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QUALITY AND PERFORMANCE IMPROVEMENT PROGRAM

Summary:

Health Services for Children with Special Needs, Inc. (HSCSN) will maintain an active Quality and Performance Improvement Program. For the purposes of oversight and assessment of the health plan enrollees and to ensure that the children, youth and young adults with special needs have access to appropriate, essential, quality care, service and cost effective healthcare.

The Program focuses on the performance of organization-wide functions that significantly affect enrollee health outcomes and perceptions of the enrollees and their families about the quality, safety and value of the services being provided. Structural systems are in place, which enable appropriate individuals and inter-department teams to work collaboratively to plan and implement initiatives including targeted interventions to improve performance and quality, eliminate disparities and related health outcomes. This is accomplished by continuously assessing, monitoring, measuring and lastly evaluating operational performance outcomes of healthcare and service delivery processes.

HSCSN shall cooperate with the Department of Health Care Finance (DHCF) external quality review organization (EQRO) as well any DHCF staff or contractor assisting DHCF in its continuous quality improvement (CQI) efforts. This shall include on-site and off-site quality improvement audits, staff and enrollee interviews, medical record reviews, policies and procedures, reports, committee activities, credentialing and re-credentialing activities, corrective action and follow-up plans, peer review process, satisfaction survey results, grievances, appeals and lastly staff as well as provider qualifications.

Details:

Mission Statement– To improve the health status and quality of life for children and youth with special needs, their families and communities, to enhance the knowledge of medical professionals providing services to special needs populations through accredited educational activities, and to participate in related local, regional, and national projects with government, private, and philanthropic organizations.

Vision – To measurably improve the health status and quality of life for children, youth and young adults with special needs, their families and the greater community we serve.

Values and **Guiding Principles**

A. **Excellence** – Consistently put forth our best efforts, actively seek ways to improve our individual performance and collaborate as a team to improve the performance of our organization as a whole.

B. **Service –**Keep our members, families and coworkers as the focus of our work by providing reliable, responsive and empathic care, exceeding expectations of all customers we serve and dedicating our efforts to making a positive difference in their lives.

C. **Fairness** – Be clear about performance expectations and provide constructive feedback to help our colleagues learn and improve. Do not passively condone inappropriate behavior or provide biased advantages to certain individuals.

D. **Commitment** – Faithful to the HSC System mission, positively promote our organization in the community, fully commit to quality and safety in every aspect of our work and assume responsibility and accountability for carrying out our roles and knowing those of our colleagues.

E. **Communication** – Promote an open line of communication to facilitate the exchange of ideas and information accurately, reliably and timely to beneficiaries, stakeholders and the community at large.

F. **Diversity** – Seek other's opinions, work toward inclusion by inviting others to be a part of the process, seek to understand different perspectives and treat all families, colleagues and business associates with dignity and respect.

G. **Respect** – Listen carefully to each other in our daily interactions, deal directly and respectfully with a person with whom we have a conflict and honor the contributions of all staff.

H. **Ethical** – Tell the truth as we know it, engage fully in open communication, do not participate in spreading rumors or gossip and discourage rumors and gossip when they are presented.

This Program will serve to guide the organizational structure and operation of quality improvement activities; to ensure quality of care, service and access in a timely, appropriate, cost effective manner and to improve the health status of our membership. HSCSN's Quality and Performance Improvement Program incorporates and aligns with the DHCF's goals, as defined in its *Continuous Quality Improvement Plan for Oversight & Assessment of Medicaid Managed Care Organizations* and shall incorporate all applicable Department of Health (DOH) initiatives. The Program also relies upon assessment, monitoring, and measurement to denote accomplishment or effectiveness throughout the year using various performance measure results, such as, but not limited to, Healthcare Effectiveness Data and Information Set (HEDIS), CAHPS member satisfaction survey, provider satisfaction survey, the National Committee for Quality Assurance (NCQA) and external quality review organization (EQRO) results. As comparable to DHCF's Continuous Quality Improvement Plan, HSCSN incorporates its own organizational

mission, vision, values, and guiding principles into the Quality and Performance Improvement Program.

The Program ensures quality of care, service, and access in the most appropriate, timely, and cost effective manner to improve the health status of our enrollees. HSCSN will submit its Quality and Performance Improvement Program Description, Work Plan and Evaluation of such Program to its Board of Directors for approval annually.

The following categories listed are aligned with DHCF's Continuous Quality Improvement Plan and incorporated in HSCSN's Quality and Performance Improvement Program.

- Access/Availability: Ensuring an appropriate network of providers through monitoring processes for credentialing and re-credentialing, and promoting ethical and cultural competent care.
- Coordination/Continuity of Care: Assessing the healthcare needs of enrollees, develops an appropriate plan of care, and coordinates care across multiple healthcare providers while enhancing the families' ability to contribute to the care giving process.
- Practice Guidelines: Adopting and implementing clinical practice guidelines based upon valid/reliable clinical evidence or consensus.
- Utilization Management: Maintaining an effective utilization management program with the use of medical necessity criteria, authorizations, inter-rater reliability testing, a process for denials and appeals, and an annual program evaluation.
- Cultural Competency: Providing cultural competency training to staff and ensuring network providers are cognitive of culturally competent care. Ensuring information is communicated in easily understandable language and accounts for cultural considerations.
- Satisfaction: Conducting a satisfaction assessment of enrollee, family, and providers using HSCSN's services.
- Regulatory Compliance with DHCF External Quality Review Organization: Ensuring organizational policies and procedures are in place for addressing regulatory, accreditation/certification standards and contractual compliance.
- Quality and Performance Improvement: Maintaining an effective quality and performance program including the QI work plan and applicable policies and procedures through monitoring, measurement and program evaluation annually.

