goals: For activities delegated to an NCQA accredited CM organization - Certificate of accreditation may be presented in lieu of activities and goals. • Assesses the characteristics and needs of its member population and subpopulations • Reviews and updates its complex case management processes to address member needs, if necessary Reviews and updates its complex case agreement resources to address members, if necessary	Managing Director of Clinical Operations	Annually			x											QMMC		
22	**Monitor Activities related to EPSDT**	**DMS, Report #24**	Submit a report on activities, utilization and services	• Provide an overview of activities related to EPSDT, Pregnant Women, Maternal and Infant Death programs and trends noted in prenatal visit appropriateness, birth outcomes, including death, and program interventions • Describe activities of the EPSDT staff, including outreach, education, and case management. • Provide data on levels of compliance during the report period (including screening rates) with EPSDT regulations.	EPSDT Screening: 80%, participation 80% WCC - BMI 81% WCC-N 77% W15 83% W34 68% AWC 50% CIS - multiple TBD LSC 86% ADV 63% IMA-M 89% IMA-T 93% IMA-H 22% IMA-C1 87% IMA-C2 23%	Director of Quality	Quarterly Monitoring Annual report									x				QMMC		
23	**Monitor Activities related to Pregnant Women, Maternal and Infant Death**	**DMS, Report #24**	Prevention of unintended pregnancies to impact a decrease in Low Birth Weight (LBW), Very Low Birth Weight (VLBW), and Pre-Term Deliveries (PTD). Improve social determinants of care impacted by unintended pregnancies	• Provide an overview of activities related to EPSDT, Pregnant Women, Maternal and Infant Death programs and trends noted in prenatal visit appropriateness, birth outcomes, including death, and program interventions • Describe activities of the EPSDT staff, including outreach, education, and case management. • Provide data on levels of compliance during the report period (including screening rates) with EPSDT regulations.	Mommy Steps: Maintain Preterm Delivery rate more favorable than the Healthy People 2020 rate of 11.4% Maintain Low Birth Weight rate more favorable than the Healthy People 2020 rate of 7.8% Maintain Very Low Birth Weight rate more favorable than the Healthy People 2020 rate of 1.4% Increase the Use of Long Acting Reversible Contraceptives within 90 days post delivery	Maternity Care Program Manager	Quarterly Monitoring Annual report									x				QMMC		
24	**Adoption and Distribution of Clinical Practice and Preventive Health Guidelines**	**DMS, MED 2**	The Plan is accountable for adopting and disseminating clinical practice guidelines relevant to its members via the website for the provision of non-preventive acute and chronic medical services and for preventive and non- preventive behavioral health services. The Plan also disseminates guidelines for its practitioners. Guidelines are adopted from recognized sources or from involvement of board- certified practitioners from appropriate specialties	Clinical Practice and Preventive Health guidelines must be updated annually or when the following circumstances exist: • New scientific evidence or national standards are published prior to the annual review date • National guidelines change prior to the annual review date	Objective: Adoption and dissemination by: •Establishing the clinical/scientific basis for the guidelines •Updating the guidelines annually • Distributing guidelines to appropriate practitioners • Making guidelines available to members via the website	Assoc. Dir Medical and Utilization Policies	Annually												x	QMMC		

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25	**Performance Measurement of Clinical Practice and Preventive Health Guidelines**	**DMS**	The Plan annually measures performance against at least two important aspects of 6 clinical practice and preventive health guidelines to determine practitioner adherence and to improve the guidelines.	Annually The Plan must: • Address and measure two specific aspects of care covered in the guidelines. Must consider: • 2 CPGs for an acute or chronic medical condition • 2 CPGs for a behavioral health condition • 2 Preventive health guidelines • Relate performance to the clinical process of care found within the guidelines that are most likely to affect care.	• Data must be collected to determine practitioner adherence to adopted guidelines and improve practitioner performance. • Collection methodology must be sound enough to produce valid and reliable results that show areas or parts of the guidelines that are not being used. • Identify a process for monitoring CPGs through audits in 2019	QI RN	Annually												x	QMMC		
26	**2018 Utilization Management Program Evaluation**	**UM1**	The Utilization Management Program Evaluation is conducted annually to review activities from the prior year and measure performance on initiatives to support clinical excellence. A summary of these results is presented to the UMC & QC that covers overall program effectiveness, performance outcomes, improvement opportunities, and changes to the program.	Evaluation includes: • Completed and ongoing activities • Quantitative and Qualitative Analysis • Evaluation of effectiveness	For activities delegated to an NCQA accredited UM organization - Certificate of accreditation may be presented in lieu of activities and goals. • Committee discussion and input on program summary • Actions, if applicable • Committee approval of 2019 UM Program	Director of UM	Annually				x												
27	**2019 UM Program Description**	**UM1**	Utilization Management annually updates the UM PD. UM incorporates recommendations from the UM Program Evaluation	Program Description includes: - Program Structure - BH Aspects - Designated Sr Physician - BH practitioner - Scope and process used to determine benefit coverage and medical necessity - Sources used to determine benefit coverage and medical necessity	For activities delegated to an NCQA accredited CM organization - Certificate of accreditation may be presented in lieu of activities and goals. • All requirements must be met • Reviewed and updated annually • Submitted to the Quality Committee and Advisory Council	Director of UM	Annually							x									
28	**Evaluating Utilization Management Criteria**	**UM2A**	Utilization Management conducts an annual review of the UM criteria and the procedures for applying them, and updates the criteria when appropriate.	The Plan's UM Department has: • Written UM decision-making criteria that are objective and based on medical evidence • Has written policies for applying the criteria based on individual needs • Has written policies for applying the criteria based on an assessment of the local delivery system • Involves appropriate practitioners in developing, adopting and reviewing criteria	For activities delegated to an NCQA accredited CM organization - Certificate of accreditation may be presented in lieu of activities and goals. Objective: Criteria must consider at least the following when applying criteria to a given individual: • Age • Comorbidities • Complications • Progress of Treatment • Psychosocial situation • Home environment, when applicable	Director of UM	Annually										x						
29	**Monitoring Consistency of Applying UM Criteria (IRR)**	**UM 2C**	Utilization Management monitors and reviews the application of UM criteria to ensure consistency in applying criteria. If reports show there was an inconsistency, action is taken to improve the consistency of reviewer determinations.	The Plan's Utilization Management Department annually: • Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making • Acts on opportunities to improve consistency, if applicable	For activities delegated to an NCQA accredited CM organization - Certificate of accreditation may be presented in lieu of activities and goals. Goal: • 85% Accuracy Rate for Criteria Application	Director of UM	Quarterly			x			x			x			x		UMC, QC		
30	**Analyze UM Timeliness Decisions and Notifications**	**UM5G**	Analyze the timeliness of all UM decisions and notifications (both approvals and denials). Report data separately for each UM case type (urgent and non-urgent precertification, urgent concurrent and post-service) for non-behavioral, behavioral and pharmacy services	Monitor reports of timeliness of decisions and notifications	For activities delegated to an NCQA accredited CM organization - Certificate of accreditation may be presented in lieu of activities and goals.	Director of UM	Annually			x													
31	**Monitoring of Formulary and Pharmaceutical Management Procedures**	**UM11B UM11D**	Formulary and pharmaceutical management procedures are presented to the Pharmacy and Therapeutics Committee on an annual basis for review and discussion. Minutes from the P&T meeting are presented and reviewed at the QC on a bi-monthly basis. The review of the formulary and pharmaceutical management procedures is documented in the P&T minutes.	The Plan's Clinical Department annually: • Reviews the procedures • Reviews its list of pharmaceuticals • Updates the procedures and pharmaceuticals, as appropriate • Distribute formulary information to all existing practitioners and members (UM 11B).	For activities delegated to an NCQA accredited CM organization - Certificate of accreditation may be presented in lieu of activities and goals. Goal: • Must present and review all pharmaceutical management procedures annually to address areas for improvement	Pharmacy Director	Annually and updates, as needed												x		P&T (Delegate), QC review		

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32	**Continuity and Coordination of Medical Care**	**QI5**	Annual identification of opportunities to improve coordination of medical care by: • Monitor at least four aspects of continuity and coordination of care between medical care providers • Conducting qualitative and causal analysis of data to identify four improvement opportunities • Take action on three opportunities for improvement • Measure the effectiveness of at least three actions implemented to improve continuity and coordination of care between medical care providers	Procedure: • Identify four measures which monitor continuity and coordination of care for baseline year of 2017, set performance goal, identify potential barriers and opportunities for improvement. year one measurement cycle for 2019 • Implement three interventions in 2019. • Perform regular monitoring of interventions. • Measure effectiveness annually	Goals: • Performance goals to be set during baseline data analysis • All reporting and accreditation requirements met.	Clinical Operations Director	Annually											x			QC		
33	**Continuity and Coordination Between Medical Care and Behavioral Healthcare**	**QI6**	Annual identification of opportunities to improve coordination of medical and behavioral healthcare by: • Monitor the continuity and coordination of medical and behavioral health care, addressing all 6 requirements in this element. Analyze results and implement at least two actions to address opportunities for improvement • Measure the effectiveness of at least two actions implemented to improve continuity and coordination of care between medical and behavioral health care providers	Procedure: • Collect Data for following areas: 1. Exchange of information. 2. Appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care. 3. Appropriate use of psychotropic medications. 4. Management of treatment access and follow-up for members with coexisting medical and behavioral disorders. 5. Primary or secondary preventive behavioral healthcare program implementation. 6. Special needs of members with severe and persistent mental illness. • Perform analysis, identify and act on two opportunities	Goals: • Performance goals to be set during baseline data analysis • All reporting and accreditation requirements met.	Clinical Operations Director/Behavioral Health Director	Annually											x			QC		
34	**Pharmaceutical Patient Safety Issues**	**PHM1A**	The Pharmacy Benefit Manger has information about member pharmaceutical use that may not be available to pharmacists or practitioners. This represents an opportunity to provide patient safety information to practitioners and patients likely to be affected by drug recalls and withdrawals for patient safety reasons.	• Identifying and notifying members and prescribing practitioners affected by Class II recall or voluntary drug withdrawals from the market for safety. • An expedited process for prompt identification and notification of members and prescribing practitioners affected by Class I recall. Results are presented to Compliance Committee annually and QC for review and feedback semiannually.	Goals: 100% Compliance for: • Class I: Affected members and providers notified no later than seven days of the Food and Drug Administration (FDA) notification. • Class II: Affected members and providers notified within thirty days of the FDA notification. • Class III: Affected members and provider notified within sixty days of FDA notification.	Director of Pharmacy	Annually											x			QC		

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35	**Performance Improvement**																					
36	**2019 Healthcare Effectiveness Data and Information Set (HEDIS) Analysis**	**N/A**	HEDIS is a quality requirement program which determines how well health plans perform on a variety of quality processes and outcome variables. HEDIS consists of 24 in the beta year for measures that span 8 domains of care which allow for comparison of quality performance nationally across health plans.	Procedure: • HEDIS data is collected annually through surveys, medical charts, pharmacy data, lab reports and insurance claims for hospitalizations, medical office visits and procedures. • Data validation prior to submission date • Meet submission deadline • Data from the HEDIS project is analyzed to determine areas of intervention and improvement.	Objective: In addition to annual HEDIS reporting, QI should aim to demonstrate at a minimum quarterly analysis of HEDIS quality measure trends and activities including: • Performance trend presentation to the QC • Qualitative and quantitative analysis to identify opportunities for improvement documented in the QC meeting minutes. • Decrease medical record non- compliance. • To measure effectiveness of intervention; analysis will be accomplished by comparing annual rates compared to prior MY and on quarterly basis using YTD rates. • Based on trends, identify barriers and collaborate across departments implementing interventions.	Director of Quality	Quarterly Monitoring, Annual Reporting	x			x			x			x			QMMC		
37	**Performance Improvement Projects** **OPEN PIP for 2019** EPSDT	**DMS**	Conduct a performance improvement project aligned with the goal of the QAPI, contractual requirement and relevant to the Medicaid population. The PIP should target and address the needs of the Medicaid population to improve access, treatment and services.	• Submit PIP proposal to State/DMS and obtain approval (only applicable when Plan reaches 2 current PIPs or unless requested by DMS). • Perform PIP for 3 years and report baseline, interim and final results. • Quarterly monitor performance of implemented PIP intervention and identify new barriers and mitigate timely. • Report performance to QMMC quarterly and DMS per contractual requirement.	Goal: • Demonstrate positive outcome as defined in the PIP documents • Monitor PIP performance and activities and report trend quarterly at a minimum • Identify barriers timely and implement intervention • Engage workgroup and collaborate internally and externally to identify best practices and coordinate care to demonstrate a positive impact.	QI Manager	Quarterly	x						x						QMMC		
38	**Performance Improvement Projects** **OPEN PIP for 2019** Prenatal Smoking	**DMS**	Conduct a performance improvement project aligned with the goal of the QAPI, contractual requirement and relevant to the Medicaid population. The PIP should target and address the needs of the Medicaid population to improve access, treatment and services.	• Submit PIP proposal to State/DMS and obtain approval (only applicable when Plan reaches 2 current PIPs or unless requested by DMS). • Perform PIP for 3 years and report baseline, interim and final results. • Quarterly monitor performance of implemented PIP intervention and identify new barriers and mitigate timely. • Report performance to QMMC quarterly and DMS per contractual requirement.	Goal: • Demonstrate positive outcome as defined in the PIP documents • Monitor PIP performance and activities and report trend quarterly at a minimum • Identify barriers timely and implement intervention • Engage workgroup and collaborate internally and externally to identify best practices and coordinate care to demonstrate a positive impact.	QI Manager	Quarterly	x						x						QMMC		
39	**Performance Improvement Projects** **OPEN PIP for 2019** Potentially Preventable Hospital Admissions and ED Visits due to ACSC	**DMS**	Begin new PIP study to address and intervene on avoidable ACSC admissions and ED visits	**Procedure:** • Submit PIP proposal to State/DMS and obtain approval (only applicable when Plan reaches 2 current PIPs or unless requested by DMS). • Perform PIP for 3 years and report baseline, interim and final results. • Quarterly monitor performance of implemented PIP intervention and identify new barriers and mitigate timely. • Report performance to QMMC quarterly and DMS per contractual requirement.	Goal: • Demonstrate positive outcome as defined in the PIP documents • Monitor PIP performance and activities and report trend quarterly at a minimum • Identify barriers timely and implement intervention • Engage workgroup and collaborate internally and externally to identify best practices and coordinate care to demonstrate a positive impact.	QI Manager	Quarterly	x			x			x			x					
40	**2019 QI Strategy Interventions**	**N/A**	Implement interventions for targeted HEDIS measures that align with key areas of focus across the organization.	• Run monthly reports to identify members within the target measure • Take action on target intervention based on monthly reporting. • Monitor rate changes to measure effectiveness of intervention. • Alter interventions with no significant improvements.	Measure/Intervention • CDC Neph, DRE - Autodialer with live agent: • CDC DRE, Neph - Auto dialer with recorded message: • CDC DRE, Neph - Diabetes Incentive Mailing: • Antidepressant, CDC DRE & Neph - Member Incentives • PCE Bronch, MMA, CDC Neph, AMM Acute, AWC - Provider Incentives • CDC Neph - Care Gap Reporting • CDC DRE - Superior Member Mailing • PCE - HEDIS Team COPD Outreach calls • Asthma, Antidepressants, Diabetes - Rx Adherence Calls Goal: 2% improvement over previous year's rate and meeting 50th, 75th, or 90th percentile	Director of Quality	Monthly monitoring, Quarterly reporting	x	x	x	x	x	x	x	x	x	x	x	x	QMMC		

