# 2024 QUALITY IMPROVEMENT PROGRAM EVALUATION

## ✻ HIGHLIGHTS OF PLAN ACCOMPLISHMENTS FOR 2024 INCLUDE: ✻

### CONTINUED EFFORTS TO IMPROVE ACCESS AND AVAILABILITY

- Implemented the new Member and Provider Portals in April 2022. As of 12/29/24, 1,501 members created a member portal account.
- In November, Provider Services sent a reminder to all contracted providers regarding the free language assistance services available to our members and that the need/use of an interpreter should not delay care.
- VCHCP contracted with Teladoc in November 2019 to provide our members with 24/7 access to a licensed physician. There were 576 visits via Teladoc in 2024 and 3,546 visits since inception. According to Teladoc's 2024 Satisfaction Survey, 85% of the 39 respondents stated that their overall satisfaction with Teladoc was either good or outstanding.
- A total of 125 case agreements were executed during 2024.These agreements are made with non-contracted providers to support member clinical needs. VCHCP executed 9 new provider contracts, 3 specialty providers and 6 ancillary providers. Credentialed 163 new providers and recredentialed 277. Completed 7 site visits in 2024; all were due to initial contracting and recredentialing.
- Clinic Managers are required to investigate the access issues for their clinic and report back with their findings each month, and the Provider Services Program Administrator tracks and monitors their responses.
- Ongoing monitoring of VCHCP's delegates relative to Access.

### EFFECTIVENESS OF COMPLEX CASE MANAGEMENT PROGRAM:

- Completed the MCG Cite of Care Stand Alone system configuration, used for complex case management (CCM), which includes evidenced-based clinical guidelines or algorithms to conduct assessment and management of members identified for CCM.
- Collaborated with Optum Behavioral Health (BH) ensuring that the behavioral needs of members are coordinated between medical and behavioral health services.
- Collaborated with Express Script's Population Health Manager to address members with medication adherence issues.
- The CCM member satisfaction survey scored 100%, exceeding the 85% goal. The medical CCM engagement rate at 17.4% is below the < 20% goal. Plan to update CM screening script to emphasize the importance of CCM for case managers when speaking with the member.
- The BH CM engagement rate at 72.4% is below the > 75% goal. Plan to include information about BH CM program in the member newsletter annually.

### EFFECTIVENESS OF EPISODIC CASE MANAGEMENT PROGRAM:

- Continued maintenance in the volume of referral source/member screened for candidate records in 2024 is due to the continued expansion of the data mining report with continued efforts to add members with certain diagnosis.

- Collaborated with Optum BH to identify members with behavioral needs for medical behavioral coordination of care.
- Increased ECM referral sources by continuing to add members with certain diagnosis and members receiving certain services to the data mining report.
- The ECM acceptance rate continues to be above the goal of 20%.
- VCHCP conducts an annual member satisfaction survey of members that participated and enrolled in the Episodic Case Management program. In 2024, members in the program were asked to provide feedback via a mailed satisfaction survey. The survey was sent to 165 members during October 2024. Member satisfaction with the case manager was 96%. 11 percentage points above the established goal. This result met and above the goal of 85%.

## EFFECTIVENESS OF DISEASE MANAGEMENT PROGRAM:

- Continued use of the VCHCP Quality Application System (Quality App) as a data management tool created internally for Disease Management (DM) program to manage DM registry, view member care gaps, manage DM risk stratification, record member opt outs, as well as special conditions.

*VCHCP continues to tirelessly monitor members who are moderate to high risk for asthma and diabetes using Asthma systematic HEDIS and Diabetes A1c systematic laboratory.

- In 2024, 170 members were identified in moderate and at high risk for diabetes and had health coaching. This is an increase of 3% in member identification and an increase of 40 percentage points on health coaching compared to the previous year.
- In 2024, 98 members were identified as moderate and high risk for asthma, 23 (23.5%) had health coaching. This is an increase of 7.1% of members identified, and a 10.5 percentage points increase in health coaching compared to the previous year.
- HbA1c control <8% for diabetes is at the 75th percentile ranking using NCQA benchmark, exceeding the 50th percentile goal.
- Overall satisfaction rates regarding the educational information received by mail were 100% for Asthma and 86% for Diabetes Disease Management programs, both meeting the established goal of greater than 85%.
- Health Effectiveness Data Information Set (HEDIS) birthday card to include preventive services care gaps and case management referral information.