Program Goals

1. Availability/Access of Services
    a. Maintain a Network of Appropriate Providers; Sufficient in Number, Mix, Geographical Distribution and Cultural Competency
    b. Promote and Monitor Access to Services.
    c. Maintain a Process for Credentialing and Re-credentialing of Physicians and other Licensed Healthcare Professionals
    d. Actively Promote the Delivery of Ethical, Culturally Competent Care

2. Facilitate the Development of a Multi-disciplinary Treatment Plan through Collaboration and the Monitoring of Continuity of Care and Periodic re-assessments.

3. Ensure the Coordination of Healthcare Services, Case Management and Ensure the Inclusion of Cultural Considerations.

4. Ensure Organizational Policies & Procedures are in place for Addressing Compliance with all Applicable Privacy, Confidentiality, Information Security Requirements, Language Access & the provision of Interpreter Services and Periodic Training/Education of Staff.

5. Maintain an Effective Utilization Management Program as well as an Annual Program Evaluation.

6. Maintain an Effective Risk Management Program and an Annual Program Evaluation.

7. Facilitate a Culture of Safety by Emphasizing the Importance of Member Safety and the Development of a Member Safety Program and Annual Evaluation.

8. Adoption/Implementation of Clinical Practice Guidelines based upon valid/reliable clinical evidence or consensus, updated periodically, as appropriate.

9. Maintain an Effective Quality and Performance Improvement Program with the inclusion of QI Work Plan and Annual Evaluation.

10. Satisfaction Assessment of Enrollee, Family/Caregiver and the Provider Network.

11. Comply with External Quality Review Organizations, Accreditation, Certification and other Regulatory Entity Standards.

Authority, Accountability and Structure

The Quality and Performance Improvement Program extends across all internal operational areas as well as the healthcare and services rendered by the provider network. The Program, incorporating all appropriate healthcare professionals, is an interdisciplinary structure that drives and coordinates the performance improvement activities within the plan. This structure represents a systematic organization-wide approach to planning for quality and performance initiatives. Through the committees and communication channels of the Quality and Performance Improvement Program, performance improvement efforts within these functions are identified, prioritized and quantified.

The Program represents a transition from an approach in which performance improvement is a distinct set of activities to one in which performance improvement is integrated into the operational structure. This cross-organizational approach ensures that the monitoring and evaluation of care coordination and healthcare service delivery occur within existing operational committees.

HSCSN Board of Directors

The HSCSN Board of Directors (BOD) holds final authority, accountability and responsibility for the allocation of resources and decisions concerning the quality, utilization and outcomes of healthcare and care coordination of services. The Board of Directors, on an annual basis, will approve the Quality and Performance Improvement Program, work plan and annual evaluation.

The Board of Directors delegates appropriate responsibility, authority, and accountability for the activities and outcomes of the program to the Chief Operating Officer (COO), Chief Medical Officer(s), and the Performance Outcomes and Improvement Committee.

Chief Operating Officer Responsibilities-The COO, in conjunction with the Chief Medical Officer(s), has overall responsibility for program implementation and outcomes.
Responsibilities include, but not limited to:

- Recommend the strategic direction.
- Provide resources and support systems for the quality and performance improvement program.
- Review information needed to educate the Board members about their responsibility for the quality of care, service, coordination of those services and provider health delivery system.
- Require the evaluation of the Quality and Performance Improvement Program at least annually.

Chief Medical Officer Responsibilities- serves as a leader within the HSCSN network regarding medical management issues and as a clinical liaison with healthcare providers. The role is responsible for ensuring the reporting of outcomes and mechanisms for monitoring and evaluating the quality and safety of services. Ensuring that all service delivery and member-related policy and decisions follow medical, ethical and quality principles and practices and collaborates with the Director of Quality/Accreditation and appropriate staff.

Chief Psychiatric Medical Officer Responsibilities- serve as a leader within the HSCSN network regarding mental health issues and as a clinical liaison with behavioral health providers. The role focuses on ensuring that all mental/behavioral health service delivery and member-related policy and decisions follow medical, ethical and quality standards, principles and practices and collaborates with the Director of Quality/Accreditation and appropriate staff**.**

Corporate Vice President of Quality and Compliance – responsible for providing guidance and consultation to the health plan relating to the Quality and Performance Improvement Program, Risk Management and Member Safety Program, third party accreditation and external regulatory reporting requirements. The Corporate Vice President of Quality and Compliance serves as the Compliance Officer and is directly responsible for corporate compliance and the Fraud Waste and Abuse Program.

Director of Quality/Accreditation Responsibilities - is administratively and operationally responsible and accountable for the leadership and management of the Quality and Performance

Improvement Program, compliance with external quality review organization activities and accreditation or certification entities.