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41	**Network Adequacy**																					
42	**Assess Cultural Needs**	**NET1A**	Assess the cultural needs and characteristics of members and determine whether the contracted provider network adequately meets those needs	1. Identify language needs and ethnic background of members, including prevalent languages and cultural groups, using U.S. Census data and enrollment data. 2. Correlate data with members' expressed preferences based on feedback or complaint data. 3. Identify languages and ethnic background of practitioners in the network to assess whether they meet members' language needs and cultural preferences. 4. Take action to adjust the practitioner network if the current practitioner network does not meet members' language needs and cultural preferences.	1. Using 2019 Language analysis translate the Pediatric HRA into top 10 Languages. 2. Collect REaL 20% of members receiving care coordination. 3. Establish baseline for EPSDT for non-English speaking children between 6-14 years of age. 4. Increase EPSDT Participation Rate by 10 % for non-English speaking children between the age of 6 and 14 years of age.	Health Equity Manager	Annually					x							x	QMMC		
43	**Measure Practitioner Availability**	**NET1 B, C, D**	Measure PCP, high-volume and high impact specialist, and behavioral health practitioner availability against organization standards	1. Establishes measurable standards for the number of each type of practitioner providing primary care, specialty care and BH. 2. Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care, specialty care, and BH. 3. Annually analyzes performance against the standards for the number of each type of practitioner providing primary care, specialty care and BH. 4. Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care, specialty care and BH.	•Meet or exceed GeoAccess standards for PCPs and SCPs: •Urban & Rural membership: 1 PCP for every 1500 members. •High-volume SCP membership: 1 SCP to every 5000 members. •BH SCP membership: 1 BH SCP to every 5000 members.	Director of Provider Network Management	Annually					x								QMMC		
44	**Monitor Practitioner Accessibility**	**NET2A, B, C**	The Provider Relations Department conducts this study to determine the process a member would undertake to reach a live representative to schedule an appointment . A summary of this study is presented annually to the QC, highlighting major findings and opportunities for improvement. The QC develops corrective actions, when appropriate, to improve service to members in conjunction with Provider Relations.	**Procedure:** The organization measures access for: 1. PCP - routine appointments 2. PCP - urgent care appointments 3. PCP after-hours care 4. BH -Care for non-life-threatening emergency within 6 hours 5. BH - urgent care within 48 hours 6. Initial routine visit within 10 business days 7. BH - Follow-up routine care 8. Specialist - high-volume appointments 9. Specialist - high-impact appointments	•Meet or exceed GeoAccess standards for PCPs and SCPs: •Urban & Rural membership: 1 PCP for every 1500 members. •High-volume SCP membership: 1 SCP to every 5000 members. •BH SCP membership: 1 BH SCP to every 5000 members.	Director of Provider Network Management	Semi-Annually				x	x						x				QMMC		
45	**Monitoring Member Satisfaction with the Network**	**NET3A**	Analyze member experience with accessing the network through review of member complaints, appeals and out-of-network utilization for behavioral health and non-behavioral health services to identify network gaps which could impact member ability to access care	• Out-of-network requests or utilization for all accredited product lines when evaluating non-behavioral health and behavioral health network adequacy • Analyze member experience, complaints and appeals	•Assess PCP and SCP (including BH) for compliance with accessibility. •Assess 5% of PCP, SCP, and BH network for accessibility compliance •Routine/Preventative appointments within 30 days •Urgent care appointments within 48 hours •Prenatal Preventative appointments: 1st trimester-14 days, 2nd trimester-7 days, 3rd trimester-3 days •Non-life threatening emergency within 6 hours •Emergency care with crisis stabilization within 24 hours •Services post-discharge from an Acute Psychiatric Hospital within 7 days •Routine office visit within 10 days •Other services within 60 days •Missed appointment follow up within 24 hours to reschedule •Conduct site visits to 5% of PCPs, SCPs, and BH offices to assess compliance	Director of Provider Network Management	Annually					x								QMMC		
46	**Evaluation of Access to Health Services**	**NET3B, C**	Identify opportunities to improve access to non-behavioral health and BH services through review of data from NET 1B -D and NET 2A - C analyses plus member complaints, appeals and CAHPS survey results related to non-behavioral health and BH network adequacy. Implement actions to address at least one opportunity and measure the effectiveness of those interventions	• Implement intervention to improve access • Measure effectiveness of intervention.	•Member complaints due to access are tracked quarterly •A full investigation will be conducted by a Special Support Tech in Provider Services •Passport analyzes grievances to determine trends/patterns and takes corrective actions as needed •Provider Relations will perform provider education when necessary	Director of Provider Network Management	Annually					x								QMMC		

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47	**Accuracy of Online Physician Directory**	**NET6C, D**	Evaluate the accuracy of the online physician directory data on office locations and phone numbers, hospital affiliations, accepting new patients and awareness of physician office staff of practitioner network participation status using valid methodology.	• Perform quarterly audits of physician directory • Analyze results, identify opportunities to improve the accuracy of information in the directory and implement action to improve performance • Create annual evaluation and update process as needed.	•Review network adequacy report monthly • Analyze network adequacy report to determine if there are any provider types in specific areas that need to be targeted for recruitment • If area of need is determined then provider rep will perform outreach to out of network providers in that area to attempt to get them contracted with Passport	Sr. Director of Provider Data Management	Quarterly Monitoring Annual report					x								QMMC		
48	**Annual Communications**																						
49	**Information about the QI Program**	**QI2B**	The organization informs members about QI activities.	• Sends newsletter to members about the QI program and where to access more information online • Updates the QI Program Description and evaluation on the member website	Meet all communication requirements by projected due date	Director of Quality	Annually			x											QMMC		
50	**Pediatric to adult care transition**	**QI**	The organization informs members turning 18 that they can get assistance finding an adult primary care practitioner.	• Sends newsletter to members transitioning to adult PCP to call the Care Management team should assistance be needed.	Meet all communication requirements by projected due date	Managing Director of Clinical Operations	Annually			x											QMMC	Complete	
51	**PHM Program Communications**	**PHM5A**	Informing members, caregivers and practitioners about the CM programs and instructions for making referrals to case management	• Sends newsletter to members and practitioners about the CM program and the process for making referrals.	Meet all communication requirements by projected due date	Managing Director of Clinical Operations	Annually			x											QMMC	Incomplete	
52	**Availability of Criteria**	**UM2B**	Informing practitioners how to obtain UM criteria and that the criteria is available upon request.	• Sends newsletter and provider manual practitioners about the process for obtaining UM criteria and how to request it.	Delegated to Evolent Health - Provide NCQA UM Accreditation Certificate	Director of UM	Annually	x													QMMC	Incomplete	
53	**UM Staff**	**UM3A**	Informing members about how to access staff and the UM process for authorizations.	• Sends newsletter and member handbook about the TDD/TTY and language services available to members.	Delegated to Evolent Health - Provide NCQA UM Accreditation Certificate	Director of UM	Annually	x													QMMC	Incomplete	
54	**UM Affirmative Statement**	**UM4G**	The organization distributes a statement to all members and to all practitioners, providers and employees who make UM decisions, affirming the following: • UM decision making is based only on appropriateness of care and service and existence of coverage. • The organization does not specifically reward practitioners or other individuals for issuing denials of coverage. • Financial incentives for UM decision makers do not encourage decisions that result in underutilization.	• Sends member newsletter and member handbook with affirmative statement • Sends practitioner/provider newsletter and provider manual with affirmative statement • Sends organization wide newsletter to employees with affirmative statement	Meet all communication requirements by projected due date, Evolent UM employees are notified by Evolent Health and verification of notification is provided to Passport.	Director of UM	Annually	x													QMMC	Incomplete	
55	**Pharmaceutical Restrictions/Preferences**	**UM11B**	The organization informs members and practitioners: 1. A list of pharmaceuticals, including restrictions and preferences. 2. How to use the pharmaceutical management procedures. 3. An explanation of limits or quotas. 4. How prescribing practitioners must provide information to support an exception request. 5. The organization's process for generic substitution, therapeutic interchange and step-therapy protocols.	• Sends member handbook and newsletter • Sends provider manual and newsletter • Provides updates as necessary	Delegated to Evolent Health - Provide NCQA UM Accreditation Certificate	Pharmacy Director	Annually	x													QMMC	Incomplete	
56	**Practitioner Rights**	**CR1B**	Informing practitioners of their rights to: 1) review information submitted to support their credentialing application 2) correct erroneous information 3) receive status of their credentialing or recredentialing application upon their request	• Sends information in the credentialing/recredentialing application • Sends provider manual and newsletter and on provider website	Meet all communication requirements by projected due date	Credentialing Manager	Ongoing in applications, Annually	x													QMMC	Incomplete	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V
57	**Member Rights and Responsibilities, Subscriber Information**	**RR1B** **RR3A**	Informing members and practitioners about member rights and responsibilities (RR1B) Informing members about subscriber information (RR3A)	• Sends new members the R&R statement and subscriber information in the member handbook upon enrollment • Sends new practitioners the R&R statement in the provider manual upon enrollment • Existing Members: Member Newsletter, points to member website • Existing Providers: Provider Newsletter. points to the provider website	Meet all communication requirements by projected due date	Member Services Manager	Ongoing - New, Annually - Existing	x	x	x	x	x	x	x	x	x	x	x	x	QMAC		
58	**Assessing Member Understanding**																					
59	**Physician and Hospital Directory Usability Testing (conduct after transition to CHC in early 2020)**	**NET6K**	Evaluates the web-based physician and hospital directory for understandability and usefulness to members and prospective members.	Evaluation considers: • Font size • Reading level • Intuitive content organization • Ease of navigation • Directories in additional languages, if applicable to membership	Goals: • There must be a documented process demonstrating how usability testing is performed and how testing frequency is determined. • Reports indicating initial usability testing was performed before and after any upgrades to functionality or design that directly affects how members use the site	Provider Data Management	Annually												x	QMMC		
60	**Accessing Member Understanding of The Plan's Procedures (changing vendor 2020)**	**RR4C**	Evaluations new member understanding of key policies and procedures.	Assessment includes: • Monitoring new member understanding of procedures through focus groups and complaint data • Implementing procedures to maintain accuracy of marketing communication • Acts on opportunities for improvement	Goals: • There must be evidence of a systematic and ongoing process for assessing new-member understanding of operations and policies. • If findings indicate that new members have enrolled without an accurate understanding of key policies and procedures, Passport must initiate a quality improvement process to correct the possibility of future misrepresentation.	Marketing	Annually										x				QMAC		
61	**Ongoing Monitoring**																					
62	**Ongoing Monitoring of Practitioner Sanctions, Complaints and Quality Issues**	**CR5**	The Plan has policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality. Reports on tracking and trending patterns of complaints and sentinel evenest/adverse occurrences about individual practitioners at least ever 6 months	Ongoing review and monitoring by: • Collecting and reviewing sanctions or limitations on licensure • Collecting and reviewing complaints • Collecting and reviewing information from identified adverse events	Goals: • Review sanction information within 30 calendar days of its release • Implementing appropriate interventions when instances of poor quality are identified	Credentialing Manager	Ongoing	x					x							Credentialing Committee		
63	**Monitoring Member Services' Benefit Information for Quality and Accuracy**	**MEM3C**	The Member Services Department has a quality improvement process in place to assess the quality and accuracy of plan benefit information provided to members telephonically and online.	Components of the process: • Collecting data on quality and accuracy of information provided • Analyzing data against standards or goals • Determining the cause of deficiencies, as applicable • Acts to improve identified deficiencies, as applicable	Goals: • Telephone: 80% accuracy • Online: 80% accuracy	Member Services Manager	Annually			x										QMAC	Incomplete	
64	**Monitoring Pharmacy Benefit Information for Quality and Accuracy - CVS certification**	**MEM2A, C**	The Pharmacy Benefits Manager has a quality improvement process in place to assess the quality and accuracy of pharmacy benefit information provided to members telephonically and online. The Plan works in partnership with the PBM to monitor for any quality issues	Components of the process: • Collects data on quality and accuracy of pharmacy benefit information provided telephonically and online • Analyzes data results • Acts to improve identified deficiencies.	Goals: • Telephone: 80% accuracy • Online: 80% accuracy	Member Services Manager	Annually			x										QMMC	Incomplete	
65	**Delegation**																					
66	**Quality Improvement Delegation Oversight**	**QI7C1**	Audits all QI delegates	For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its delegate's QI program. 2. Annually audits complex case management files against NCQA standards for each year that delegation has been in effect, if applicable. 3. Annually evaluates delegate performance against NCQA standards for delegated activities. 4. Semiannually evaluates regular reports, as specified in Element A.	All audits pass with a score of "High". If a score is lower than a "High", a corrective action plan is implemented with the delegate.	Delegation Oversight Manager	Ongoing monitoring of reports/Annually for audits	x			x			x			x				Credentialing Committee		

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V
67	**Population Health Management Delegation Oversight**	**PHM7C1-4**	Audits all PHM delegates	For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its delegate's PHM program. 2. Annually audits complex case management files against NCQA standards for each year that delegation has been in effect, if applicable. 3. Annually evaluates delegate performance against NCQA standards for delegated activities. 4. Semiannually evaluates regular reports, as specified in Element A.	All audits pass with a score of "High". If a score is lower than a "High", a corrective action plan is implemented with the delegate.	Delegation Oversight Manager	Ongoing monitoring of reports/Annually for audits	x			x		x			x			QMMC		
68	**Network Management Delegation Oversight**	**NET7C1, 3**	Audits all NET delegates	For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its delegate's network management procedures. 2. Annually evaluates delegate performance against NCQA standards for delegated activities. 3. Semiannually evaluates regular reports, as specified in Element A.	All audits pass with a score of "High". If a score is lower than a "High", a corrective action plan is implemented with the delegate. For those delegates with NCQA UM certification/accreditation, factor 2 & 3 are scored "yes" with delegate certificate	Delegation Oversight Manager	Ongoing monitoring of reports/Annually for audits	x			x		x			x			QMMC		
69	**Utilization Management Delegation Oversight**	**UM12C1**	Audits all UM delegates	For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its delegate's UM program. 2. Annually audits UM denials and appeals files against NCQA standards for each year that delegation has been in effect. 3. Annually evaluates delegate performance against NCQA standards for delegated activities. 4. Semiannually evaluates regular reports, as specified in Element A.	All audits pass with a score of "High". If a score is lower than a "High", a corrective action plan is implemented with the delegate. For those delegates with NCQA UM certification/accreditation, factor 2 & 3 are scored "yes" with delegate certificate	Delegation Oversight Manager	Ongoing monitoring of reports/Annually for audits	x			x		x			x			QMMC		
70	**Credentialing Delegation Oversight**	**CR8C**	Audits all CR delegates	For delegation arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its delegate's credentialing policies and procedures. 2. Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect. 3. Annually evaluates delegate performance against NCQA standards for delegated activities. 4. Semiannually evaluates regular reports, as specified in Element A.	All audits pass with a score of "High". If a score is lower than a "High", a corrective action plan is implemented with the delegate. For those delegates with NCQA CVO or CR certification/accreditation, factor 2 & 3 are scored "yes" with delegate certificate. Factor 4 is scored "yes" for CVO certified organizations.	Delegation Oversight Manager	Ongoing monitoring of reports/Annually for audits	x			x		x			x			QMMC		
71	**Member Rights and Responsibilities Delegation Oversight**	**RR5C**	Audits all RR delegates	For delegation arrangements in effect for 12 months or longer, the organization: 1. Semiannually evaluates regular reports, as specified in Element A. 2. Annually evaluates delegate performance against NCQA standards for delegated activities.	All audits pass with a score of "High". If a score is lower than a "High", a corrective action plan is implemented with the delegate.	Delegation Oversight Manager	Ongoing monitoring of reports/Annually for audits	x			x		x			x			QMMC		
72	**Member Connection Delegation Oversight**	**MEM5C**	Audits all MEM delegates	For delegation arrangement in effect for 12 months or longer, the organization: 1. Semiannually evaluates regular reports, as specified in Element A. 2. Annually evaluates delegate performance against NCQA standards for delegated activities.	All audits pass with a score of "High". If a score is lower than a "High", a corrective action plan is implemented with the delegate.	Delegation Oversight Manager	Ongoing monitoring of reports/Annually for audits	x			x		x			x			QMMC		

Passport Health Plan
2019 Quality Improvement Work Plan

The Passport Work Plan reflects ongoing progress of QI activities throughout the year. It captures the yearly planned activities and objectives for improving:
- Quality of clinical care.
- Safety of clinical care.
- Quality of service.
- Member experience.
- Regulatory QI requirements.
The work plan is a dynamic document that may contain revisions throughout the year to reflect areas of focus and opportunity.

Project Name	Standard	Key Objectives/Initiatives	Tracking Notes	Lead Staff
2018 to 2019 Quality Program Structure				
QMMC	MOC-Quality	Meeting frequency	In 2018 shifted to quarterly frequency	Betsy Simpson
Quality of Service				
No changes	MoC-Quality			
Quality of Clinical Care				
Care Coordination, Transitions & UM metrics	MOC-Care Coordination	Care management & UM services delegated to Evolent Health as of 1/1/2019	Monthly reporting projected to be more timely and accurate for monitoring and corrective action, as appropriate.	Betsy Kirk - CC, Anna Page - UM
Patient/Member Safety metrics	MOC-Quality	Added metrics for Quality of Care member concerns and Sentinel/Adverse events	For closer monitoring of patient safety activity formerly delegated to Health Integrated.	Denise Matz
Performance				
Refined Quality Measure monitoring	MOC-Quality	Refined target quality measures based on revised 2019 MOC	Activation of Identifi-HEDIS rules aligned with target quality measures for care gap reporting & monitoring	Paul Zuradzki
Stars dashboard	MOC-Quality	To be added (Q2 2019) Stars Dashboard	Monthly report of Star measures including target Quality measures.	Paul Zuradzki
Network Adequacy				
Annual Communications				
Notification of CPG annual updates	MOC-Network	2019 CPG updates	Upon receipt of memo and inventory update PAD website of any CPG link/resource changes.	Cheri Schanie
Ongoing Monitoring				
Combined Credentialing reporting	MOC-Network	Added Medicare Opt-out and vendor SLA reporting.	Added quarterly metrics for monitoring.	Sharlee LeBleu
Delegation				
Care Coordination, Transitions & UM services to Evolent Health	MOC	For 2019 delegated to Evolent Health		Kimberly Hughes

Notes:

Definitions	
Quality Improvement	Measures and planned actions used to meet the objectives of the program defined in the QI Work plan.
Performance Improvement	Measure rates used to measure clinical performance
Process and Performance Indicators	Measures and planned actions used to indicate the effectiveness of the program over time.
Project/Element	The operational area of focus being measured
Goal	The metric used to measure the area of focus
Status	The metric rate for the quarter
Data Source	The requirement for the Project - documented process, materials or reports
Measure Type	For HEDIS or HEDIS-like measures, the use of admin only data or a hybrid source
Key Findings	For the measurement period, any significant information to be communicated to leadership/QMMC. Significant findings should be representative of a substantial change in the trend data which would warrant a barrier assessment. Signficance testing may be used to determine if a finding is signficant in comparison to previous reports.
Barriers	For key findings which do not meet the performance goal, what is the possible root cause
Interventions	Actions being taken to address barriers
Recommendations	Potential future interventions on which to implement to address barriers

Instructions		Owner
For each objective in the QI Work Plan, the business owner, in collaboration with the Quality department, must track measures to monitor quality, performance and process improvement		
Items in the highlighted cells are reportable to the Quality department/Quality Committee		
Quality Improvement Goals		
Definition	The section is pulled from the current Work Plan Master tab or from internal program goals summarized in the Work Plan.	
1	Capture each measure from the QIWP in the QI Goal Section	Quality
2	Track the rate in the Status field	Department
3	Determine if there are significant findings from the quarterly rates. Capture a summary of the findings in the Key Findings/Results field	Department
4	Document barriers if the performance goal is not met	Department
5	Document Interventions in place to address barriers or improve rates	Department
6	Document potential recommendations if current interventions are not producing improvements	Department
7	Create executive summary from Key Findings/Results, Barriers, Interventions and Recommendations (in the yellow sections) for the QMMC	Department
8	Present findings, if any, to QMMC.	Department