## EFFICIENCY IN UTILIZATION MANAGEMENT:

- Collaborated with providers and administrators through the VCHCP Ops Triad Committee to analyze members and provider satisfaction, access to specialist care, barriers to care, clarification of policies/procedures, and working together to ensure care is delivered timely and efficiently to members.
- Continued enhancement of the Healthx provider and member portals for submission of authorization requests and viewing authorizations.
- Continued collaboration between VCHP and Optum Behavioral Health through Medica-Behavioral Coordination of Care work group, addressing PCP-Behavioral Health provider coordination and communication.

- Continued collaboration with QA on medical-medical coordination of care, medical-behavioral coordination of care, HEDIS interventions, member/provider satisfaction and potential quality issues identification.
- Maintained regulatory compliance for UM processing and decision notification timeframes at 97%, above 95% target.
- Major retraining of physician reviewers and UM staff on the clear, concise and easily understood reasons for denials and modifications in the UM notification letters.
- Physician and Nurse inter-rater reliability testing met the 90% goal.

## SERVICES:

- Percentage of Network closed to New Members averaged 17% in 2024. Member Services telephone stats were reviewed and analyzed on a weekly basis, and adjustments were made to the daily phone coverage schedule to accommodate staff absences and to ensure appropriate availability.

## SURVEYS:

- All surveys were completed in a timely manner, which included 2 directory assessments, After-Hours Survey, PAAS, and the Provider Satisfaction survey.
- After Hours Survey conducted by VCHCP was started in March 2024 and concluded in July 2024. Provider Satisfaction Survey conducted by Press Ganey (May 2024 – July 2024). Provider Appointment Availability Survey (PAAS) was conducted by QMetrics for MY 2024. Provider Directory Assessments were conducted in May and October 2024. Geo Access Study completed by Quest Analytics in October 2024

## PROCESSES:

- The VCHCP Member Services Department exceeded all their phone, email and portal goals. The percentage calls answered within 30 seconds, and the abandonment rate results improved compared to the previous year, even though the calls per 1,000 members increased.
- Implemented the UM Systems Control with systems configurations and operational updates. Audit results show meeting the 100% goal.
- UM physicians and nurses met the passing score of 90% or better on inter-rater testing.

## COMMUNICATIONS:

- Distributed member and provider newsletters twice a year, highlighting services offered by the Plan, as well as education about these services, benefits and guidelines.
- Continued to utilize email/fax-blasts to providers to relay important updates to practitioners on a timely basis; for example, the VCHCP drug formulary update (additions and deletions).

- Mailed postcard reminders to members re: needed mammograms, colorectal screenings and reminder on appropriate use of the Emergency Room.
- As the Health Plan moves to 2025, continuing the established QI structure is recommended, with emphasis on the following initiatives that proved to be key challenges in 2024. These initiatives will serve as the priority of focus for VCHCP in 2025
  - o Getting Needed Care:
    - Contracting approval process can be challenging when trying to add additional specialists to the network.
    - Lack of awareness and understanding of the timely access standards.
  - o Getting Care Quickly:
    - Contracting approval process can be challenging when trying to add additional specialists to the network.
    - Lack of awareness and understanding of the timely access standards
    - Practitioners unclear on the Plan's authorization and referral requirements.

## POPULATION HEALTH STRATEGY:

- Medical Complex Case Management – engagement rate is 17.4% which is below the 20% goal.
- Behavioral Health (BH) case management (CM) engagement rate is 72.4% which is below the >75% goal.
- Clinical Measures specifically HEDIS data on Childhood Immunization Status (CIS). CIS annual HEDIS rate of 29.47% does not meet the 38.2% goal.
- Clinical Measures specifically HEDIS data on Colorectal Cancer Screening. Colorectal Cancer Screening rate of 58.4% does not meet the 62% goal.

## WHILE THE PLAN REALIZED MULTIPLE ACCOMPLISHMENTS THROUGHOUT 2024, THERE WERE KEY CHALLENGES FOR THE PLAN IN 2024 THAT CAME TO LIGHT:

- Identification of barriers and interventions that will improve Health Effectiveness Date Information Set (HEDIS) scores overall, with the emphasis on the following measures:
  - o Hemoglobin A1C Control for Patients with Diabetes (HBD)
  - o Cervical Cancer Screening (CCS)
  - o Childhood Immunization Status (CIS)
  - o Plan All-Cause Readmission (PCR)
- Consistent timeliness of follow-up care:
  - o After Emergency Room visits
  - o After Inpatient hospital admissions
  - o Postpartum
- Timely communication of feedback from behavioral health providers to PCPs through increased collaboration between Optum Behavioral Health and VCHCP.
- Increase rates of member participation in the Case Management program.
- Increased A1c testing compliance, decreased A1c level and decreased risk level of members with successful health coaching and case management.
- Maintain volume of members stratified as moderate and high risk to allow health coaching and case management screening and intervention to more members.