Quality Council of Network Providers (QC)
The Quality Council (QC) is comprised of network providers and licensed practitioners actively practicing in the network and routinely providing care to enrollees. The QC committee is chaired by the Chief Medical Officer and will meet at least quarterly and maintain a written record of its activities. Responsibilities include, but not limited to:

- Serve in an advisory capacity regarding performance improvement initiatives to the management team and/or the Performance Outcomes and Improvement Committee (POIC)
- Approve evidence-based clinical guidelines reflecting current standards of care at least every two years for acute, chronic and mental/behavioral healthcare relevant to the HSCSN population; revisions can be made and incorporated as changes occur in professional and/or industry standards
- Receive and review network performance activities of providers.
- Receive and review performance improvement reports, initiatives and activities.
- Receive, provide input and approve clinical criteria

Performance Outcomes and Improvement Committee (POIC)) The POIC committee is responsible for approving quality initiatives consistent with organizational priorities, and is comprised of the HSCSN management team. The team oversees the implementation and application of the Quality and Performance Improvement Program throughout the organization. The committee is chaired by the Director of Quality/Accreditation and will meet at least ten (10) times a year and maintains a written record of its activities.

The BOD authorizes the POIC committee to:

- Identify areas needing remedial action as appropriate
- Recommend and approve performance improvement initiatives
- Approve and implement at least one disease management program initiative based on the analysis of the demographic and clinical characteristics of the HSCSN population and/or contractual requirements of the District of Columbia (DC) Department of Health Care Finance (DHCF).
- Forward timely reports about quality concerns and initiatives to the Board of Directors and Quality Council (when involving the network of providers); when appropriate.
- Review the Quality and Performance Improvement Program and program evaluation annually.
- Forward the annual evaluation of the Quality and Performance Improvement Program and updated Quality and Performance Improvement Program for approval to the Board of Directors.
- Coordinate interdisciplinary activities and facilitate exchange of information to provide feedback to health professionals and HSCSN staff.
- Develop and approve the annual performance indicator “Report Card” (QI work plan) and performance goals, targets and historical benchmarks. Ensuring validity via oversight of the design and methodology of clinical and non-clinical initiatives or indicators and focused studies.
- Receive and evaluate reports from internal coordinating committees, performance

improvement teams, and organizational performance indicators according to a pre-established reporting calendar and/or external sources according to mandated frequencies.
- Identify and prioritize performance improvement initiatives according to areas of highest volume, highest risk, and greatest impact on enrollees served.
- Charter performance improvement teams comprised of relevant stakeholders to improve quality of care and services provided
- Receive and make recommendations regarding all areas of services provided by the organization
- Receive reports on status of implementation of plans for improvement
- Monitor Salazar internal corrective action plan (CAP)

Operations Committee

The Operations Committee, under the direction of the Director of Quality & Accreditation will review and evaluate operational processes and outcomes at the departmental level utilizing the performance indicator "Report Card" (QI work plan). Additionally, the Committee will have overall responsibility for recommending corrective actions when there are variances identified in the data and barriers to successful outcomes. This will be accomplished through the use of performance improvement (PI) teams utilizes the Plan Do Check Act (PDCA) model for continuous quality improvement. This committee will meet at least ten (10) times a year and is chaired and co-chaired by a Quality/Accreditation department designee and maintains a written record of its activities.

Responsibilities include, but not limited to:

- Analyze and monitor performance indicators "Report Card" (QI work plan) for trends/variances and communicate recommendations to POIC as needed to improve processes and outcomes.
- Develop and implement quality improvement activities based on results of the performance indicator analysis using the PDCA model.
- Perform an annual analysis of Access & Availability enrollee survey, the HEDIS CAHPS Member Satisfaction Survey, Secret Shopper Survey and the Provider Satisfaction Survey results and presents the analysis and recommendations to POIC.

Member Safety/Risk Management Committee

The Member Safety/Risk Management Committee, under the guidance and peer protection of the Department of Quality/Accreditation is committed to promoting a culture of safety by creating an environment that encourages error identification, remediation, non-punitive reporting and prevention of recurrences utilizing education, systems redesign, and/or quality and process improvement.

This committee will serve to monitor safety through quality care, service, appropriate access, in a timely and cost effective manner; particularly areas of enrollee rights, enrollee, provider education as well as continuity of care. This committee will meet at least six (6) times a year and is chaired by a Quality/Accreditation department designee and maintains a written record of its activities.

Responsibilities include, but not limited to:

- Review identified “high profile/high risk” cases, review root cause analysis, as needed, and develop standards/best practices for the management of similar cases.
- Mortality Review
- Unusual Occurrences
- Complaints/Grievances
- Potential Quality of Care Reviews
- Critical, Sentinel and Never Events
- Provider/Practitioner corrective action plans (CAP)s
- Provide a mechanism for discussing potential and high profile legal issues identified via; but not limited to: the high profile/high risk reviews, grievance process including appeals or fair hearings.

Organization wide Committees
The following committees and or advisory boards are responsible for key functions/programs and communicating findings to senior management, other committees and staff. The Committee Chairs will present an executive summary to POIC.