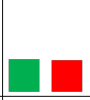
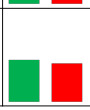
Performance Improvement Goals		
Definition	The section captures the HEDIS data associated with the program or a preselected set of measures determined to be applicable to the effectiveness of the program	
1	Determine HEDIS rates applicable to the program in the Performanc Improvement Section	Quality with input from the Department
2	Input Annual HEDIS Trend Data (3-years)	Quality
3	Calculate Goal	Quality
4	Input quarterly/annual HEDIS rates	Quality
5	Update Measure Type	Quality
6	Determine Frequency	Quality
7	Determine if there are significant findings from the rates. Capture a summary of the findings in the Key Findings/Results field	Quality
8	Document barriers if the performance goal is not met	Department and Quality
9	Document Interventions in place to address barriers or improve rates	Department and Quality
10	Document potential recommendations if current interventions are not producing improvements	Department and Quality
11	Create executive summary from Key Findings/Results, Barriers, Interventions and Recommendations (in the yellow sections) for the QMMC	Department and Quality
12	Present findings, if any, to QMMC.	Department and Quality
Process and Performance Indicators		
Definition	The section identifies key operational performance indicators associated with a program to determine the pragram effectiveness .	
1	Determine operations KPIs relevant to program effectiveness	Department with input from Quality
2	Update Trend Data based on frequency, if necessary	Quality
3	Calculate Goal	Department with input from Quality
4	Input quarterly/annual KPI data	Department
5	Update Measure Type	Department
6	Determine Frequency	Department with input from Quality
7	Determine if there are significant findings from the rates. Capture a summary of the findings in the Key Findings/Results field	Department with input from Quality
8	Document barriers if the performance goal is not met	Department
9	Document Interventions in place to address barriers or improve rates	Department
10	Document potential recommendations if current interventions are not	Department
11	Create executive summary from Key Findings/Results, Barriers, Interventions and Recommendations (in the yellow sections) for the QMMC	Department and Quality
12	Present findings, if any, to QMMC.	Department and Quality

2019 QI Work Plan Business Area Report - QI Strategy

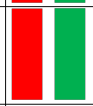
Quality Improvement Goals

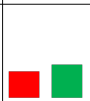
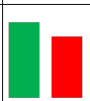
Project Element	2019 Goals	Q4 Status	Frequency	Data Source	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
Provider Engagement Strategy	- Positive PHM quality-related engagement with 80% of top 50 practices by Sept 1 - <10% of providers have significant issues with report data integrity		Quarterly	Internal Measures	Data not yet reportable	High level confidence in group rosters – practice rosters for groups with providers credentialed at multiple locations will always be a challenge	Providing care gap reports; educating on member incentives; placing ORS in offices that are receptive to direct help in scheduling appointments	N/A
Member Engagement Strategy	- 15% of members (45K) engaged in texting campaign by year end - PCP visit % of 70%+ for engaged providers - Highly developed understanding of ROI of outreach approaches		Quarterly	Internal Measures	Consent process being developed; Member PCP visit data not yet available; ROI data is process	Understanding of business requirements for texting; data for visits not yet available; data for ROI still being analyzed	N/A	N/A
Accreditation and State Reporting	- Maintain "outstanding" or "accredited" status - Develop ownership over a culture of quality across PHP		Quarterly	Internal Measures	Mock Audit underway and meeting >85% of requirements	Delegation agreements taking time in the legal process, Awaiting reports from directory vendor	Escalation through DOC to potentially implement a CAP with directory vendor	F/U with DOC for resolution

Performance and Process Indicators

Project Element	Annual Trend	2017 (PY) HEDIS Results	2018 (PY) HEDIS Results	Quarterly Trend	Frequency	Data Sources DP=Documented process FR=File review M=Materials R=Reports	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
HEDIS Measures										
Breast Cancer Screening*		52.92%	50.96%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows slight decrease in HEDIS rate	No mobile breast cancer screening bus during 2018	Member incentives for annual screenings,	Reinstitue mobile mammogram screenings in 2020
Cervical Cancer Screening*		51.58%	57.91%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows INCREASE in HEDIS rate	N/A	Member incentives for annual screening - keep the same	N/A
BMI Assessment Adult		70.32%	83.91%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows INCREASE in HEDIS rate	N/A	Member incentive for adult well visit	N/A
BMI Assessment Child		71.65%	80.54%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows INCREASE in HEDIS rate	N/A	EPSDT IVR calls and outreach	Adding Member Incentive for Well Child visit. Reinstituting work with health departments for home visits in select counties
Diabetes care - HbA1c testing*		86.31%	87.96%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows INCREASE in HEDIS rate	N/A	Diabetic outreach calls at the start of 2019, Member Incentive	Continue with Member Incentive, work with provider offices to close care gaps with embedded Quality staff, addition to 2020 HealthPlus VB contracting
Diabetes care - HbA1c control <8.0%*		34.67%	33.58%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows slight decrease in HEDIS rate	Supplemental data not submitted from member incentive forms, Less outreach in 2018, Member Incentive hard to earn	Member incentive easier to earn, Pharmacy outreach regarding med adherence	Continue to work with providers to close care gaps
Diabetes care - eye exam*		44.53%	40.69%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows slight decrease in HEDIS rate	Supplemental data not submitted from member incentive forms, Less outreach in 2018, Member Incentive hard to earn	Member incentive easier to earn, work with providers to close care gaps	Project to gather all supplemental data from vistion vendor in 2019

Controlling blood pressure		33.42%	48.18%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows INCREASE in HEDIS rate	N/A	N/A	Continue current interventions	
Prenatal and Postpartum Care—Timeliness of Prenatal Care*		71.28%	77.89%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows INCREASE in HEDIS rate	N/A	Meternity program outreach and member incentive	Continue with existing interventions	
Prenatal and Postpartum Care—Postpartum Care*		55.59%	63.39%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows INCREASE in HEDIS rate	N/A	Meternity program outreach and member incentive	Continue with existing interventions	
Follow Up After Hospitalization for Mental Illness - 30 day*		49.08%	46.36%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows slight decrease in HEDIS rate	Less interaction and engagement from vendor	Continue to partner with vendor.	Implement internal BH programs to address FUH	
Follow Up After Hospitalization for Mental Illness - 7 day		24.54%	23.92%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows slight decrease in HEDIS rate	Less interaction and engagement from vendor	Continue to partner with vendor.	Implement internal BH programs to address FUH	
Statin Therapy for Patients with Cardiovascular Disease		73.61%	65.21%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows slight decrease in HEDIS rate	Limited data available to providers during measurement year	Data and care gaps will identify members that may be identified for Statin therapy.	Work with providers to educate based on care gaps	
Medication Management for People with Asthma – 75%		37.44%	37.06%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows slight decrease in HEDIS rate	More data is needed to identify decrease in this measure	Pharmacy outreach	Continue Phamarcy outreach on med adherence. Work on outreach plan for providers. Incorporating in 2020 Health Plus	
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		24.83%	31.74%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows INCREASE in HEDIS rate	N/A	N/A	Continue with eduction to providers , add information in provider newsletter	
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total		33.96%	35.65%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows INCREASE in HEDIS rate	N/A	Work with foster care population regarding education	Continue with eduction to providers , add information in provider newsletter	
Follow Up Care for Children Prescribed ADHD Medication—Initiation		42.88%	40.85%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows slight decrease in HEDIS rate	Most likely that side effects mya be the reason members do not stay on initial prescripton	Work with foster care population regarding education	Continue with eduction to providers , add information in provider newsletter	
Follow Up Care for Children Prescribed ADHD Medication— Continuation & Maintenance Phase		49.90%	52.12%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows INCREASE in HEDIS rate	N/A	Work with foster care population regarding education; provider education	Continue with eduction to providers , add information in provider newsletter	
Statin Use in Persons with Diabetes (SUPD) - Received Therapy		59.68%	53.32%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows slight decrease in HEDIS rate	More data is needed to identify decrease in this measure	More data is needed to identify decrease in this measure	More data is needed to identify decrease in this measure	
Statin Use in Persons with Diabetes (SUPD) - Adherence		66.75%	58.05%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows slight decrease in HEDIS rate	More data is needed to identify decrease in this measure	More data is needed to identify decrease in this measure	More data is needed to identify decrease in this measure	

Chlamydia Screening in Women		58.41%	59.86%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows INCREASE in HEDIS rate	N/A	Member Incentive	Keep incentives	
Adults' Access to Preventative/Ambulatory Health Services*		78.33%	78.34%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows INCREASE in HEDIS rate	N/A	N/A	Addressed through incentives to other measures	
Children and Adolescents' Access to Primary Care Practitioners 12-24 mo		96.36%	96.64%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows INCREASE in HEDIS rate	N/A	N/A	Addressed through incentives to other measures	
Children and Adolescents' Access to Primary Care Practitioners 25 mo - 6 yrs		87.54%	87.69%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows INCREASE in HEDIS rate	N/A	N/A	Addressed through incentives to other measures	
Children and Adolescents' Access to Primary Care Practitioners 7-11		90.72%	92.13%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows INCREASE in HEDIS rate	N/A	N/A	Addressed through incentives to other measures	
Children and Adolescents' Access to Primary Care Practitioners 12-19		88.70%	90.41%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows INCREASE in HEDIS rate	N/A	N/A	Addressed through incentives to other measures	
Well-Child Visits in the fifteen months of life - 0		2.01%	1.39%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows slight decrease in HEDIS rate	No incentives for this measure	Only EPSDT outreach	Add member incentive for 2020, incentive for providers	
Well-Child Visits in the fifteen months of life - 6*		68.59%	68.06%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows slight decrease in HEDIS rate	No incentives for this measure	Only EPSDT outreach	Add member incentive for 2020, incentive for providers	
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*		72.41%	65.67%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows slight decrease in HEDIS rate	No incentives for this measure	Only EPSDT outreach	Add member incentive for 2020, incentive for providers	
Adolescent Well-Care Visits*		54.01%	56.23%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows INCREASE in HEDIS rate	N/A	Mutliple member incentives,	Call campaigns to continue, member incentives	
Childhood Immunization Status (13)- Combo 10*		32.36%	33.58%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows INCREASE in HEDIS rate	N/A	Mutliple member incentives,	Call campaigns to continue, member incentives	
Lead Screening in Children		76.16%	74.21%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows slight decrease in HEDIS rate	More data is needed to identify decrease in this measure	More data is needed to identify decrease in this measure	Provider education, CPG review	
Adolescent Immunizations (3)*		27.98%	34.79%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows INCREASE in HEDIS rate	N/A	Mutliple member incentives,	Call campaigns to continue, member incentives	

Follow Up After Emergency Department Visit for Mental Illness - 7 Day		40.37%	34.79%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows slight decrease in HEDIS rate	Less interaction and engagement from vendor	Continue to partner with vendor.	Implement internal BH programs to address FUH	
Follow Up After Emergency Department Visit for Mental Illness - 30 Day		58.02%	56.06%		Quarterly		Quarterly trend data will be available after the first week in Nov. Annual trend shows slight decrease in HEDIS rate	Less interaction and engagement from vendor	Continue to partner with vendor.	Implement internal BH programs to address FUH	
Follow up After Emergency Deparrtment Visit for Alcohol or other Drug Abuse or Dependence 30 day - 7 Day		21.68%	22.84%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows INCREASE in HEDIS rate	Less interaction and engagement from vendor	Continue to partner with vendor.	Implement internal BH programs to address FUH	
Follow up After Emergency Deparrtment Visit for Alcohol or other Drug Abuse or Dependence 30 day - 30 Day		28.33%	35.37%		Quarterly		Quarterly trend data will be available after the first week in Nov. Annual trend shows INCREASE in HEDIS rate	Less interaction and engagement from vendor	Continue to partner with vendor.	Implement internal BH programs to address FUH	
Pharmacotherapy Mgmt of COPD Exacerbation- Systemic Corticosteroid		65.86%	52.61%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows slight decrease in HEDIS rate	Limited outreach during year from modification in COPD program	Restructure of program to incorporate PCE as a target measure	Integrate into NCQA Continuity and coordination of care	
Pharmacotherapy Mgmt of COPD Exacerbation- Systemic Bronchodilator		79.70%	64.72%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows slight decrease in HEDIS rate	Limited outreach during year from modification in COPD program	Restructure of program to incorporate PCE as a target measure	Integrate into NCQA Continuity and coordination of care	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications		83.13%	84.69%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows INCREASE in HEDIS rate	N/A	PDIP	Conintue during 2020 with BH programs	
Diabetes Monitoring for People with Diabetes and Schizophrenia		68.87%	73.14%		Quarterly	HEDIS	Quarterly trend data will be available after the first week in Nov. Annual trend shows INCREASE in HEDIS rate	N/A	PDIP	Conintue during 2020 with BH programs	
CAHPS Measures											
		CAHPS 2018 (PY)	**CAHPS 2018 (PY)**								
Annual Flu Vaccine - Adult		34.11%	43.84%		Annually	CAHPS	Increase	N/A	Member Incentive	N/A	
Getting Needed Care - Adult		80.66%	87.82%		Annually	CAHPS	Increase	N/A	N/A	N/A	
Getting Needed Care - Child		84.59%	87.26%		Annually	CAHPS	Increase	N/A	N/A	N/A	
Getting Appointments and Care Quickly - Adult		85.55%	87.62%		Annually	CAHPS	Increase	N/A	N/A	Provider education on access	
Getting Appointments and Care Quickly - Child		91.54%	90.56%		Annually	CAHPS	Decrease	Provider Claims TPA transition	Provider education on access	Provider education on access	
Customer Service - Adult		90.08%	86.39%		Annually	CAHPS	Decrease	Potential rollback of KY Health caused high volume of calls several times during the year.	Hiring additional temporary staff	Hiring additional Staff	
Customer Service - Child		87.37%	89.28%		Annually	CAHPS	Increase	N/A	N/A	N/A	
Rating of Health Care Quality - Adult		73.44%	78.17%		Annually	CAHPS	Increase	N/A	N/A	N/A	
Rating of Health Care Quality - Child		85.58%	85.76%		Annually	CAHPS	Increase	N/A	N/A	N/A	

Rating of Health Plan - Adult		84.73%	82.45%		Annually	CAHPS	Decrease	Potential link to press coverage of rate issue	N/A	Additional satisfaction surveys during the year	
Rating of Health Plan - Child		91.24%	89.57%		Annually	CAHPS	Decrease	Potential link to press coverage of rate issue	N/A	Additional satisfaction surveys during the year	
Care Coordination - Adult		83.23%	89.13%		Annually	CAHPS	Increase	N/A	N/A	N/A	
Care Coordination - Child		80.85%	84.82%		Annually	CAHPS	Increase	N/A	N/A	N/A	
Rating of Drug Plan - Adult		84.73%	82.45%		Annually	CAHPS	Decrease	Formulary changes	N/A	Education	
Rating of Drug Plan - Child		91.24%	89.57%		Annually	CAHPS	Decrease	Formulary changes	N/A	Education	
Getting Needed Prescription Drugs - Adult		89.09%	99.00%		Annually	CAHPS	Increase	N/A	N/A	Education	
Getting Needed Prescription Drugs - Child		93.55%	93.48%		Annually	CAHPS	Decrease	Minimal decrease	N/A	Education	

2019 QI Work Plan Business Area Report Template - CAD (Previously Healthy Heart)

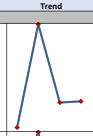
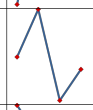
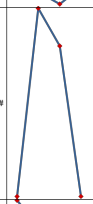
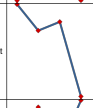
Quality Improvement Goals

Project Element	2019 Goal	2019 Status	DP=Documented process FR=File review M=Materials R=Reports	Frequency	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
Reduce All-Cause Readmissions for Members with Dx of CAD enrolled in Condition Care	Decrease ACR by 2% from baseline (2018) rate for members enrolled in the CAD program	-2%	R	Annual	All Cause Readmissions decreased in 2019 by 2% from 2018.	None at this time.	Outreach to member within 2 days of known hospital discharge to follow up and ensure they have what they need. Educate on signs and symptoms to look out for and when to call their provider.	Increase provider education about the Condition Care CAD program to increase provider referrals. Partner more proactively with providers around members' care plans and needs to encourage members to utilize their PCP and specialists proactively for their care needs.
Reduce ER visits for Members with Dx of CAD enrolled in Condition Care	Decrease ER Visits for members enrolled in the CAD program by 2% from baseline (2018) rate	-1%	R	Annual	ER visits decreased in 2019 by 1% from 2018.	Due to working with providers to improve our value based programming, care conferences were not taking place the latter part of 2019, which may have impacted our ability to meet goal but we did still see improvement.	CAD symptom self-management and increasing healthy lifestyle behaviors are core components of the Condition Care CAD program. This includes education about appropriate ER utilization and when to use a different level of care and after hours triage available. Patient panel information regarding ER utilization is shared with providers by the Population Health managers which are set to renew visits with practices and sharing of information end of Q1 2020.	A new brochure has been created and approved by DMS regarding when to use ER vs. other levels of care. Recommend sending to highest ED utilizers. Retrain staff regarding emphasis on member education around appropriate ED use, connecting members to their PCPs and specialists, and teaching members how to manage their CAD symptoms.
Improve Member Satisfaction	Increase the member experience response from 87% to 90% of members response of "YES" to the question "The program helped me to understand my health condition." during MY 2019	100%	R	Annual	Results of the Patient Satisfaction Survey equated to 100% for the question, "The program helped me to understand my health condition." for the year.	None at this time. Goal was met.	Continued Education to staff members regarding prevalent conditions. Educating staff on new ways to help members understand and teach back the signs and symptoms of CAD.	Increase emphasis of survey importance during closure call and/or member mailings.

Performance Improvement Goals

Project Element	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Trend (2017-2019)	Goal (2018 QC 90th Percentile) Met	2019 Status	Measure Type (Admin/Hybrid)	Frequency	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
CAD (Previously Healthy Heart)												
CBP	59.95%	33.42%	48.18%			48.18%	H	Annual	See QI Strategy page			
SPC - Adherence 80%	75.32%	70.91%	60.02%			60.02%	H	Annual				
PBH	96.41%	82.43%	73.70%			73.70%	H	Annual				
MPM - Total	89.48%	89.35%	90.95%			90.95%	H	Annual				

Process and Performance Indicators

Project Element	Trend	2019 Goal	Q12019	Q22019	Q32019	Q42019	DP=Documented process FR=File review M=Materials R=Reports	Frequency	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
CAD (Previously Healthy Heart)												
CAD Program - Total Number of Members Identified		N/A	132	282	168	170	R	Quarterly	There was an increase in number of members identified for CAD Condition Care from Q1 to Q2, decrease from Q2 to Q3 and slight increase from Q3 to Q4.	N/A	Passport utilizes predictive modeling to identify members with CAD who are at rising risk of an event such as inpatient hospitalization. These are the members primarily targeted for intervention. Cases are requested to be identified/pushed based on staff availability (openings in caseloads).	Utilize the Population Health Managers and Provider Network Management teams to increase provider awareness of the Condition Care CAD program to increase provider referrals.
CAD Program - Total Number of Members Engaged		N/A	60	83	39	54	R	Quarterly	Engagement numbers will vary based on number of members identified. The number corresponds appropriately	N/A	Passport utilizes predictive modeling to identify the majority of program referrals. Staff objectives and key results focus on increasing engagement with stratified members. Staff utilizes multiple methods/tools to locate accurate member contact information.	PNM/PHM's increasing provider awareness of various care management programs to increase provider referrals.
Engagement Rate (numerator members engaged, denominator of members identified)		25%	45.45%	29.43%	23.21%	31.76%	R	Quarterly	Engagements rates were higher for Q1 and then decreased in the 2nd & 3rd quarters. Q3 rate fell below target for the program. Q4 increased significantly and exceeded target%	Unable to reach rates are higher for Condition Care programs than for other CM programs.	Staff utilizes multiple methods/tools to locate accurate member contact information.	Continue montioring team performance via chart and call audits with attention to engagement techniques..
Hospital Utilization - ER Visits (net change in number of members visiting the ER prior to engagement vs. post-engagment whereby #members visiting the ER as numerator, # members engaged total as denominator)***		Baseline	-3%	2%	1%	-3%	R	Quarterly	This is a baseline measurement, will be monitored for trending; remained consistent throughout the year	N/A	CAD symptom self-management and increasing healthy lifestyle behaviors are core components of the Condition Care CAD program. This includes education about appropriate ER utilization and when to use a different level of care and after hours triage available. Patient panel information regarding ER utilization is shared with providers by the Population Health Management managers which are set to renew visits with practices and sharing of information end of Q1 2020.	A new brochure has been created and approved by DMS regarding when to use ER vs. other levels of care. Recommend sending to highest ED utilizers. Retrain staff regarding emphasis on member education around appropriate ED use, connecting members to their PCPs and specialists, and teaching members how to manage their CAD symptoms.
Hospital Utilization - Inpatient Admissions (net change in number of members visiting inpatient prior to engagement vs. post-engagment whereby #members visiting inpatient as numerator, # members engaged total as denominator)***		Baseline	0%	-6%	-4%	-21%	R	Quarterly	This is a baseline measurement, will be monitored for trending increased significantly in Q4	N/A	Member education via care management programs. Sharing patient panel information regarding utilization with providers via care conferences and other methods such as reports and data analysis	Increase provider education about the Condition Care CAD program to increase provider referrals. Partner more proactively with providers around members' care plans and needs to encourage members to utilize their PCP and specialists proactively for their care needs.
Member Satisfaction: # of members response of "YES" to the question "The program helped me to understand my health condition."			4	11	5	12	R	Quarterly	Results appear to be consistent with previous years, and will continue to be monitored.	Upon program graduation, members are likely more difficult to reach. Surveys are done via IVR rather than by a live person.	Staff continue to request that members answer/respond to survey calls after program graduation. Cue to remind staff is embedded within documetnatio	Increase emphasis of survey importance during closure call and/or member mailings. n.

2019 QI Work Plan Business Area Report Template - Diabetes

Quality Improvement Goals

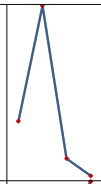
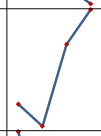
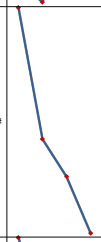
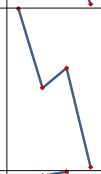
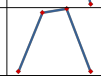
Project Element	2019 Goal	2019 Status			2019	DP=Documented process FR=File review M=Materials R=Reports	Frequency	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
Reduce All-Cause Readmissions for Members with Dx of Diabetes enrolled in Condition Care	Decrease ACR of members in the Diabetes Program by 2% from baseline (2018) rate				-1%	R	Annual	All Cause Readmissions decreased in 2019 by 1% from 2018.	Staffing changes in our Transtion Care Program caused lower than normal outreach after discharge from hospital.	Outreach to member within 2 days of known hospital discharge to follow up and ensure they have what they need. Educate on signs and symptoms to looks out for and when to call their provider. Also offering Remote Care Monitoring to members engaged in Condition Care program to monitor their vitals and symptoms daily so they can recognize issues early and seek treatment from PCP, avoiding unneccessary inpatient admissions.	Watch member identification trends to ensure the # identified doesn't trend downward. Passport's CM programs are proven to reduce inpatient utilization, but outcomes are impacted when lower #'s of members are identified. Focus/emphasis on closing care gaps related to diabetes care.
Reduce ER visits for Members with Dx of Diabetes enrolled in Condition Care	Decrease ER visits for members in the Diabetes Program by 2% from baseline (2018) rate				-5%	R	Annual	ER visits decreased in 2019 by 5% from 2018.	None at this time.	Diabetes self-management is a core component of the Condition Care Diabetes program. This includes education about appropriate ER utilization and when to use a different level of care. Also offering Remote Care Monitoring to members engaged in Condition Care program to monitor their vitals and symptoms daily so they can recognize issues early and seek treatment from PCP, avoiding unneccessary ER visits. Patient panel information regarding ER utilization is shared with providers by the Population Health Management team.	A new brochure has been created and approved by DMS regarding when to use ER vs. other levels of care. Recommend sending to highest ED utilizers. Retrain staff regarding emphasis on member education around appropriate ED use, connecting members to their PCPs and specialists, and teaching members how to manage their diabetes symptoms.
Improve Member Satisfaction	Increase the member experience response from 87% to 90% of members response of "YES" to the question "The program helped me to understand my health condition." during MY 2019				93%	R	Annual	Results of the Patient Satisfaction Survey equated to 93% for the question, "The program helped me to understand my health condition." for the year.	None at this time. Goal was met.	Continued Education to staff members regarding prevalent conditions. Educating staff on new ways to help members understand and teach back the signs and symptoms of diabetes.	Increase emphasis of survey importance during closure call and/or member mailings.

Performance Improvement Goals

Project Element	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Trend (2017-2019)	Goal (2018 QC 90th Percentile) Met	Q1	Q2	Q3	Q4	Measure Type (Admin/Hybrid)	Frequency	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
						2019 Status									
Diabetes Measures															
CDC HbA1c Testing	86.73%	86.31%	87.96%					87.96%		H	Annual	see QI Strategy tab			
CDC HbA1c Poor Control <9% (lower is better)	37.15%	56.93%	58.58%					58.58%		H	Annual				
CDC HbA1c Control <8%	50.91%	34.67%	33.58%					33.58%		H	Annual				
CDC Hba1c Good Control <7%	34.59%	23.98%	24.32%					24.32%		H	Annual	see QI Strategy tab			
CDC Eye Exams	42.62%	44.53%	40.69%					40.69%		H	Annual				
CDC Nephropathy	90.05%	89.78%	88.50%					88.50%		H	Annual				
CDC Blood Pressure <140/90	65.01%	52.37%	52.37%					52.37%		H	Annual	see QI Strategy tab			
SPD Received	59.76%	59.68%	53.32%					53.32%		A	Annual				
SPD Adherence	46.46%	66.75%	58.05%					58.05%		A	Annual				

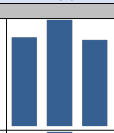
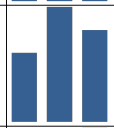
Performance Indicators

Project Element	Trend	2019 Goal *	Q12019	Q22019	Q32019	Q42019	DP=Documented process FR=File review M=Materials R=Reports	Frequency	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
			2019 Status									
Diabetes Program - Total Number of Members Identified		N/A	365	688	235	184	R	Quarterly	There was an increase in number of members identified for Diabetes Condition Care from Q1 to Q2 and a decrease from Q2 to Q3 and again from Q3 to Q4.	N/A	Passport utilizes predictive modeling to identify members with Diabetes who are at rising risk of an event such as inpatient hospitalization. These are the members primarily targeted for intervention. Cases are requested to be identified/pushed based on staff availability (openings in caseloads).	PNM/PHM's increasing provider awareness of various care management programs to increase provider referrals. None at this time

Diabetes Program - Total Number of Members Engaged		N/A	96	170	72	61	R	Quarterly	Engagement numbers will vary based on number of members identified. The number corresponds appropriately.	N/A	Passport utilizes predictive modeling to identify the majority of program referrals, staff objectives and key results focus on increasing engagement with stratified members. Staff utilizes multiple methods/tools to locate accurate member contact information. Program protocols require that all members identified by attempted/outreached within 30 days of identification.	PNM/PHM's increasing provider awareness of various care management programs to increase provider referrals.
Engagement Rate (numerator members engaged, denominator of members identified)		25%	26.30%	24.71%	30.64%	33.15%	R	Quarterly	Engagements rates remained at around 24-26% the first two quarters, then increased by about 5% in the last two quarters of 2019.	N/A	Staff utilizes multiple methods/tools to obtain accurate member contact information. Chart and phone audits are completed monthly for every Health Educator to monitor quality and engagement skills. Monthly 1:1 meetings are held with each Health Educator to share feedback, provide coaching, etc.	Continue montioring team performance via chart and call audits with attention to engagement techniques.
Hospital Utilization - ER Visits (net change in number of members visiting the ER prior to engagement vs. post-engagment whereby #members visiting the ER as numerator, # members engaged total as denominator)***		Baseline	2%	-5%	-7%	-10%	R	Quarterly	This is a baseline measurement, will be monitored for trending.	N/A	Diabetes self-management is a core component of the Condition Care Diabetes program. This includes education about appropriate ER utilization and when to use a different level of care. Also offering Remote Care Monitoring to members engaged in Condition Care program to monitor their vitals and symptoms daily so they can recognize issues early and seek treatment from PCP, avoiding unneccessary ER visits. Patient panel information regarding ER utilization is shared with providers by the Population Health Management team.	A new brochure has been created and approved by DMS regarding when to use ER vs. other levels of care. Recommend sending to highest ED utilizers. Retrain staff regarding emphasis on member education around appropriate ED use, connecting members to their PCPs and specialists, and teaching members how to manage their diabetes symptoms. Focus on closure of gaps in care related to diabetes.
Hospital Utilization - Inpatient Admissions (net change in number of members visiting inpatient prior to engagement vs. post-engagment whereby #members visiting inpatient as numerator, # members engaged total as denominator)***		Baseline	1%	-3%	-2%	-7%	R	Quarterly	This is a baseline measurement, will be monitored for trending.	N/A	Member education via care management programs. Sharing patient panel information regarding utilization with providers via care conferences and other methods. Also offering Remote Care Monitoring to members engaged in Condition Care program to monitor their vitals and symptoms daily so they can recognize issues early and seek treatment from PCP, avoiding unneccessary inpatient stays.	Watch member identification trends to ensure the # identified doesn't trend downward. Passport's CM programs are proven to reduce inpatient utilization, but outcomes are impacted when lower #'s of members are identified. Focus/emphasis on closing care gaps related to diabetes care.
Member Satisfaction: # of members response of "YES" to the question "The program helped me to understand my health condition."			11	26	27	11	R	Quarterly	Results appear to be consistent with previous years, and will continue to be monitored.	Upon program graduation, members are likely more difficult to reach. Surveys are done via IVR rather than by a live person.	Staff continue to request that members answer/respond to survey calls after program graduation.	Increase emphasis of survey importance during closure call and/or member mailings.

2019 QI Work Plan Business Area Report Template -Special Populations

2019 QI Work Plan Business Area Report - Sub-Populations

Project Element	Trend	2019 Goals	Q12019	Q22019	Q32019	Q42019	DP=Documented process FR=File review M=Materials R=Reports	Frequency	Key Findings/Results	Barriers	Interventions	Recommendations
			2019 Status									
Special Population Engagement Rates												
Foster Care - Engagement Count		N/A	243	291	236	250	R	Quarterly	Foster Care Engagement remained stable throughout 2019.	Minors in relative placements now carry same plan code as foster children, making it more difficult to determine actual members in foster care. Internal delivery of new foster care member updates is delayed.	Improve communication between DCBS, FC specialists and other staff. Work with internal Analytics team to develop more frequent reporting of newly enrolled foster care members.	Work with Passport Analytics Team to increase the frequency of reporting on newly enrolled Foster Care members.
Guardianship Program - Engagement Count		N/A	9	15	12	12	R	Quarterly	Guardianship Program engagement increased from Q1 to Q2 and remained stable the rest of 2019.	Internal delivery of new guardianship member updates is delayed.	Regular communication between DAIL, guardianship specialists and other staff. Staff continues to outreach individual PCHs statewide to provide care gap information and facilitate provider access.	Work with Passport Analytics Team to increase the frequency of reporting on newly enrolled Guardianship members.
Refugee Program and Outreach		N/A	163	233	237	89	R	Quarterly	Engagement numbers remained stable throughout the first three quarters, but decreased in Q4.	Distrust in the medical community because refugees have high health literacy barriers, multiple SDoH. Drop in fourth quarter due to dedicated staff person temporarily assigned to special project.	Staff person dedicated to refugee population embedded at Kentucky Refugee Ministries and Catholic Charities to meet with Passport members face to face to coordinate care.	Continue with interventions in place.
Homeless Program and Outreach		N/A	28	34	66	82	R	Quarterly	Outreach increased from quarter to quarter throughout the year.	Difficult to maintain contact with enrolled members.	Passport Social Worker embedded at FQHC for the homelessto increase engagement in the homeless care coordination program.	Create better collaborations with homeless-serving organizations to increase engagement and provide better care coordination.