Community Service Advisory Committee (CSAC)
Benefits Utilization Management Committee (BUMC)
Behavioral Health Utilization Management Committee (Sub-committee to BUMC)
Pharmacy Utilization Management Committee (Sub-committee to BUMC)
Operations Committee (Sub-committee to POIC)
Member Safety & Risk Management Committee (Sub-committee to POIC)
Continuing Medical Education Committee
Health Education Committee

Key Functions and Scope of Program

This program reviews healthcare and services furnished by the network provider system including but are not necessarily limited to: primary care, specialty care, preventive care, dental care, hospitals, home health agencies, early intervention and day treatment programs, medical or mental/behavioral long-term care (institutions and group homes), rehabilitative therapies including physical therapy (PT), occupational therapy (OT) and speech therapy; mental/behavioral health services and therapies, psychiatric residential treatment centers, pharmaceutical and durable medical equipment (DME) providers.

There are many key functions that support positive enrollee outcomes. The following organizational wide functions are incorporated in the evaluation process:

1. Rights, Responsibilities and Ethics
2. Member Safety
3. Continuum of Care
4. Education and Communication
5. Health Promotion and Disease Prevention

6. Leadership
7. Network Performance
8. Satisfaction
9. Utilization Management
10. Risk Management

These functions are performed by many different members of the HSCSN team, with appropriate input, participation, executive and medical leadership and network providers. Some of these functions are managed through committees or departments, while others rely on advisory panels or other mechanisms.

Care Management, Care Coordination and Utilization Management Programs
Care Management is the foundation of the HSCSN health plan and is designed to ensure that access to medically necessary care is provided throughout the integrated care delivery system. The scope of the care management program includes care coordination of services, care management interventions and utilization management.

A significant benefit and distinction of the HSCSN health plan is that each member is assigned to a care manager for their entire period of enrollment. The care manager, a registered nurse, social worker, or other health care professional, has day-to-day continuous involvement in the enrollee's medical care. The Care Manager is responsible for facilitating cooperative relationships between health providers to support the enrollee and to meet their clinical needs. The overarching goal of Care Management is to ensure that enrollees are regularly examined to identify potential or actual health problems requiring prevention, treatment, rehabilitation and/or education in self-care by coordinating access to all appropriate health services and monitoring the delivery of services for effectiveness in maintaining the enrollee's optimal health status.

Care Management interventions are extensive and include: an initial assessment; the development and maintenance of a Care Coordination Plan in collaboration with the Primary Care Physician and members of the treatment team; authorization of services; provision of educational materials for clinical conditions; identification of resources for members; facilitation of transportation; participation in Individual Education Plans (IEP), Individual Family Service Plans (IFSP); discharge planning; scheduling medical appointments; compliance follow-up; referrals to Outreach (food, housing, burial information, etc.); referral to Customer Care for telephonic services; transition planning (from Early Intervention Programs to school; from pediatric to adult services; from HSCSN membership to other health insurance plans or waiver programs); community referrals for support and social services; coordination and monitoring of EPSDT services; coordination of benefits; telephonic and written collaboration with physicians, specialists, and service providers; coordination of language interpretation/translation services; coordination of mental health services; explanation of benefits and services; and address enrollee and provider concerns; and, facilitating access to the prescription drug program.

The Utilization Management (UM) Program is designed to maximize the appropriateness, cost-effectiveness and efficiency of healthcare services available to and utilized by the enrollee of HSCSN.

The integration of the Care Management, Care Coordination and Utilization Management Programs are essential to enhance quality of care/service and directly impacts the Quality and

Performance Improvement Program. All activities are reported to POIC at least quarterly via BUMC and/or Operations committees.

Risk Management Program

The integration of Risk Management Program functions are essential to enhancing member quality and safety and are an integral component of the Quality and Performance Improvement Program. The program proactively identifies opportunities to decrease risk for the organization and is essential to HSCSN's risk reduction efforts. The purpose is to identify and avoid situations of risk for the organization, the enrollee and the network providers; initiate strategies that positively mediate conditions and/or create remedial action when unexpected risk situations occur; protect the financial assets of the organization; and educate staff, providers and enrollees about methods for avoiding situations of risk and promoting network safe clinical practices.

Member Safety Program

The integration of Member Safety Program functions is essential to the facilitation of quality care, service and access in the most appropriate, timely and cost effective manner. The Member Safety Program is an integral component of the Quality and Performance Improvement Program. By promoting a culture of safety it encourages error identification, remediation, non-punitive reporting and prevention of recurrences through education, systems redesign and process improvement.

The Risk Manager under the direction of the Director of Quality/Accreditation and in collaboration with the Chief Medical Officer(s), COO, Compliance Officer and legal counsel, if applicable, are responsible and accountable for monitoring, evaluating and reporting actions taken and outcomes of the Risk and Member Safety Program. All activities are reported through the Member Safety & Risk Management Committee and are reported to POIC at least quarterly.

Organization-Wide Performance Improvement Team

Organization-wide Performance Improvement (PI) Teams at HSCSN are multidisciplinary teams that are charged by senior leadership to use the PDCA (Plan, Do, Check, Act) process to make improvements in a specific process. PI Teams use the principles, concepts, and tools of basic statistical and performance analysis to define, analyze measure and improve the key processes that achieve the outcomes that meet our customers' needs. The PI team membership may consist of Team Leader (owner of the process), Facilitator (individual who has expertise in performance improvement methodology), and Team Members.

Quality Improvement Process Model

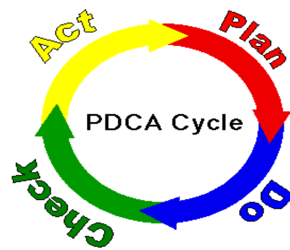
In an effort to continually improve organizational performance and maintain high quality of care/services, HSCSN evaluates the development of new processes as well as the redesign or improvement of existing processes.

A system approach is utilized to:

- Identify the new process or potential improvement
- Assess/test the strategy for change
- Analyze data from the test (to determine if the change produced the desired results)
- Implement the improvement strategy system-wide when applicable

The **PDCA Cycle** includes the following steps:

PLAN – Plan to improve outcomes by finding out what things are going wrong (Assessment Phase) and coming up with ideas for solving these problems (Development Phase)
DO – Do pilot the changes designed to solve the problems first. This minimizes disruption to routine activity while testing whether the changes will work or not.
CHECK – Check whether the pilot achieved the desired result or not. Continuously Check outcome measures to ensure you know what the quality of the output is at all times and to ID any new problems when they crop up.
ACT – Implement changes on a larger scale if the pilot is successful.



Selection of Improvement Priorities

Organizational improvement priorities are selected both proactively and in response to problems that are identified through ongoing assessment of performance indicators and analysis of adverse events. Proactive selection of priorities occurs through the strategic planning process.

This formal, two tiered process, which includes an environmental assessment and assessment of community needs, results in the identification of annual performance indicators that drive the performance improvement priorities. More specifically, the following sources of information are used to identify performance improvement opportunities:

- Strategic planning process
- Enrollee, provider, staff perceptions or satisfaction/grievance/complaint data
- Occurrences or near misses
- Operational efficiency and financial impact including UM and claims data (cost reduction)
- Non-compliance with laws and regulations
- Non-compliance with contractual requirements of DC DHCF
- Mandated studies by regulatory bodies and contractual requirements (e.g. EPSDT/Health Check tracking and reporting).

Other performance indicators will include but not be limited to:

- High volume, risk, cost, complex chronic diagnoses, procedures or tasks
- Identified health disparities

The HSCSN leadership, at least annually will identify a number of organization-wide performance initiatives or indicators that will be monitored (quantitative and qualitative analysis, barriers and opportunities for improvement as well as data set comparison to national, regional or internal data for benchmarks) trended and evaluated on a ongoing basis through the Operations committee and reported

to the POIC. Specific indicators will include those applicable and/or required contractually by DC DHCF or nationally authoritative entities including but not necessarily limited to:

- HEDIS Performance Measures (**Attachment A**)
- DHCF QI Collaborative Measures
- HEDIS CAHPS Member Satisfaction and *Chronic Care Conditions* Survey
- Provider Satisfaction Survey
- External Quality Review Organization (EQRO)
- National Committee for Quality Assurance (NCQA)
- Periodic Medical Record Review
- CASSIP Contract

All EQRO performance improvement projects (PIP) study design, methodology, sampling methodology, if applicable, shall undergo a formal data validation audit annually conducted by EQRO, Delmarva.

Medical Record Reviews
HSCSN conducts periodic medical record reviews as part of several ongoing operational processes such as the credentialing and re-credentialing process, HEDIS Reporting, focused studies, mortality reviews and potential quality of care issues. These reviews assess the following elements, but not limited to:

- Documentation Standards
- Plan of Care
- Compliance with standards of care (clinical practice guidelines)
- Treatment consistent with diagnosis
- Appropriate referrals
- Continuity and coordination of care
- Health Education
- Health check/EPSDT
- Access/Availability

Performance Measurement System
The BOD and management team believe that indicators are central to the performance improvement process and have assigned the coordination of monitoring of the organization wide performance indicator data by the Quality/ Accreditation department. HSCSN proposes a model for organizing reports describing the performance and outcomes of activities utilizing the following descriptors:

- Clinical Measures:
    - Mental/Behavioral
    - Medical
    - Care Management
- Utilization Management
- Quality Management
- Financial
- Credentialing
- Provider Services
- Enrollment

- Outreach
- NCQA, EQRO, Balanced Budget Act, CMS and DC DHCF reporting requirements will be incorporated, if applicable, as well as other descriptors specific to the special needs population.

Using this model, HSCSN can create a "report card" or QI work plan for special needs pediatric, adolescent and young adult populations to provide public accountability for HSCSN performance and provide the basis for quality improvement activities with the District's CASSIP population but is potentially applicable for similar populations across the nation. (**Attachment B**.)

Information Flow:
Multiple departments and disciplines contribute to the evaluation and improvement of coordination of care services and healthcare delivery systems through their participation in the monitoring process and interdisciplinary committees and teams.

Accountability for Indicators:
The list below defines the specific performance indicators, the frequency with which they are monitored in the Operations committee and reported to the POIC, the department responsible for each indicator, and their role in evaluating and communicating the results.