2019 QI Work Plan Business Area Report - Credentialing

Quality Improvement Goals

Project Element	Goal	Q1	Q2	Q3	Q4	Data Sources DP=Documented process FR=File review M=Materials R=Reports	Key Findings or Results	Barriers, Risks	Interventions in Place	Discussion/Recommendation
		2019 Status								
Track Ongoing Monitoring and Interventions - annual analysis of actions taken	Complete annual analysis. Meet compliance and NCQA guidelines.	X	X	X	X	R				

Performance Indicators

Project Element	Metrics	Q1	Q2	Q3	Q4	Data Sources	Key Findings or Results	Barriers, Risks	Interventions in Place	Discussion/Recommendation
		2019 Status								
Ongoing Monitoring Reviews	Number of providers on monthly monitoring & sanctions report	22155	22883	23999	24887	R	•Ongoing monitoring of sanctions for facilities gap closed effective 01/2020 •Ongoing monitoring of sanctions for non-par providers, groups, and facilities is currently down;	•Lack of documented ongoing monitoring of facilities by Aperture	•Working with Aperture to remediate and put ongoing monitoring of sanctions in place for facilities •Working on a stop gap solution for sanction monitoring of non-par providers, groups, and	
Medicare Opt Out Reviews	Number of providers on monthly monitoring & sanctions report	9435	10163	11380	12268	R				
Sanction Monitoring Count	Number of providers on monthly monitoring & sanctions report	58	80	73	127	R				
Current Status-Aperture& KPCA Credentialing, Inc.	**(Combined)**									
Activity, Goal, and Frequency of Monitoring	**Primary Source Verification - Initial**									
Goal: Credential and recredential all eligible provider types in accordance with NCQA Standards and Guidelines, State, Regulatory requirements and Health Plan policies. Objectives: 1) Prepare all Type I provider profiles to ensure 95% Type I Health Plan credentialing (plan participation) decisions have been made within ten (10) days of the CVO credentialing file completion date. Credentialing file contains all NCQA CR 3 required credentialing verification elements. 2) Identify and act on quality safety issues in a timely manner between credentialing cycles (Ongoing Monitoring of Sanctions). 3) Notify all providers who require initial credentialing of the Health Plan credentialing decision within sixty (60) days of the credentialing decision date. 4) Quarterly, oversight of credentialing activities for all entities for whom Health Plan has delegated credentialing. Ongoing Monitoring: Passport reports # of providers who matched providers in Passport provider database that were on the monthly Monitoring of Sanctions report. These include Par and Non-par providers. KPCA, an entity for whom Passport has delegated credentialing, perform monthly sanction and opt-out for all providers and only reports with number of positive hits, meaning those with sanctions and those who have opted-out. They do not report total number of reviews as they review all providers monthly. Oversight: Credentials Committee Frequency: Quarterly	# Initial Practitioner Applications	746	415	880	773	R				
	Practitioner Initials - Average TAT from Start Date	33.9	34.0	26.7	24.0	R				
	Practitioner Initials - Average TAT from Application Completion	26.3	23.0	17.8	16.0	R				
	Practitioner Initials - App Complete %	97.5%	96.0%	95.5%	97.3%	R				
	# New Facility Applications	43	21	68	27	R				
	Facility Initials - TAT (Days) from Start Date	53.7	48.0	36.9	35.0	R				
	Facility Initials - TAT (Days) from App Comp	7.6	5.0	2.3	5.0	R				
	Facility Initials - App Complete %	57.0%	53.0%	64.7%	53.8%	R				
	Primary Source Verification - Recredentialing									
	# Recredentialing Practitioner Applications	785	917	1526	3084	R				
	Practitioner Recredentialing - Average TAT from Start Date	52.43	61	51	41.0	R				
	Practitioner Recredentialing - Average TAT from Application Completion	36.8	41.0	37.4	32.0	R				
	Practitioner Recredentialing - Application Completion %	91.5%	86.0%	85.8%	89.9%	R				
	# Facility Recredentialing Applications	Facility cred & recred are combined-see above	Facility cred & recred are combined-see above	Facility cred & recred are combined-see above	Facility cred & recred are combined-see above	R				
	Facility Recreds TAT (Days) from Start Date	Facility cred & recred are combined-see above	Facility cred & recred are combined-see above	Facility cred & recred are combined-see above	Facility cred & recred are combined-see above	R				
	Facility Recreds TAT (Days) from App Complete	Facility cred & recred are combined-see above	Facility cred & recred are combined-see above	Facility cred & recred are combined-see above	Facility cred & recred are combined-see above	R				
	Facility-Recred App Complete %	Facility cred & recred are combined-see above	Facility cred & recred are combined-see above	Facility cred & recred are combined-see above	Facility cred & recred are combined-see above	R				
	Actual Starts									
	Initial	746	728	950	773	R				
	Recreds	785	917	1654	6177	R				
	Facility	43	21	81	27	R				
	In Process at the end of the quarter									
	Initial	226	590	271	591	R				
	Recreds	718	1342	876	9604	R	•Passport recredentialing inventory dramatically increased due to move to statewide contract with DMS in 2017			
	Facility	29	26	25	26	R				
	Completes									
	Initial	947	754	349	888	R				
	Recreds	842	886	427	3084	R				
	Facility	34	35	20	52	R				
	Aperture Performance SLAs									
Frequency: Quarterly	SLA - PSV004 Rate <10%	4.3%	4.8%	8.0%	5.7%	R	•Aperture has met SLAs for Passport for all months in Q4			
	SLA - PSV005 Rate <10%	7.1%	15.0%	5.2%	3.5%	R	•Aperture has met SLAs for Passport for all months in Q4			
	SLA - Initials Completes 97% equal to or less than 30 days	71.4%	75.0%	98.0%	99.6%	R	•Aperture has met SLAs for Passport for all months in Q4			
	SLA - Initials Completes 100% equal to or less than 45 days	74.0%	100.0%	100.0%	100.0%	R	•Aperture has met SLAs for Passport for all months in Q4			

2019 QI Work Plan Business Area Report - EPSDT

Quality Improvement Goals

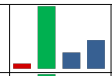
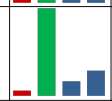
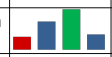
Project Element	2019 Goals	Q1	Q2	Q3	Q4	Data Sources DP=Documented process FR=File review M=Materials R=Reports	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
		2019 Status								
Maintain the number of members receiving appropriate EPSDT Screening at 80% (screening rate) during FFY 2018.	80%	64%	84%	86%	88%	R	Screening rate has met goal this quarter.	1. Incorrect demographic information TPL coordination of benefits. 2. Transportation issues 3. pcp lack of understanding and awareness of EPSDt screening, billing, and coding requirements. 4. Inability to track EPSDT services provided in a school setting of DOH- the plan may not be notified or able to confirm EPSDT services rendered. 5. members understanding of importance of screenings.	Provide EPSDT orientation and education to provider relations to utilize information to educate provider offices. Education also available on website. Evaluate opportunities to improve member and caregiver knowledge of transportation assistance, importance and schedule of epsdt screenings and develop information exchange between schools and DOH collaboration.	initiating quality resources to make additional EPSDT outreach calls starting 2nd quarter. Quality Advisors have continued EPSDT, combo 10 and combo 2 outreach for 3rd and 4th Quarter to work to improve rates. Care connectors have continued to make live follow up calls after IVR calls are completed. age ranges include 1-12 months, 15- 30 months, 3yrs- 11 yrs, 12 yrs- 20 yrs.
Increase the number of members participating in the EPSDT program to 80% (participation rate) during FFY 2018.	80%	57%	56%	60%	60%	R	EPSDT participation rate continues to be under goal due to barriers that	1. Incorrect demographic information TPL coordination of benefits. 2.	Provide EPSDT orientation and education to provider relations to utilize information	initiating quality resources to make additional EPSDT outreach calls starting 2nd quarter.
Annually, monitor and collaborate with dental delegate to increase annual dental visits rate. Increase annual dental visits by 10%.	56.60%			57%		R	Surpassed Quality compass goal of 56.60% with the ADV hedis result of 57.46%.		dental incentives annual visit to dentist ($30) 2nd visit to denist for ages 2-20 ($15)	There was a total of 6740 dental visits provided incentives. 1st Qtr- 1579, 2nd Qtr- 1603, 3rd Qtr 1868, 4th Qtr- 1690.

Performance Improvement Goals

Project Element	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Trend (2017-2019)	Goal (2018 QC 90th Percentile) Met	Q1	Q2	Q3	Q4	Measure Type (Admin/Hybrid)	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
						2019 Status								
LSC	81.94%	76.16%	74.21%					74.21%		H	See QI Strategy tab	N/A	N/A	
CIS Combo 10	31.71%	32.36%	33.58%					33.58%		H				
W15	59.25%	68.59%	68.06%					68.06%		A				
W34	70.00%	72.41%	65.67%					65.67%		A				
AWC	44.46%	54.01%	56.23%					56.23%		A				
IMA Combo 1	85.15%	76.64%	83.70%					83.70%		H				
HPV	25.29%	33.09%	38.20%					38.20%		H				
ADV Total	60.60%	60.15%	57.46%					57.46%		A				

Process and Performance Indicators

Project Element	Trend	2019 Goal	Q12019	Q22019	Q32019	Q42019	Data Sources DP=Documented process FR=File review M=Materials R=Reports	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
			2019 Status								
Screening Rate		80%	64%	84%	86%	88%	R	Screening rate has met goal this quarter.	N/A	Provide EPSDT orientation and education to provider relations to utilize information to educate provider offices. Education also available on website. Evaluate opportunities to improve member and caregiver knowledge of transportation assistance, importance and schedule of epsdt screenings and develop information exchange between schools and DOH collaboration.	initiating quality resources to make additional EPSDT outreach calls starting 2nd quarter. Quality Advisors have continued EPSDT, combo 10 and combo 2 outreach for 3rd and 4th Quarter to work to improve rates. Care connectors have continued to make live follow up calls after IVR calls are completed. age ranges include 1-12 months, 15- 30 months, 3yrs- 11 yrs, 12 yrs- 20 yrs.
Participation Rate		80%	57%	56%	60%	60%	R	EPSDT participation rate continues to be under goal due to barriers that prevent us achieving a more significant rate improvement. Participant ratio looks at each member that should have at least one screening, and checks to see if they have that screening This demonstrates the greater awareness to members and providers on the importance of participating in EPSDt services is vital to optimizing the health and wellness fo rchildren and adolescents.	1. Incorrect demographic information TPL coordination of benefits. 2. Transportation issues 3. pcp lack of understanding and awareness of EPSDt screening, billing, and coding requirements. 4. Inability to track EPSDT services provided in a school setting of DOH- the plan may not be notified or able to confirm EPSDT services rendered. 5. members understanding of importance of screenings.	Provide EPSDT orientation and education to provider relations to utilize information to educate provider offices. Education also available on website. Evaluate opportunities to improve member and caregiver knowledge of transportation assistance, importance and schedule of epsdt screenings and develop information exchange between schools and DOH collaboration.	initiating quality resources to make additional EPSDT outreach calls starting 2nd quarter. Quality Advisors have continued EPSDT, combo 10 and combo 2 outreach for 3rd and 4th Quarter to work to improve rates. Care connectors have continued to make live follow up calls after IVR calls are completed. age ranges include 1-12 months, 15- 30 months, 3yrs- 11 yrs, 12 yrs- 20 yrs.

Telephonic outreach & education indicated by successful/attempted	Successful			58	679	178	312	R	Telephonic outreach provided by care connector team. Live calls made from call list that were not reached by automated call.	Demographic information is often inaccurate resulting in unsuccess phone calls	Telephonic outreach as second attempt to reach members to notify them of need for screening and option to help set up appointment with pcp/pediatrician, age ranges include 1-12 months, 15- 30	Initiating quality resources to make additional EPSDT outreach calls starting 2nd quarter. Quality Advisors have continued EPSDT, combo 10 and combo 2 outreach for 3rd and 4th Quarter to work to improve rates. Care
	Attempted			225	3,916	649	1,126	R	Telephonic outreach provided by care connector team. Live calls made from call list that were not reached by automated call.		reach members to notify them of need for screening and option to help set up appointment with pcp/pediatrician. age ranges include 1-12 months, 15- 30 months, 3yrs- 11 yrs, 12 yrs- 20 yrs. Additional quality resources outreaching 12	EPSDT outreach calls starting 2nd quarter. Quality Advisors have continued EPSDT, combo 10 and combo 2 outreach for 3rd and 4th Quarter to work to improve rates. Care connectors have continued to make live follow up calls after IVR calls are completed. age
Number of Department of Health (DOH) provided home visit outreach (Contact only) for EPSDT and Dental education	Successful		N/A	0	0	0	0	R	In the process of building a new application to manage DOH home visit outreach. Plan to complete during 2nd Quarter. Unable to issue	Extensive hours required to complete application to provide DOH home visit referrals	Unable to complete home visits at this time until completion of application. Expectation of completion in 2nd Quarter of 2020	
	Attempted		N/A	0	0	0	0	R	In the process of building a new application to manage DOH home visit outreach. Plan to complete during 2nd Quarter. Unable to issue	Extensive hours required to complete application to provide DOH home visit referrals	Unable to complete home visits at this time until completion of application. Expectation of completion in 2nd Quarter of 2020	
Postcards mailed to EPSDT/Postpartum members regarding EPSDT & Dental Services			N/A	46	100	143	54	R		Demographic information is often inaccurate resulting in unsuccess mail receipt	Postcards mailed to new mothers to encourage postpartum check ups and to take newborn for EPSDt screenings	
Community collaboration and outreach events where EPSDT & Dental Information was distributed			N/A	yes	yes	yes	yes	R			Multiple outreach events including resource fairs and open houses for parents and children , Health and wellness	
Member Incentives Adolescent/Well-Child Screens Completed			N/A	393	319	603	871	R			Child Incentive 7-20 yo visit your doctor for a well child visit ($50), Child Incentive age 9-13 who recieve their immunizations	
Member Newsletters regarding EPSDT & Dental Services			N/A	yes	yes	yes	yes	R	Newsletters are mailed to members and posted on the website. New issues are released in April, July and	Demographic information is often inaccurate resulting in unsuccess mail receipt	First issue in April to contain articles on EPSDT and dental Second issue for July to include EPSDT and dental, and third issue in	
SoundCare Messages regarding EPSDT & Dental Services			N/A	yes	yes	yes	yes	R	Monthly on hold messages		January- EPSDT, February - EPSDT and dental, March- EPSDT April- EPSDT, May EPSDT and Dental, June- EPSDT, July -	
Automated call outreach			N/A	22,399	24,751	50, 399	45,670	R	large automated telephone campaigns utilized monthly to reach members/parents to notify of missed screenings	Demographic information is often inaccurate resulting in unsuccess phone calls	Utilizing automated telephone technology to reach large numbers of members and provide reminders of screenings due. Providing contact information to speak to	age ranges include 1-12 months, 15- 30 months, 3yrs- 11 yrs, 12 yrs- 20 yrs

2019 QI Work Plan Business Area Report - Provider Network

Quality Improvement Goals

Project Element	2019 Goals	Q1	Q2	Q3	Q4	Data Sources	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
		Status				DP=Documented				
Measure Practitioner Availability - Measure PCP, high-volume and high impact specialist, and behavioral health practitioner availability against organization standards	•Meet or exceed GeoAccess standards for PCPs and SCPs: •Urban & Rural membership: 1 PCP for every 1500 members. •High-volume SCP membership: 1 SCP to every 5000 members. •BH SCP membership: 1 BH SCP to every 5000 members.	X	X	X	X	R				
Monitor Practitioner Accessibility - Procedure: The organization measures access for: 1. PCP - routine appointments	•Meet or exceed GeoAccess standards for PCPs and SCPs: •Urban & Rural membership: 1 PCP for every 1500 members.	X	X	X	X	R				
Monitoring Member Satisfaction with the Network- Analyze member experience with accessing the network through review of member complaints, appeals and out-of-network	•Assess PCP and SCP (including BH) for compliance with accessibility. •Assess 5% of PCP, SCP, and BH network for accessibility compliance	X	X	X	X	R				
Evaluation of Access to Health Services - Identify opportunities to improve access to non-behavioral health and BH services through review of data from NET 1B -D and NET 2A - C analyses plus member complaints, appeals and CAHPS survey results related to non-behavioral health and BH network adequacy. Implement actions to address at least one opportunity and measure the effectiveness of those interventions	•Member complaints due to access are tracked quarterly •A full investigation will be conducted by a Special Support Tech in Provider Services •Passport analyzes grievances to determine trends/patterns and takes corrective actions as needed •Provider Relations will perform provider education when necessary	X	X	X	X	R				

Previously Tracked Goals (2017) & Recommendations for Performance Indicators

Project Element	Trend		2019 Goal	Q12019		Q22019		Q32019		Q42019		Data Sources	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
				2019 Status								DP=Documented				
Practitioner Availability																
	Availability Mean	**Miles Mean**		Availability Ratio	Miles Ratio	Availability Ratio	Miles Ratio	Availability Ratio	Miles Ratio	Availability Ratio	Miles Ratio					
PCP Urban - Availability	1:8	1.0	The PHP standard for urban PCPs is 30 minutes or miles from a member's home zip code. Urban and Rural membership: one PCP for every 1500 members.	1:8	1.0	1:8	1.3	1:2	0.4	1::5	1::03	R	Availability & Miles ratios seemed consistent during Q1-Q4 of 2019.	There were no barriers identified at this time	NA	Further evaluation of the data to take place for any opportunities and changes for 2020.
PCP Rural	1:8	1.9	The PHP standard for rural PCPs is 45 minutes or miles from a member's home zip code. Urban and Rural membership: one PCP for every 1500 members.	1:8	1.9	1:7	1.2	1:5	5.7	1::6	1::2	R	Availability & Miles ratios seemed consistent during Q1-Q4 of 2019.	There were no barriers identified at this time	NA	Further evaluation of the data to take place for any opportunities and changes for 2020.
High - Volume Specialists - Urban	1:7	1.5	The PHP standard for high volume urban specialists is no more than 60 minutes or miles from a member home zip code High-volume/Impact SCP membership: one SCP to every 5000 members.	1:7	1.5	1:8	1.5	1:7	1.5	1::4	0.3	R	Availability & Miles ratios seemed consistent during Q1-Q4 of 2019.	There were no barriers identified at this time	NA	Further evaluation of the data to take place for any opportunities and changes for 2020.
High - Volume Specialists - Rural	1::12	8.6	The PHP standard for high volume rural specialists is no more than 60 minutes or miles from a member home zip code. High-volume/Impact SCP membership: one SCP to every 5000 members.	1::12	8.6	1::10	9.2	1::12	8.5	1::5	1.7	R	Availability & Miles ratios trended down in Q4.	There were no barriers identified at this time	NA	Further evaluation of the data to take place for any opportunities and changes for 2020.
High - Impact Specialists - Urban	1:9	2.1	The PHP standard for high impact urban specialists is no more than 60 minutes or miles from a member home zip code High-volume/Impact SCP membership: one SCP to every 5000 members.	1:9	2.1	1::7	2.6	1:9	2.2	1::151	1.5	R	Availiabilty ratio increased tremendously in Q4.	Increased ratio may be due to the large number of providers/groups terminated effective 12/31/2019.	NA	Further evaluation of the data to take place for any opportunities and changes for 2020.
High - Impact Specialists - Rural	1::18	8.9	The PHP standard for high impact rural specialists is no more than 60 minutes or miles from a member home zip code. High-volume/Impact SCP membership: one SCP to every 5000 members.	1::18	8.9	1::22	8.4	1::20	8.9	1::141	6.5	R	Availiabilty ratio increased tremendously in Q4.	Increased ratio may be due to the large number of providers/groups terminated effective 12/31/2019.	NA	Further evaluation of the data to take place for any opportunities and changes for 2020.
Hospital-Urban	1::1908	1.2	The PHP standard for urban hospitals is no more than 30 minutes or miles from a member home zip code.	1::1908	1.2	1::1601	1.2	1::1724	2.0	1::149	1::2	R	Availiabilty ratio decreased tremendously in Q4.	The original data source for Q1-Q3 data changed in Q4 & may have had an impact on this measure.	NA	Further evaluation of the data to take place for any opportunities and changes for 2020.
Hospital-Rural	1::1299	1.8	The PHP standard for rural hospitals is no more than 60 minutes or miles from a member home zip code.	1::1299	1.8	1::761	1.2	1::817	7.2	1::63	1::6	R	Availiabilty ratio decreased tremendously in Q4.	The original data source for Q1-Q3 data changed in Q4 & may have had an impact on this measure.	NA	Further evaluation of the data to take place for any opportunities and changes for 2020.
Cardiologist – Urban	1::77	1.3	The PHP standard for cardiologist urban specialists is no more than 60 minutes or miles from a member home zip code High-volume/Impact SCP membership: one SCP to every 5000 members.	1::77	1.3	1::73	1.1	1::73	1.6	1::57	1::1	R	Availability & Miles ratios seemed consistent during Q1-Q4 of 2019.	There were no barriers identified at this time	NA	Further evaluation of the data to take place for any opportunities and changes for 2020.
Cardiologist – Rural	1::78	1.4	The PHP standard for cardiologist rural specialists is no more than 60 minutes or miles from a member home zip code. High-volume/Impact SCP membership: one SCP to every 5000 members.	1::78	1.4	1::71	1.5	1::46	5.9	1::57	1::1	R	Availability & Miles ratios seemed consistent during Q1-Q4 of 2019.	There were no barriers identified at this time	NA	Further evaluation of the data to take place for any opportunities and changes for 2020.
Oncologist - Urban	1::23	2.6	The PHP standard for oncologist urban specialists is no more than 60 minutes or miles from a member home zip code High-volume/Impact SCP membership: one SCP to every 5000 members.	1::23	2.6	1::25	3.1	1::25	2.6	1::151	1.5	R	Availiabilty ratio increased tremendously in Q4.	Increased ratio may be due to the large number of providers/groups terminated effective 12/31/2019.	NA	Further evaluation of the data to take place for any opportunities and changes for 2020.
Oncologist - Rural	1::47	7.7	The PHP standard for oncologist rural specialists is no more than 60 minutes or miles from a member home zip code. High-volume/Impact SCP membership: one SCP to every 5000 members.	1::47	7.7	1.55	7.2	1::47	8.3	1::141	6.5	R	Availiabilty ratio increased tremendously in Q4.	Increased ratio may be due to the large number of providers/groups terminated effective 12/31/2019.	NA	Further evaluation of the data to take place for any opportunities and changes for 2020.
OB/GYN – Urban	1::100	1.1	The PHP standard for OBGYN urban specialists is no more than 60 minutes or miles from a member home zip code o High-volume/Impact SCP membership: one SCP to every 5000 members.	1::100	1.1	1::93	1.1	1::97	1.1	1::80	1::1	R	Availability & Miles ratios seemed consistent during Q1-Q4 of 2019.	There were no barriers identified at this time	NA	Further evaluation of the data to take place for any opportunities and changes for 2020.
OB/GYN – Rural	1::115	1.5	The PHP standard for OBGYN rural specialists is no more than 60 minutes or miles from a member home zip code. o High-volume/Impact SCP membership: one SCP to every 5000 members.	1::115	1.5	1::105	1.1	1::78	5.9	1::93	1::5	R	Availability & Miles ratios seemed consistent during Q1-Q4 of 2019.	There were no barriers identified at this time	NA	Further evaluation of the data to take place for any opportunities and changes for 2020.