Expectations of Indicator Owners:
- Develop operational definitions for indicators (i.e., describe the numerator and denominator and how they are derived).
- Ensure that all components of the clinical enterprise are included in the aggregate data where appropriate and that denominators are adjusted accordingly.
- Maintain expertise on what the expected or optimal value for each is (e.g., based on information from professional groups, regulatory agencies, comparative data sources, etc.,)
- Review indicators on a monthly/quarterly basis, as indicated by owner, to identify trends
- Report the following items to the Quality/Accreditation department.
    - Operational definitions
    - Data in run or control chart format (including a line to indicate goal or benchmark if available)
    - Improvement actions that have been implemented
    - Recommendations to leadership

- As appropriate, develop a schedule to report data routinely to other people or committees. A committee or team determines if the data reveals acceptable statistical means and variation and if the data display any unusual patterns. If any unusual patterns are detected, further investigation is conducted to determine the cause. Improvement efforts might also be initiated to improve the mean and/or amount of variation. Once areas that require improvement are confirmed, an action is planned and then implemented. A reassessment effort is completed to ensure that the changes have had their intended effect.

- If significant patterns of variation are detected in monthly reviews or if other significant changes in performance occur (e.g., performance not in compliance with regulatory

agencies), this information should be reported immediately to the Quality/Accreditation department.

External Data Sources for Comparison: One way the opportunities for improvement are identified is through the use of external comparative databases and benchmarks. The following is a list of the sources of data available for use in improvement activities.

Data Sources-type of Data Available

Child 4.0 Member Satisfaction Survey & Chronic Care Condition (HEDIS CAHPS)	Member Satisfaction
NCQA HEDIS Performance Measurements	Clinical, Process & Outcome Performance Measurement
NCQA Quality Compass	National, Regional and Local Benchmarks
CASSIP Contract	Performance Indicators
HEDIS Data Validation Audit	HEDIS Performance Measures
External Quality Review (EQR)	Balanced Budget Act
EQR QI Collaborative Data Validation Audit	QI Collaborative Performance Measures
EQR Performance Improvement Projects	Balanced Budget Act
Best Clinical and Administrative Practices (BCAP)	Clinical Performance Indicators
Agency for Healthcare Research and Quality (AHRQ)	Clinical Performance Indicators
HSCSN Historical Administrative Data	Internal Benchmarks
National Quality Forum	Consensus Development for Healthcare Quality Measurement Indicators

Documentation and Recordkeeping

All committee meeting minutes will be kept and will reflect the date, duration of the meeting, the persons present and absent/excused, person recording the minutes and the names and titles of guests. The minutes will include a summary of discussions, decisions and actions and are signed and dated.

Confidentiality

All minutes generated by HSCSN committees addressing Quality and Performance Improvement concerns are considered confidential and peer protected. This material will not be provided to parties outside the organization unless directed to do so by the Chief Executive Officer, Chief Operating Officer, Chief Medical Officer(s), or legal counsel. HSCSN shall make available the meeting minutes from the internal continuous quality improvement committee meetings upon request by DHCF and the EQRO for review. All such minutes shall be kept confidential and any materials submitted to the HSCSN BOD to enable appropriate oversight and follow through of its duties and responsibilities are maintained as confidential as well.

Conflict of Interest

No members serving on the Board of Directors, Quality Council or Grievance and Appeals committees will review cases in which he/she has a material interest or involvement.

Annual Evaluation

On an annual basis, the Program will be evaluated on achieving continuous performance improvements for the organization and report the findings from this evaluation to POIC, Quality Council and the HSCSN BOD for approval.

The Quality and Performance Improvement Program may be revised, if necessary and a copy of the updated plan will be submitted to DC DHCF within 30 days of revision.

Approval:

Signature Title Date

Signature Title Date

Attachment A.

Table of Performance Measures for CASSIP Contract (HEDIS Requirements)
1. Childhood Immunizations Status
2. Lead Screening in Children
3. Immunizations for Adolescents
4. Appropriate Testing for Children with Pharyngitis
5. Appropriate Treatment for Children with Upper Respiratory Infection
6. Use of Appropriate Medications for People with Asthma
7. Comprehensive Diabetes Care
8. Controlling High Blood Pressure
9. Antidepressant Medication Management
10. Follow-Up Care for Children Prescribed ADHD Medication
11. Follow-Up After Hospitalization for Mental Illness (7 & 30 day)
12. Children's and Adolescents' Access to Primary Care Practitioners
13. Annual Dental Visit
14. Prenatal and Postpartum Care
15. Adult Access to Preventive/Ambulatory Health Services
16. Frequency of Ongoing Prenatal Care
17. Well-Child Visits in the First 15 Months of Life
18. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
19. Adolescent Well-Care Visits
20. Adult BMI Assessment
21. Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents
22. Chlamydia Screening in Women (Ages 16-20), (Ages 21-24) and (Total)
23. Board Certification
24. Language Diversity of Membership
25. Race/Ethnicity Diversity of Membership
26. Weeks of Pregnancy at Time of Enrollment
27. Call Abandonment
28. Call Answer Timeliness
Table of Performance Measures for CASSIP Contract (Child CAHPS w/CCC Requirements)
1. Percentage of parents of health plan members who reported how much of a problem they had with getting specialized services for their children with chronic conditions
2. Percentage of parents of health plan members who reported they had assistance in coordinating care and services for their children with chronic

conditions
Table of Performance Measures for CASSIP Contract Child CAHPS
1. Getting Care Quickly
2. Getting Needed Care
3. Customer Service
4. Rating of Health Plan
5. How Well Doctors Communicate
6. Rating of All Health Care

Quality Improvement Work Plan
2011 Performance Indicator "Report Card"

Attachment B.