Behavioral Health Providers – Urban	1:9	1.1	The PHP standard for behavioral health provider specialists is no more than 60 minutes or 60 miles from a member home zip code. o BH SCP membership: one BH SCP to every 5000 members.	1:9	1.1	1:5	1.1	1:4	0.8	1::4	1::05	R	Availability & Miles ratios seemed consistent during Q1-Q4 of 2019.	There were no barriers identified at this time	NA	Further evaluation of the data to take place for any opportunities and changes for 2020.
Behavioral Health Providers – Rural	1:11	1.3	The PHP standard for behavioral health provider specialists is no more than 60 minutes or 60 miles from a member home zip code. o BH SCP membership: one BH SCP to every 5000 members.	1:11	1.3	1:6	1.3	1:8	1.5	1::6	1::2	R	Availability & Miles ratios seemed consistent during Q1-Q4 of 2019.	There were no barriers identified at this time	NA	Further evaluation of the data to take place for any opportunities and changes for 2020.
Identify languages and ethnic background of practitioners in the network to assess whether they meet members' language needs and cultural preferences.	**NA**	**NA**	Maintain a provider network that meets members' needs and preferences. Monitor the language and cultural backgrounds of providers to ensure the network meets members' needs and preferences. Monitor provider network to ensure network adjustments are not needed.	X	X	X	X	X	X	X	X	R	**Region 1**: Members speak 2 different languages, all languages covered except Cambodian **Region 2**: Members speak 2 different languages, all languages covered except Degalo **Region 3**: Members speak 10 different languages, all languages covered except Karen **Region 4:** Members speak 3 different langauges, all languages covered except Egyptian and Mandarin **Region 5**: Members speak 7 different languages, all langauges covered except Ethiopian and Egyptian **Region 6**: Members speak 2 different langauges, all langauges covered except Braille **Region 7**: Members speak 1 language, language is covered **Region 8**: Members speak 1 language, language is covered	**Region 1**: 1 member speaks Cambodian, with no Cambodian speaking providers in network, in Region 1 **Region 2**: 1 member speaks Degalo, with no Degalo speaking providers in network in Region 2 **Region 3**: 19 members speak Karen, with no Karen speaking providers in network in Region 3 **Region 4**: 1 member speaks Egyptian and 1 member speaks Mandarin, with no Egyptian or Mandarin speaking providers in network in Region 4 **Region 5**: 1 member speaks Ethiopian and 2 members speak Egyptian, with no Ethiopian or Egyptian speaking providers in network in Region 5 **Region 6**: 1 member reads Braille, with no Providers that read Braille in Region 6 **Region 7**: No barriers at this time **Region 8**: No barriers at this time	Provider Reps in each region where members do not have a provider that speaks their langauges are attempting to locate any providers in that region that does speak that language that can be contracted and brought into the network	Further evaluation of the data to take place for any opportunities and changes for 2020.
Take action to adjust the practitioner network if the current practitioner network does not meet members' language needs and cultural preferences.	**NA**	**NA**	Maintain a provider network that meets members' needs and preferences. Monitor the language and cultural backgrounds of providers to ensure the network meets members' needs and preferences. Monitor provider network to ensure network adjustments are not needed.	X	X	X	X	X	X	X	X	R	Provider Reps in each region where members do not have a provider that speaks their langauges are attempting to locate any providers in that region that does speak that language that can be contracted and brought into the network	Some regions do not have providers that speak specific languages that a member would need	Usage of the interpreter line is edcuated to the providers throughout the state via the provider reps in these such cases where a member goes into a provider and the provider does not speak the members language	Further evaluation of the data to take place for any opportunities and changes for 2020.

Practitioner Accessibility: Site Visits	**Trend**	**Goal**	**Overall Site Vistis**	**Q1**	**Q2**	**Q3**	**Q4**
PCP/SCP		NA	568	153	132	169	114
BH		NA	141	37	68	11	25

Practitioner Education: Webinars Completed	**Trend**	**Goal**	**Overall Webinars**	**Q1**	**Q2**	**Q3**	**Q4**

2019 QI Work Plan Business Area Report - Member Services

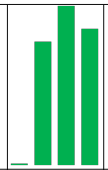
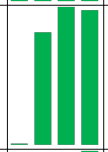
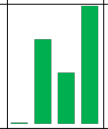
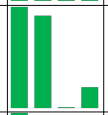
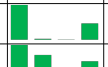
Quality Improvement Goals

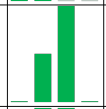
Project Element	2019 Goals	Q1	Q2	Q3	Q4	Data Sources DP=Documented process FR=File review M=Materials	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
		Status								
Annual Analysis of Member Experience - Aggregate member complaints and appeals by reason, showing rates related to: • **Quality of Care** • **Access** • **Attitude and Service** • **Billing and Financial** • **Quality and Practitioner Office Site** • **Pharmacy** • **Enrollment/Eligibility** • **Plan Administration**	**Evidence of monitoring includes:** • **Quarterly reporting from all departments to establish opportunities for improvement.** • **Root-cause analysis provided to identify opportunities for improvement.** • **Annual reporting to the QC**	• Quality of Care = 3 • Access = 4 • Attitude and Service = 10 • Billing and Financial = 1 • Quality and Practitioner Office Site = 0 • Pharmacy = 1 • Enrollment/Eligibility = 0 • Plan Administration = 0	• Quality of Care = 4 • Access = 10 • Attitude and Service = 19 • Billing and Financial = 6 • Quality and Practitioner Office Site = 0 • Pharmacy = 1 • Enrollment/Eligibility = 0 • Plan Administration = 0	• Quality of Care = 3 • Access = 28 • Attitude and Service = 18 • Billing and Financial = 17 • Quality and Practitioner Office Site = 0 • Pharmacy = 1 • Enrollment/Eligibility = 0 • Plan Administration = 0	• Quality of Care = 5 • Access = 10 • Attitude and Service = 14 • Billing and Financial = 1 • Quality and Practitioner Office Site = 0 • Pharmacy = 1 • Enrollment/Eligibility = 0 • Plan Administration = 0	R				
Member Service Telephone Accessibility Standards • **Collect member average speed of answer** • **Collect member abandonment rate**	• Meet or exceed ASA of 30 seconds goal. • Meet or exceed AR of 5% goal. • Improve ASA to meet and/or exceed the 2017 Quality Compass® 90th Percentile by 12/31/18. • Improve member satisfaction with customer service as measured via CAHPS to meet and/or exceed the 2017 Quality Compass® 90th Percentile by 12/31/2018	• Goal achieved ASA - Y • Goal achieved AB- Y	• Goal did not achieved ASA - N • Goal achieved AB- Y	• Goal achieved ASA - N • Goal achieved AB- Y	• Goal achieved ASA - Y • Goal achieved AB- Y	R				
Monitoring Member Services' Benefit Information for Quality and Accuracy Components of the process: • **Collecting data on quality and accuracy of information provided** • **Analyzing data against standards or goals** • **Determining the cause of deficiencies, as applicable** • **Acts to improve identified deficiencies, as applicable**	• Telephone: 90% • Online: 90%	• Telephone: 93% • Online: 100%	• Telephone: 94.7% • Online: 100%	• Telephone: 92.1% • Online: 100%	• Telephone: 93.3% • Online: 100%	R				

Performance Indicators

Project Element		2019 Goal		Q12019	Q22019	Q32019	Q42019	Data Sources DP=Documented process FR=File review M=Materials R=Reports	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
				2019 Status								
Total Complaints / Grievances		**Addressed within 5 business days**	**Completed within 30 days**									
Quality of Care		100%	100%	Total Complaints: 3 Addressed within 5 business days: 3 Completed within 30 days: 3	Total Complaints: 4 Addressed within 5 business days: 4 Completed within 30 days: 2	Total Complaints: 3 Addressed within 5 business days: 3 Completed within 30 days: 3	Total Complaints: 5 Addressed within 5 business days: 5 Completed within 3days: 30 days, 2 pended	R	2 additional grievances were closed within 44 days with extension letter sent, so all grievances were within compliance.			
Access		100%	90%	Total Complaints: 4 Addressed within 5 business days: 4 Completed within 30 days: 4	Total Complaints: 10 Addressed within 5 business days: 10 Completed within 30 days: 5	Total Complaints: 28 Addressed within 5 business days: 21 Completed within 30 days: 15 Pending Resolution: 8	Total Complaints: 10 Addressed within 5 business days: 08 Completed within 30 days: 2 Pending Resolution: 02	R	4 additional grievances were closed within 44 days with extension letter sent, and 1 was outside the 44 days due to Office Being unavailable due to holiday.			
Attitude and Service		100%	100%	Total Complaints: 10 Addressed within 5 business days: 10 Completed within 30 days: 6	Total Complaints: 19 Addressed within 5 business days: 19 Completed within 30 days: 16	Total Complaints: 18 Addressed within 5 business days: 13 Completed within 30 days: 12 Pending Resolution: 6	Total Complaints:14 Addressed within 5 business days: 9 Completed within 30 days: 15 Pending Resolution: 5	R	3 additional grievances were closed within 44 days with extension letter sent, so all grievances were within compliance.			
Billing and Financial Issues		83%	100%	Total Complaints: 1 Addressed within 5 business days: 1 Completed within 30 days: 1	Total Complaints: 6 Addressed within 5 business days: 5 Completed within 30 days: 4	Total Complaints: 17 Addressed within 5 business days: NA Completed within 30 days: 16	Total Complaints: 01 Addressed within 5 business days: NA Completed within 30 days: 0 1 Pending resolution	R	2 additional grievances were closed within 44 days with extension letter sent. There was one case mailed in that didn't make it to grievances within the the 5 day window, hence the one not addressed within 5 business days.			
Quality of Practitioners Office Site		100%	100%	Total Complaints: 0 Addressed within 5 business days: Completed within 30 days:	Total Complaints: 0 Addressed within 5 business days: Completed within 30 days:	Total Complaints: 0	Total Complaints: 0	R	No quality of office received.			
Other		100%	100%	Total Complaints: 0 Addressed within 5 business days: Completed within 30 days:	Total Complaints: 1 Addressed within 5 business days: 1 Completed within 30 days: 0	Total Complaints: 0	Total Complaints: 0	R	Pharmacy complaint received.			
Goal Aggregate Total (Total # of Complaints)/1000 Members		97.50%	97.50%	Total Complaints: 18	Total Complaints: 40	Total Complaints: 66	Total Complaints: 39					
Average Speed to Answer		30 Seconds		0:16	0:45	0:34	0:16	R - Cisco and Evolent Internal (IM)				
Average Abandonment Rate		5%		0.61%	2.08%	1.30%	0.06%	R - Cisco and Evolent Internal (IM)				

2019 QI Work Plan Business Area Report - UM											
Quality Improvement Goals											
Project Element		**2019 Goals**	**Q1**	**Q2**	**Q3**	**Q4**	**Data Sources** DP=Docum	**Key Findings/Results**	**Barriers to meeting goal**	**Interventions in place**	**Recommendations**
			Status								
Analysis of Member Experience: Aggregate member appeals by reason code: • Quality of Care • Access • Attitude and Service		Complete Analysis by June 2019		X			R	Reported in Annual UM Report	None		
Member Satisfaction with the UM Process: Components of the process: • Collecting and analyzing data on member and practitioner satisfaction to identify improvement opportunities • Taking action designed to improve member and practitioner		Complete Analysis by June 2019		X			R	Reported in Annual UM Report	None		
2019 Utilization Management Program Evaluation: • Completed and ongoing activities • Quantitative and Qualitative Analysis • Evaluation of effectiveness		Complete Analysis by June 2019		X			R	Evaluation of 2019 UM program will be completed Q1 2020	None		
2019 UM Program Description: • Program Structure • BH Aspects • Designated Sr Physician • BH practitioner • Scope and process used to determine benefit coverage and		Complete Program Update by July 2019		X			R	2020 UM Program Description will be completed Q1 2021	None	N/A	N/A
Evaluating Utilization Management Criteria: The Plan's UM Department has: • Written UM decision-making criteria that are objective and based on medical evidence • Has written policies for applying the criteria based on individual needs • Has written policies for applying the criteria based on an		For activities delegated to an NCQA accredited UM organization - Certificate of accreditation may be presented in lieu of activities and goals.					R	Noted in UM policy 201 E Medical Criteria, Guideline, Policy and Protocol Development, Review and Adoption and 2019 Program Description	None	N/A	N/A
Monitoring Consistency of Applying UM Criteria (IRR): The Plan's Utilization Management Department annually: • Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making • Acts on opportunities to improve consistency, if applicable		to an NCQA accredited UM organization - Certificate of accreditation may be presented in lieu of activities and goals.					R	Noted in 2019 Program Description IRR testing conducted at a minimum annually	None	N/A	N/A
Analyze UM Timeliness Decisions and Notifications: Monitor reports of timeliness of decisions and notifications		For activities delegated to an NCQA accredited UM organization - Certificate of accreditation may be					R	Turn around times are monitored monthly for all UM including all Case , appeals review timeliness and reported on a monthly	None	N/A	N/A
UM Staff: Informing members about how to access staff and the UM process for authorizations. • Sends newsletter and member handbook about the TDD/TTY		Complete by Q4 2018				X	M	Also noted in member handbook page 20	None	N/A	N/A
UM Affirmative Statement: The organization distributes a statement to all members and to all practitioners, providers and employees who make UM decisions, affirming the following: • UM decision making is based only on appropriateness of care and service and existence of coverage. • The organization does not specifically reward practitioners or other individuals for issuing denials of coverage		Complete by Q4 2019 (Newsletters to members and providers) Employee update delegated to Evolent Health				X	M	Provided by Evolent Health to all employees making UM decisions, Provider Manual, and in the Member Handbook	None	N/A	N/A
Performance and Process Indicators											
Project Element	**Trend**	**2019 Goal**	**Q12019**	**Q22019**	**Q32019**	**Q42019**	**Data Sources** DP=Documented process FR=File review	**Key Findings/Results**	**Barriers to meeting goal**	**Interventions in place**	**Recommendations**
			2019 Status								