Performance Indicator		Benchmark/Threshold, if Applicable	2011 CY Results	Reporting Timeframe
Customer Care				
Telephone Statistics				
Call Volume				**Monthly**
Call Abandonment Rate		**2.56%**		**Monthly**
Call Answer Timeliness ***Enrollment Management***		**88.99%** **30 seconds or <**		**Monthly**
Membership				
Total Number of New Enrollees				
Total Number of Disenrollees (*Rationale*)				
	Unable to Contact			
	Voluntary			
	Aged Out			
	Incarcerated			
	Moved out of DC			
	Lost Eligibility			
		Lost Eligibility (Rationale)		
			1.	
			2.	
			3.	
Total Number of Re-enrollees				

Performance Indicator		Benchmark/Threshold, if Applicable	2011 CY Results	Reporting Timeframe
Percentage of Disenrolled that re-enrolled		**80%**		
Provider Operations				
Provider Education & Training				**Monthly**
PCP EPSDT Training		**100%**		
PCP Blood Lead Screening Education		**100%**		
Provider IDEA Education		**100%**		**Monthly**
Provider Perinatal QI Collaborative Training		**100%**		
GEO Access/Maps by Zip Code		**100%**		**Annual**
	PCP & Specialist serving as PCP			
	Dental (dentist, pediatric dentists, orthodontists & oral surgeon)			
	Mental Health			
	High Volume Specialist			
Credentialing				
% Accuracy of Completed Credentialing Files		**95%**		**Quarterly**
% Accuracy of Completed		**95%**		**Quarterly**

Performance Indicator		Benchmark/Threshold, if Applicable	2011 CY Results	Reporting Timeframe
Recredentialing Files				
Completion Time (days) Initial Credentialing Files w/I 35 days		35 days		Quarterly
Completion Time (days)Re-credentialing Files w/I 15 days		15 days		Quarterly
Outreach				
# & % of Enrollment Packets send to retroactive enrollees within 24 hours		80%		Monthly
Financial Management				
Medical Loss Ratio		89.7%		Quarterly
Administrative Cost Ratio		9.2% (Budgeted)		Quarterly
Administrative Cost Ratio (Variance)				Monthly
Interest Paid on Clean Claims>30 days old		$1,000.00		Monthly
Care Management				
# of Births				
48 Hour Newborn Visit		95%		Monthly
Non-compliant w/I 48 hour Newborn				Monthly

Performance Indicator		Benchmark/Threshold, if Applicable	2011 CY Results	Reporting Timeframe
Visit (*Rationale*)				
	Home Health Agency Non-Compliant			
	Enrollee Not Available			
	Care Management not Notified of D/C			
	Mother Refused			
	Dis-enrolled-Lost Contact			
	Care Management Non-Compliant			
% 0-4 Immunizations		**80%**		**Monthly**
%School Age Immunizations		**80%**		**Monthly**
% EPSDT Participation Ratio		**80%**		**Monthly**
	# DUE			**Monthly**
	# Completed			
# EPSDT Pre Notice		**4**		**Monthly**
0 to 1 years of age		**2**		
	# DUE			
	# Phone			
	# Letter			
	% Phone	**80%**		
	% Letter	**80%**		
1 to 2 years of age		**2**		
	# DUE			
	# Phone			
	# Letter			
	% Phone	**80%**		
	% Letter	**80%**		

Performance Indicator		Benchmark/Threshold, if Applicable	2011 CY Results	Reporting Timeframe
2 to 21 years of age		**1**		
	# DUE			
	# Phone			
	# Letter			
	% Phone	**80%**		
	% Letter	**80%**		
# EPSDT Missed Appt. Notices (CM)		**1**		**Monthly**
0 to 21 years of age		**1**		
	# DUE			
	# Phone			
	# Letter			
	% Phone	**80%**		
	% Letter	**80%**		
% Care Coordination Plans Reviewed		**80%**		**Monthly**
Level One Annually	*# DUE*			
	% Complete			
Level Two (2) Annually	*#DUE*			
Level Three (3) Semi-annually	*% Complete*			
	#DUE			
CFSA/DYRS Enrollees Two (2) Annually	*% Complete*			
	# DUE			
% Blood Lead		**80%**		**Quarterly**

Performance Indicator		Benchmark/Threshold, if Applicable	2011 CY Results	Reporting Timeframe
Screening (< 12 Months)				
% Blood Lead Screening 12 to 35 Months		**80%**		**Quarterly**
% Enrollees Receiving any Dental Care		**80%**		**Quarterly**
% of DME Delivery Confirmations received w/I 24 hrs.		**80%**		**Monthly**
% of DME Confirmation visits completed w/I 72 hrs of notification		**80%**		**Monthly**
72 hr notification non-compliance (*Rationale*) *Unable to contact*				**Monthly**
Moved out of DC				
Lost Eligibility				
Delayed notification from CM to DME/Outreach Coordinator				
% of DME confirmation visits where education/equipment was identified as problem		**80%**		**Monthly**