Admissions /1000		98.1	79.2	96.4	101.4	98.2	R	Decrease in admits per 1,000; Pneumonia is the top diagnosis followed by Sepsis. Medicaid Expansion accounted for 44% of total admissions. Trending has shown a decrease from Q4 2018.	None	Continue analysis to reduce admissions to lower levels of care; Evaluate 1 and 2 day length of stay for observation	None
Days /1000		530	428.8	514.9	534.5	531.9	R	Decrease in days per 1,000 from prior quarter and decrease from Q4 2018; 39.3% of the total days were utilized by members in the Expansion Category of Aid	None	Continue to review DRG outliers	None
ALOS		5.32	5	5.5	5.3	5.7	R	No significant change from prior quarter	None	Continue to evaluate for alternatives to inpatient and 1 and 2 day LOS review for observation	None
Members placed in ER lock in		210	249	243	179	193	R	193 new members identified for lock in from claims	None	In process of re-evaluation of ER programs for 2020	None
Members removed from ER lock in		399	368	159	0	0	R	No Members met regulatory lock in removal requirements; Zero were removed from the LI Program	None	None	None
Cumulative members in Lock-In		889	1,307	1,299	1,130	1,182	R	Total of 1,182 members in the ER lock inprogram; re-review every 12 and 24	None	None	None
# of ER lock in pre-warning letters sent		123	473	315	302	317	R	317 pre-warning letters sent for members nearing lock in status	None	None	None
# of referrals to Behavioral Health		44	63	79	66	57	R	57 referrals to BH for members with ER visit for	None	None	None
# of referrals to Mommy Steps		22	32	18	17	17	R	17 referrals to Maternity Program for members	None	None	None
# of nine month follow up calls		TBD	220	212	207	161	R	161 member calls to follow up and identify barriers to care	None	None	None
# of nine month follow up calls answered		TBD	21	35	28	17	R	17 calls answered ; 11% reach rate	Invalid phone numbers	Continue measures to increase reach rate (i.e. Evening calls)	None
# of Direct member education by ER Navigators		TBD	90	149	95	104	R	104 contacts in the ER with members for education and identification of barriers to	None	None	None
Member telephonic outreach		TBD	804	116	95	724	R	95 outreach calls by Navigators for follow up	None	None	None
Outreach successful contacts		TBD	306	25	20	154	R	21% reach rate	None	None	None
Number of follow-up letters to members		TBD	225	190	95	167	R	Navigator intervention sent to	None	None	None
Appeals											
Total Number of New Requests			98	88	114	135	R - Identifi	Includes both member and provider appeals	Providers not submitting clinical at the time of original request	Ongoing outreach to providers to obtain clinical; Education to providers re:	None
Total Number Completed			120	87	110	108	R - Identifi	Includes both member and provider appeals	None	None	None
Total Number Pending			5	1	4	33	R - Identifi	Includes both member and provider appeals	None	None	None

Number of Cases from Previous Qtr Completed			18	2	5	6	R - Identifi	Includes both member and provider appeals	None	None	None
Member Medical Necessity Appeals											
Total Member Medical Necessity Appeals			15	16	8	17	R - Identifi	None	None	None	None
Appeals Expedited			0	0	0	1	R - Identifi	None	None	None	None
Appeals for Outpatient Therapy			0	0	0	0	R - Identifi	None	None	None	None
Appeals for Durable Medical Equipment			2	15	2	6	R - Identifi	None	None	None	None
Appeals Overturned			9	15	6	4	R - Identifi	None	None	None	None
Appeals Upheld			6	1	2	13	R - Identifi	None	None	None	None
Appeals Partially Overturned			0	0	0	0	R - Identifi	None	None	None	None
Member Administrative / Benefit Appeals											
Total Member Administrative/Benefit Appeals			7	9	10	7	R - Identifi	None	None	None	None
Appeals for Pharmacy Lock In			4	6	6	6	R - Identifi	None	None	None	None
Appeals for E.R. Lock In			3	3	1	1	R - Identifi	None	None	None	None
Appeals Overturned			4	5	6	4	R - Identifi	None	None	None	None
Appeals Upheld			3	4	4	3	R - Identifi	None	None	None	None
Appeals Partially Overturned			0	0	0	0	R - Identifi	None	None	None	None

2019 QI Work Plan Business Area Report Template - COPD

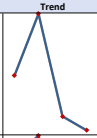
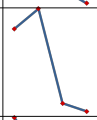
Quality Improvement Goals

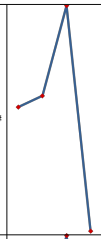
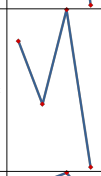
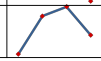
Project Element	2019 Goal	2019 Status			2019	DP=Documented process FR=File review M=Materials R=Reports	Frequency	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
Reduce All-Cause Readmissions for Members with Dx of COPD enrolled in Condition Care	Decrease ACR of members in the COPD Program by 2% from baseline (2018) rate				-2%	R	Annual	All Cause Readmissions decreased in 2019 by 2% from 2018.	None at this time.	Outreach to member within 2 days of known hospital discharge to follow up and ensure they have what they need. Educate on signs and symptoms to looks out for and when to call their provider. Also offering Remote Care Monitoring to members engaged in Condition Care program to monitor their vitals and symptoms daily so they can recognize issues early and seek treatment from PCP, avoiding unneccessary inpatient admissions.	Increase provider education about the Condition Care COPD program to increase provider referrals. Partner more proactively with providers around members' care plans and needs to encourage members to utilize their PCP and specialists proactively for their care needs.
Reduce ER visits for Members with Dx of COPD enrolled in Condition Care	Decrease ER visits for members in the COPD Program by 2% from baseline (2018) rate				-2%	R	Annual	ER visits decreased in 2019 by 2% from 2018.	None at this time.	COPD symptom self-management is a core component of the Condition Care COPD program. This includes education about appropriate ER utilization and when to use a different level of care. Also offering Remote Care Monitoring to members engaged in Condition Care program to monitor their vitals and symptoms daily so they can recognize issues early and seek treatment from PCP, avoiding unneccessary ER visits. Patient panel information regarding ER utilization is shared with providers by the Population Health Management team.	A new brochure has been created and approved by DMS regarding when to use ER vs. other levels of care. Recommend sending to highest ED utilizers. Retrain staff regarding emphasis on member education around appropriate ED use, connecting members to their PCPs and specialists, and teaching members how to manage their COPD symptoms.
Improve Member Satisfaction	Increase the member experience response from 87% to 90% of members response of "YES" to the question "The program helped me to understand my health condition." during MY 2019				88%	R	Annual	Results of the Patient Satisfaction Survey equeated to 88% for the question, "The program helped me to understand my health condition." for the year.	Low number of members responding to survey.	Continued Education to staff members regarding prevalent conditions. Educating staff on new ways to help members understand and teach back the signs and symptoms of COPD. Prompting in closure template to remind staff of educating member on survey importance.	Increase emphasis of survey importance during closure call and/or member mailings.

Performance Improvement Goals

Project Element	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Trend (2017-2019)	Goal (2018 QC 90th Percentile) Met	Q1	Q2	Q3	Q4	Measure Type (Admin/Hybrid)	Frequency	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
						2019 Status									
COPD Measures															
PCE: Systemic Corticosteroid	67.39%	65.86%	52.61%					52.61%		A	Annual	see QI Strategy tab			
PCE: Bronchodilator	78.49%	79.70%	64.72%					64.72%		A	Annual				
SPR	40.74%	34.93%	30.48%					30.48%		A	Annual				

Process and Performance Indicators

Project Element	Trend	2019 Goal	Q12019	Q22019	Q32019	Q42019	DP=Documented process FR=File review M=Materials R=Reports	Frequency	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
			2019 Status									
COPD Program - Total Number of Members Identified		N/A	270	364	208	187	R	Quarterly	There was an increase in number of members identified for COPD Condition Care from Q1 to Q2 and a decrease from Q2 to Q3 and again from Q3 to Q4.	N/A	Passport utilizes predictive modeling to identify members with COPD who are at rising risk of an event such as inpatient hospitalization. These are the members primarily targeted for intervention. Cases are requested to be identified/pushed based on staff availability (openings in caseloads).	PNM/PHM's increasing provider awareness of various care management programs to increase provider referrals.
COPD Program - Total Number of Members Engaged		N/A	100	110	63	59	R	Quarterly	Engagement numbers will vary based on number of members identified. The number corresponds appropriately.	N/A	Passport utilizes predictive modeling to identify the majority of program referrals. Staff objectives and key results focus on increasing engagement with stratified members. Staff utilizes multiple methods/tools to locate accurate member contact information.	PNM/PHM's increasing provider awareness of various care management programs to increase provider referrals.
Engagement Rate (numerator members engaged, denominator of members identified)		25%	37.04%	30.22%	30.29%	31.55%	R	Quarterly	Engagements rates have remained fairly the same throughout the year, always exceeding target rate during each quarter.	N/A	Staff utilizes multiple methods/tools to locate accurate member contact information.	Continue montioring team performance via quality and call audits with attention to engagement techniques.

Hospital Utilization - ER Visits (net change in number of members visiting the ER prior to engagement vs. post-engagment whereby #members visiting the ER as numerator, # members engaged total as denominator)***		Baseline	-2%	-1%	7%	-13%	R	Quarterly	This is a baseline measurement, will be monitored for trending.	N/A	COPD symptom self-management is a core component of the Condition Care COPD program. This includes education about appropriate ER utilization and when to use a different level of care. Also offering Remote Care Monitoring to members engaged in Condition Care program to monitor their vitals and symptoms daily so they can recognize issues early and seek treatment from PCP, avoiding unneccessary ER visits. Patient panel information regarding ER utilization is shared with providers by the Population Health Management team.	A new brochure has been created and approved by DMS regarding when to use ER vs. other levels of care. Recommend sending to highest ED utilizers. Retrain staff regarding emphasis on member education around appropriate ED use, connecting members to their PCPs and specialists, and teaching members how to manage their COPD symptoms.
Hospital Utilization - Inpatient Admissions (net change in number of members visiting inpatient prior to engagement vs. post-engagment whereby #members visiting inpatient as numerator, # members engaged total as denominator)***		Baseline	3%	-1%	5%	-5%	R	Quarterly	This is a baseline measurement, will be monitored for trending.	N/A	Member education via care management programs. Sharing patient panel information regarding utilization with providers via care conferences and other methods. Also offering Remote Care Monitoring to members engaged in Condition Care program to monitor their vitals and symptoms daily so they can recognize issues early and seek treatment from PCP, avoiding unneccessary inpatient admissions.	Increase provider education about the Condition Care COPD program to increase provider referrals. Partner more proactively with providers around members' care plans and needs to encourage members to utilize their PCP and specialists proactively for their care needs.
Member Satisfaction: # of members response of "YES" to the question "The program helped me to understand my health condition."			9	13	14	11	R	Quarterly	Results appear to be consistent with previous years, and will continue to be monitored.	Upon program graduation, members are likely more difficult to reach. Surveys are done via IVR rather than by a	Staff continue to request that members answer/respond to survey calls after program graduation.	Increase emphasis of survey importance during closure call and/or member mailings. (incorported in documentation for staff)

2019 QI Work Plan Business Area Report - Cultural and Linguistic Needs of the Member

Quality Improvement Goals

Project Element	2019 Goals	Q1	Q2	Q3	Q4	Frequency	Data Sources DP=Documented process FR=File review M=Materials	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
		Status									
Identify language needs and ethnic background of members, including prevalent languages and cultural groups, using U.S. Census data and enrollment data.	Find the top 10 languages relevant to the population.		x			Annual	R	1. Spanish, 2. Arabic, 3. Somali, 4. Nepali, 5. Swahili, 6. Mai Mai (a dialect of Somali), 7. Kinyarwanda (official language of Rwanda), 8. French, 9. Karen (tonal language spoken in Myanmar/Thailand) and 10. Vietnamese American Indian or Alaska Native	Currently the eligibility file (834) received by PHP from DMS is not well populated and some of the existing data is not accurate.	The Plan collects, assess and identifies the race, ethnicity, and language preferences of the membership using the categories designed by the Office of Management and Budget (OMB) o Census Data o Kentucky Department of Education o Local agencies and community organizations o Regional and national trend data o Eligibility files received by the Plan from	To collect REaL on Plan Members through outbound calls, online member portal and HRA.
Correlate data with members' expressed preferences based on feedback or complaint data.	100% of members in High Risk Maternity Program have expressed a language preference in the system. *Members may opt out of race and ethnicity identifiers.	x				Quarterly	R	Asian19 Black or African American333 Decline to state1 Hispanic3 Native Hawaiian or Other Pacific Islander6 Non-Hispanic Black73 Non-Hispanic White237 Other20 Undisclosed18 Unknown68	Members may opt out of race and ethnicity identifiers.	PHP is in the process to enhance its Member data repository to populate member's REaL.	Identifing Member's preffered language will be done through completed HRAs, Care Coordiantion as well as call campaings.

Performance and Process Indicators

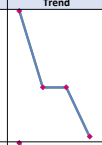
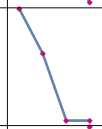
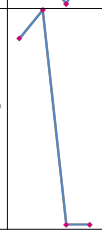
Project Element	Trend	2019 Goal	Q12019	Q22019	Q32019	Q42019		Data Sources DP=Documented process FR=File review M=Materials R=Reports	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
			2019 Status									
Cultural and Linguistic Needs of the Member												
# of Engagements with Members (through Events, Outreach, & Member Education)			60	56	48	94	Quarterly	R - CE Outreach Data Base	Q4 saw an increase in number of member engagements	The engagement types listed in the trends are held out in the community	The Plan is actively partnering with social services organizations to schedule memebr education sessions.	
# of Trainings (2018 tracking presentations sent out; 2019 we are tracking the number of clicks by staff taking the training)			64	138	0	110*	Quarterly	R - Passport Communications				Further evaluation of the data sources to take place for any opportunties and changes for 2020.
# of Translated Materials		To fulfill as many requests as possible to make sure members have materials they can understand regarding their benefits.	5	9	8	8	Quarterly	R - Passport Marketing SharePoint		Not having a place to document individual member's preffered language. This limmits the Plan from sending appropriate language material to members.	PHP is in the process to enhance its Member data repository to populate member's REaL.	
Use of Language Line - Care Coordination # of Calls			159	70	49	28	Quarterly	R - Interpreter line/Vendor	Q4 - Spanish is the 1st most used lanaguage, followed by Arabic and then Nepali.		Providing information to department and educating on the importance of capturing this data.	
Use of Language Line - Member Services # of Calls			761	982	892	874	Quarterly	R - Interpreter line/Vendor			Providing information to department and educating on the importance of capturing this data.	
# of Language Requirement Trainings - EVH/PHP*			68	24	61	0	Quarterly	R - Passport HR		Evolent and Passport employees are not split out on the Orientation so totals are combined for all MCOE associates attending orientation.		Further evaluation of the data sources to take place for any opportunties and changes for 2020.
# of Bilingual MCOE Staff			5	5	4	5	Quarterly	R - Manual Process		Currently the Plan is having some difficulting assessing this data for Evolent bilingual staff data.	This data will be requested on a quarterly basis.	Further evaluation of the data sources to take place for any opportunties and changes for 2020.

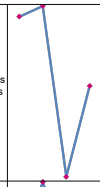
2019 QI Work Plan Business Area Report - CHF

Quality Improvement Goals

Project Element	2019 Goals	Status			2019	Data Sources DP=Documented process FR=File review M=Materials	Frequency	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
Reduce All-Cause Readmissions for Members with Dx of CHF enrolled in Condition Care	Decrease ACR by 2% from baseline (2018) rate for members enrolled in the CHF program				-4%	R	Annual	All Cause Readmissions decreased in 2019 by 4% from 2018.	None at this time.	Outreach to member within 2 days of known hospital discharge to follow up and ensure they have what they need. Educate on signs and symptoms to looks out for and when to call their provider. Also offering Remote Care Monitoring to members engaged in Condition Care program to monitor their vitals and symptoms daily so they can recognize issues early and seek treatment from PCP, avoiding unneccessary inpatient admissions.	Increase provider education about the Condition Care CHF program to increase provider referrals. Partner more proactively with providers around members' care plans and needs to encourage members to utilize their PCP and specialists proactively for their care needs.
Reduce ER visits for Members with Dx of CHF enrolled in Condition Care	Decrease ER Visits for members enrolled in the CHF program by 2% from baseline (2018) rate				7%	R	Annual	ER visits increased in 2019 by 7% from 2018.	Due to working with providers to improve our value based programming, care conferences were not taking place the latter part of 2019, which may have impacted our ability to meet goal.	CHF symptom self-management is a core component of the Condition Care CHF program. This includes education about appropriate ER utilization and when to use a different level of care. Also offering Remote Care Monitoring to members engaged in Condition Care program to monitor their vitals and symptoms daily so they can recognize issues early and seek treatment from PCP, avoiding unneccessary ER visits. Patient panel information regarding ER utilization is shared with providers by the Population Health managers which are set to renew visits with practices and sharing of information end of Q1 2020.	A new brochure has been created and approved by DMS regarding when to use ER vs. other levels of care. Recommend sending to highest ED utilizers. Retrain staff regarding emphasis on member education around appropriate ED use, connecting members to their PCPs and specialists, and teaching members how to manage their CHF symptoms.
Improve Member Satisfaction	Increase the member experience response from 87% to 90% of members response of "YES" to the question "The program helped me to understand my health condition." during MY 2019	0.00%	0.00%	0.00%	100%	R	Annual	Results of the Patient Satisfaction Survey were 100% for the question, "The program helped me to understand my health condition." for the year.	Goal was met. Fewer CHF cases than other conditions.	Continued Education to staff members regarding prevalent conditions. Educating staff on new ways to help members understand and teach back the signs and symptoms of CHF.	Increase emphasis of survey importance during closure call and/or member mailings.