Performance Indicator		Benchmark/Threshold, if Applicable	2011 CY Results	Reporting Timeframe
Did not receive instruction/education on use				
Did not understand instruction/education provided				
Equipment malfunctioning or not working				
CM Fraud, Waste & Abuse				
% of delivery tickets that match the authorization		**100%**		**Monthly**
% of equipment verified (MD order/authorization matched the delivery ticket (*i.e., model, serial number quantity*)		**100%**		**Monthly**
# of suspected FWA concerns reported to Compliance Dept.				**Monthly**
% of IFSP services initiated w/I 15 days of signature		**80%**		**Monthly**
# Enrollee Psychiatric				**Quarterly**

Performance Indicator		Benchmark/Threshold, if Applicable	2011 CY Results	Reporting Timeframe
Residential Treatment Facility (PRTF)				
# Court Ordered				
HSCSN				
# Discharge				
	PDD			
	Non-PDD			
PRTF ALOS				Quarterly
#Court Ordered				
	PDD			
	Non -PDD			
HSCSN				
	PDD			
	Non -PDD			
30 Day Readmission Rate of PRTF				Quarterly
#Court Ordered				
	PDD			
	Non-PDD			
HSCSN				
	PDD			
	Non-PDD			
# Enrollee in Sub-Acute				Quarterly
#Court Ordered				
HSCSN				
Sub-Acute ALOS				
#Court Ordered				
HSCSN				

Performance Indicator		Benchmark/Threshold, if Applicable	2011 CY Results	Reporting Timeframe
% of Initial Provider Site Visits completed w/I 60 days of notification		80%		Monthly
% Grievances Resolved w/I 30 Days		100%		Monthly
% Complaints Resolved w/I 30 Days		80%		Monthly
# of Fair Hearing				Monthly
% of Critical & Sentinel Event Reported to DHCF w/I 24 Hours		90%		Monthly
% of Critical & Sentinel Event Follow-Up reports sent to DHCF w/I 30 days		90%		Monthly
# of Mortality Reported w/I 24 Hours		100%		Monthly
Mortality Summations sent to Quality w/I 3 business days		100%		Monthly
Claims				
Claims Processed	*# Processed*			Monthly

Performance Indicator		Benchmark/Threshold, if Applicable	2011 CY Results	Reporting Timeframe
	# Processed w/I 30 Days			
	%Processed w/I 30 Days	**90%**		
Claims Received	*# Received*			**Monthly**
	# Received Electronically			
	% Received Electronically			
% Accuracy of Claims Processed		**95%**		**Monthly**
% of Claims Routed to Care Management (Yellow Sheet)		**<3%**		**Monthly**
% of Retro-Authorization received as a result of a yellow sheet (no authorization found in the system)		**<3%**		**Monthly**
Utilization Management				
Denials				
% of Non-Urgent Pre-service (Standard) decisions w/I 3 calendar days of request	*Medical* *Behavioral Health* *Home Health* *Pharmacy*	**80%**		**Monthly**
% of Urgent Pre-service (Expedited) decisions w/I 24 hrs of request	*Medical* *Behavioral Health* *Home Health* *Pharmacy*	**80%**		**Monthly**
% of Current (Urgent) w/I 24 hrs of request	*Medical* *Behavioral Health* *Home Health*	**80%**		**Monthly**

Performance Indicator		Benchmark/Threshold, if Applicable	2011 CY Results	Reporting Timeframe
	Pharmacy			
% of Post service w/I 30 calendar days of request	*Medical* *Behavioral Health* *Home Health* *Pharmacy*	**80%**		**Monthly**
Appeals				
% of Pre-Service appeals w/I 15 days of request	*Medical* *Behavioral Health* *Home Health* *Pharmacy*	**80%**		**Monthly**
% of Post Service appeals w/I 30 calendar days of request	*Medical* *Behavioral Health* *Home Health* *Pharmacy*	**80%**		**Monthly**
% of Expedited Appeals w/I 3 calendar days of request	*Medical* *Behavioral Health* *Home Health* *Pharmacy*	**80%**		**Monthly**
		DHCF QI Collaborative Measures		
Adverse Perinatal Outcomes				
Perinatal Rate (*Including & Excluding HIV*)	***Low Birth Rate <2,500gm***			**Quarterly**
	Premature: Gestational Age 32wks or <			
	HIV +			
	Fetal Mortality 20 wks or>Gestational Age			
	Infant Mortality			

Performance Indicator		Benchmark/Threshold, if Applicable	2011 CY Results	Reporting Timeframe
Adverse Chronic Disease Outcomes				**Quarterly**
Chronic Condition *Diabetes*				
	ER Visits			
	Hospital Stays			
Asthma				
	ER Visits			
	Hospital Stays			
		HEDIS Pay 4 Performance		
Lead Screening		**NCQA 90th Percentile**		
Annual Dental Visits (All Ages)		**NCQA 90th Percentile**		
Children & Adolescent Access to PCP (12-19 Years)		**NCQA 90th Percentile**		
Adult Access to PCP (20-44 Years)		**NCQA 90th Percentile**		
Use of Appropriate Meds for People w Asthma (All Ages)		**NCQA 90th Percentile**		
Follow-Up After Hospitalization for Mental Illness				
	30 Day			
	7 Day			
		HEDIS CAHPS Member Satisfaction Pay 4 Performance		
Getting Needed Care				
Coordination of Care				