Process and Performance Indicators

Project Element	Trend	2019 Goal	2019 Status Q12019	Q22019	Q32019	Q42019	Data Sources DP=Documented process FR=File review M=Materials R=Reports	Frequency	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
CHF Program - Total Number of Members Identified		N/A	25	11	11	2	R	Quarterly	There was an increase in number of members identified for CHF Condition Care from Q1 to Q2 and a remained consistent from Q2 to Q3, ending Q4 decrease from Q3.	N/A	Passport utilizes predictive modeling to identify members with CHF who are at rising risk of an event such as inpatient hospitalization. These are the members primarily targeted for intervention. Cases are requested to be identified/pushed based on staff availability (openings in caseloads).	Utilize the Population Health Management and Provider Network Management teams to increase provider awareness of the Condition Care CHF program to increase provider referrals.
CHF Program - Total Number of Members Engaged		N/A	12	8	2	2	R	Quarterly	Engagement numbers will vary based on number of members identified. The number corresponds appropriately.	N/A	Passport utilizes predictive modeling to identify the majority of program referrals. Staff objectives and key results focus on increasing engagement with stratified members. Staff utilizes multiple methods/tools to locate accurate member contact information.	PNM/PHM's increasing provider awareness of various care management programs to increase provider referrals.
Engagement Rate (numerator members engaged, denominator of members identified)		25%	48.00%	72.73%	18.18%	100.00%	R	Quarterly	Engagements rates were well above target Q1 and Q2 and below target in Q3. Q4 far exceeded all other quarters and target set.	There is a small # of members identified for the Condition Care CHF program.	Staff utilizes multiple methods/tools to locate accurate member contact information.	Continue montioring team performance via quality and call audits with attention to engagement techniques.
Hospital Utilization - ER Visits (net change in number of members visiting the ER prior to engagement vs. post-engagment whereby #members visiting the ER as numerator, # members engaged total as denominator)***		Baseline	13%	15%	0%	0%	R	Quarterly	This is a baseline measurement being monitored for trending. This may not be an impactable measure for this program.	N/A	A component of the Condition Care CHF program is education about appopriate ER utilization vs. when to use other levels of care. Also offering Remote Care Monitoring to members engaged in Condition Care program to monitor their vitals and symptoms daily so they can recognize issues early and seek treatment from PCP, avoiding unneccessary ER visits. Patient panel information regarding ER utilization is shared with providers by the Population Health Management team.	A new brochure has been created and approved by DMS regarding when to use ER vs. other levels of care. Recommend sending to highest ED utilizers. Retrain staff regarding emphasis on member education around appropriate ED use, connecting members to their PCPs and specialists, and teaching members how to manage their CHF symptoms.

Hospital Utilization - Inpatient Admissions (net change in number of members visiting inpatient prior to engagement vs. post-engagment whereby #members visiting inpatient as numerator, # members engaged total as denominator)***		Baseline	13%	15%	-17%	0%	R	Quarterly	This is a baseline measurement being monitored for trending. This may not be an impactable measure for this program.	N/A	Member education via care management programs. Sharing patient panel information regarding utilization with providers via care conferences and other methods. Also offering Remote Care Monitoring to members engaged in Condition Care program to monitor their vitals and symptoms daily so they can recognize issues early and seek treatment from PCP, avoiding unneccessary inpatient admissions.	Increase provider education about the Condition Care CHF program to increase provider referrals. Partner more proactively with providers around members' care plans and needs to encourage members to utilize their PCP and specialists proactively for their care needs.
Member Satisfaction: # of members response of "YES" to the question "The program helped me to understand my health condition."			N/A	1	0	0	R	Quarterly	Results appear to be consistent with previous years, and will continue to be monitored.	Upon program graduation, members are likely more difficult to reach. Surveys are done via IVR rather than by a live person.	Staff continue to request that members answer/respond to survey calls after program graduation. Cue for survey embedded within documentation	Increase emphasis of survey importance during closure call and/or member mailings.

2019 QI Work Plan Business Area Report Template - Asthma

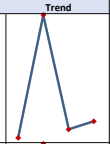
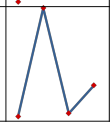
Quality Improvement Goals

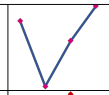
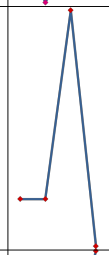
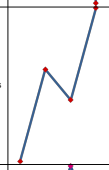
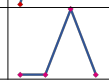
Project Element	2019 Goal	2019 Status			2019	DP=Documented process FR=File review M=Materials R=Reports	Frequency	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
Reduce All-Cause Readmissions for Members with Dx of Asthma enrolled in Condition Care	Decrease ACR of members in the Asthma Program by 2% from baseline (2018) rate				-2%	R	Annual	All Cause Readmissions decreased in 2019 by 2% from 2018.	None at this time.	Outreach to member within 2 days of known hospital discharge to follow up and ensure they have what they need. Educate on signs and symptoms to looks out for and when to call their provider. Also offering Remote Care Monitoring to members engaged in Condition Care program to monitor their vitals and symptoms daily so they can recognize issues early and seek treatment from PCP, avoiding unneccessary inpatient admissions.	Increase provider education about the Condition Care Asthma program to increase provider referrals. Partner more proactively with providers around members' care plans and needs to encourage members to utilize their PCP and specialists proactively for their care needs.
Reduce ER visits for Members with Dx of Asthma enrolled in Condition Care	Decrease ER visits for members in the Asthma Program by 2% from baseline (2018) rate				-10%	R	Annual	ER visits decreased in 2019 by 10% from 2018.	None at this time.	Asthma self-management is a core component of the Condition Care Asthma program. This includes education about appropriate ER utilization and when to use a different level of care. Also offering Remote Care Monitoring to members engaged in Condition Care program to monitor their vitals and symptoms daily so they can recognize issues early and seek treatment from PCP, avoiding unneccessary ER visits. Patient panel information regarding ER utilization is shared with providers by the Population Health Management team.	A new brochure has been created and approved by DMS regarding when to use ER vs. other levels of care. Recommend sending to highest ED utilizers. Retrain staff regarding emphasis on member education around appropriate ED use, connecting members to their PCPs and specialists, and teaching members how to manage their asthma symptoms.
Improve Member Satisfaction	Increase the member experience response from 87% to 90% of members response of "YES" to the question "The program helped me to understand my health condition." during MY 2019				84%	R	Annual	Results of the Patient Satisfaction Survey equated to 84% for the question, "The program helped me to understand my health condition." for the year.	Low number of members responding to survey.	Continued Education to staff members regarding prevalent conditions. Educating staff on new ways to help members understand and teach back the signs and symptoms of Asthma. Prompting in closure template to remind staff of educating member on survey importance.	Increase emphasis of survey importance during closure call and/or member mailings.

Performance Improvement Goals

Project Element	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Trend (2017-2019)	Goal (2018 QC 90th Percentile) Met	Q1	Q2	Q3	Q4	Measure Type (Admin/Hybrid)	Frequency	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
						2019 Status									
Asthma Measures															
MMA 50%	56.12%	61.23%	60.70%					60.75%		A	Annual	see QI Strategy tab			• Run adminstrative data on quarterly basis when HEDIS rules are built • Regular medical record review to validate quality rates were related to barriers versus poor quality
MMA 75%	29.13%	37.44%	37.06%					37.06%		A	Annual				
AMR	71.38%	65.76%	68.52%					68.52%		A	Annual				

Process and Performance Indicators

Project Element	Trend	2019 Goal	Q12019	Q22019	Q32019	Q42019	DP=Documented process FR=File review M=Materials R=Reports	Frequency	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
			2019 Status									
Asthma Program - Total Number of Members Identified		N/A	159	389	175	190	R	Quarterly	There was an increase in number of members identified for Asthma Condition Care from Q1 to Q2 and a decrease from Q2 to Q3. The number of identified members remained stable in Q4.	N/A	Passport utilizes predictive modeling to identify members with Asthma who are at rising risk of an event such as inpatient hospitalization. These are the members primarily targeted for intervention. Cases are requested to be identified/pushed based on staff availability (openings in caseloads).	PNM/PHM's increasing provider awareness of various care management programs to increase provider referrals.
Asthma Program - Total Number of Members Engaged		N/A	39	74	40	49	R	Quarterly	Engagement numbers will vary based on number of members identified. The number corresponds appropriately.	N/A	Passport utilizes predictive modeling to identify the majority of program referrals, staff objectives and key results focus on increasing engagement with stratified members. Staff utilizes multiple methods/tools to locate accurate member contact info.	PNM/PHM's increasing provider awareness of various care management programs to increase provider referrals.

Engagement Rate (numerator members engaged, denominator of members identified)		25%	24.53%	19.02%	22.86%	25.79%	R	Quarterly	Engagements rates have remained fairly stable throughout 2019, although slightly below target.	Unable to reach rates are higher for Condition Care programs (such as Asthma) than for other CM programs.	Staff utilizes multiple methods/tools to obtain accurate member contact information.	Continued MI training with staff; continued emphasis on interventions currently in place. Listen to messages left for members by Condition Care Asthma team members and provide coaching on outreach techniques.
Hospital Utilization - ER Visits (net change in number of members visiting the ER prior to engagement vs. post-engagment whereby #members visiting the ER as numerator, # members engaged total as denominator)***		Baseline	-11%	-11%	-3.00%	-13%	R	Quarterly	This is a baseline measurement, will be monitored for trending.	N/A	Asthma self-management is a core component of the Condition Care Asthma program. This includes education about appropriate ER utilization and when to use a different level of care. Also offering Remote Care Monitoring to members engaged in Condition Care program to monitor their vitals and symptoms daily so they can recognize issues early and seek treatment from PCP, avoiding unneccessary ER visits. Patient panel information regarding ER utilization is shared with providers by the Population Health Management team.	A new brochure has been created and approved by DMS regarding when to use ER vs. other levels of care. Recommend sending to highest ED utilizers. Retrain staff regarding emphasis on member education around appropriate ED use, connecting members to their PCPs and specialists, and teaching members how to manage their asthma symptoms.
Hospital Utilization - Inpatient Admissions (net change in number of members visiting inpatient prior to engagement vs. post-engagment whereby #members visiting inpatient as numerator, # members engaged total as denominator)***		Baseline	-5%	-2%	-3.00%	0%	R	Quarterly	This is a baseline measurement, will be monitored for trending.	N/A	Member education via care management programs. Sharing patient panel information regarding utilization with providers via care conferences and other methods. Also offering Remote Care Monitoring to members engaged in Condition Care program to monitor their vitals and symptoms daily so they can recognize issues early and seek treatment from PCP.	Increase provider education about the Condition Care Asthma program to increase provider referrals. Partner more proactively with providers around members' care plans and needs to encourage members to utilize their PCP and specialists proactively for their care needs.
Member Satisfaction: # of members response of "YES" to the question "The program helped me to understand my health condition."			7	7	8	7	R	Quarterly	Results appear to be consistent with previous years, and will continue to be monitored.	Upon program graduation, members are likely more difficult to reach. Surveys are done via IVR rather than by a live person.	Staff continue to request that members answer/respond to survey calls after program graduation.	Retrain staff regarding emphasis on member education around appropriate ED use, connecting members to their PCPs and specialists, and teaching members how to manage their asthma symptoms.

2019 QI Work Plan Business Area Report - Maternity

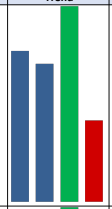
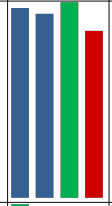
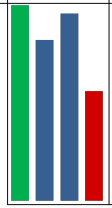
Quality Improvement Goals

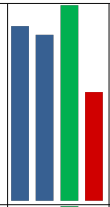
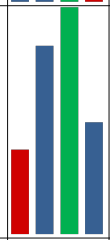
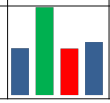
	2019 Goals	2016 Status	2017 Status	2018 Status	2019 Status	Data Sources DP=Documented process FR=File review M=Materials	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
Increase rate of member opting for LARC within 90 days of delivery by 25% from baseline year of 2018	6.3%			5%		R	Will report 2019 data in Q1 2020 Workplan to allow for claims run out and accurate data.			
Maternity Members Engagement rate in CM vs. Identified as Eligible	30%			37%	41%	R	Engagement Rates surpassed goal of 30% for 2019.	Hard to determine high risk members identified on the strat from external partner data (Lucina)	Mommy Steps members now being managed in Identifi. Continued work is being done on stratification tool to ensure the most high risk members are being identified early and outreached by the team as soon as possible. Collaboration continues with physicians to refer members early in pregnancy. Education continues with staff around motivational interviewing and engagement skills to increase engagement. Staff utilizes multiple methods/tools to locate accurate member contact information.	Continue montioring team performance via quality and call audits with attention to engagement techniques.

Performance Improvement Goals

Project Element	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Trend (2017-2019)	Goal (2018 QC 90th Percentile) Met	Q1 2019 Status	Q2 2019 Status	Q3 2019 Status	Q4 2019 Status	Measure Type (Admin/Hybrid)	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
PPC Timeliness	81.00%	71.28%	77.89%		**90.75%**			77.89%		H				
PPC Postpartum	64.39%	55.59%	63.39%		**73.97%**			63.39%		H				

Process and Performance Indicators

Project Element	Trend	2019 Goal	Q12019 2019 Status	Q22019 2019 Status	Q32019 2019 Status	Q42019 2019 Status	Data Sources DP=Documented process FR=File review M=Materials R=Reports	Key Findings/Results	Barriers to meeting goal	Interventions in place	Recommendations
Number of LBW deliveries		Baseline	152	139	197	82	R	Low birth weights remained stable throughout the first three quarters and decreased significantly in Q4.	None at this time.	Continued collaboration with the Women's Health Committee and physicians. Focus on prenatal smoking cessation and substance abuse counseling when needed. Continued work is being done on stratification tool to ensure the most high risk members are being identified early and outreached by the team as soon as possible. Collaboration continues with physicians to refer members early in pregnancy.	Utilize the Population Health Management and Provider Network Management teams to increase provider awareness of the Mommy Steps program to increase provider referrals. This will allow our team to intervene as soon as possible with as many members as possible to decrease the incidence of low birth weights.
Number of VLBW deliveries		Baseline	33	32	34	29	R	Very low birth weights stayed stable through all four quarters of 2019.	None at this time.	Continued collaboration with the Women's Health Committee and physicians. Focus on prenatal smoking cessation and substance abuse counseling when needed. Continued work is being done on stratification tool to ensure the most high risk members are being identified early and outreached by the team as soon as possible. Collaboration continues with physicians to refer members early in pregnancy.	Utilize the Population Health Management and Provider Network Management teams to increase provider awareness of the Mommy Steps program to increase provider referrals. This will allow our team to intervene as soon as possible with as many members as possible to decrease the incidence of very low birth weights.
Number of preterm deliveries		Baseline	214	176	205	120	R	Preterm deliveries decreased in Q2, then incrased again in Q3, decreasing the most in Q4.	None at this time.	Continued collaboration with the Women's Health Committee and physicians. Focus on prenatal smoking cessation and substance abuse counseling when needed. Continued work is being done on stratification tool to ensure the most high risk members are being identified early and outreached by the team as soon as possible. Collaboration continues with physicians to refer members early in pregnancy.	Utilize the Population Health Managers and Provider Network Management teams to increase provider awareness of the Mommy Steps program to increase provider referrals. This will allow our team to intervene as soon as possible with as many members as possible to decrease the incidence of preterm deliveries.

Total number of deliveries		Baseline	1,687	1,601	1,888	1,049	R	Total number of deliveries stayed fairly stable throughout the first three quarters, dipping down in Q4.	None at this time.	Continued collaboration with the Women's Health Committee and physicians. Focus on prenatal smoking cessation and substance abuse counseling when needed. Continued work is being done on stratification tool to ensure the most high risk members are being identified early and outreached by the team as soon as possible. Collaboration continues with physicians to refer members early in pregnancy.	None at this time.
Engaged Cases		Baseline	144	321	387	191	R	The number of engaged cases was the least in Q1, increasing significantly in Q2 and Q3, and then decreasing again in Q4.	None at this time.	Mommy Steps members now being managed in Identifi. Continued work is being done on stratification tool to ensure the most high risk members are being identified early and outreached by the team as soon as possible. Collaboration continues with physicians to refer members early in pregnancy. Education continues with staff around motivational interviewing and engagement skills to increase engagement. Staff utilizes multiple methods/tools to locate accurate member contact information.	Continue montioring team performance via quality and call audits with attention to engagement techniques.
Mommy Steps Program Enrollees		Baseline	5057	5280	9089	9469	R	The number of Mommy Steps enrollees remained stable in the first two quarters of 2019 and then nearly doubled in the last two quarters of the year.	None at this time.	Continued work is being done on stratification tool to ensure the most high risk members are being identified early in their pregnancy. Collaboration also continues with providers to refer members as early in pregancy as possible.	Utilize the Population Health Managers and Provider Network Management teams to increase provider awareness of the Mommy Steps program to increase provider referrals.
High risk pregnant members identified		Baseline	1767	2619	1556	2106	R	High risk pregnant members increased significantly from Q1 to Q2, then decreased to the lowest in Q3. In Q4, the number of high risk pregnant members increased again.	None at this time.	Continued work is being done on stratification tool to ensure the most high risk members are being identified early in their pregnancy. Collaboration also continues with providers to refer members as early in pregancy as possible.	Utilize the Population Health Managers and Provider Network Management teams to increase provider awareness of the Mommy Steps program to increase provider referrals, with a specific focus on high risk members.
High risk member engaged into one-on-one		Baseline	144	270	143	163	R	High risk members engaged in 1:1 care management stayed fairly stable throughout the year, except for Q2, where the number increased significantly.	None at this time.	Education continues with staff around motivational interviewing and engagement skills to increase engagement. Staff utilizes multiple methods/tools to locate accurate member contact information.	Continue montioring team performance via quality and call audits with attention to engagement techniques.