VERMONT
DEPARTMENT OF VERMONT HEALTH ACCESS

VERMONT MEDICAID PROGRAM QUALITY MANAGEMENT PLAN

December 2023

Department of Vermont Health Access & Intra-Agency Agreement Partners:
Department of Children and Families (DCF)
Department of Disabilities, Aging & Independent Living (DAIL)
Department of Mental Health (DMH)
Vermont Department of Health (VDH)

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3. INTRODUCTION

Vermont's initial Global Commitment to Health and Choices for Care Demonstrations were approved in September of 2005 and became effective October 1, 2005. The Global Commitment to Health Demonstration was extended for three years, effective January 1, 2011, and again for three (3) years, effective October 2, 2013. The Choices for Care Demonstration was extended for five (5) years effective October 1, 2010, and became part of the Global Commitment to Health Demonstration in January 2015.

The Global Commitment to Health Demonstration has since been extended and amended multiple times, most recently in July 2018 to include authority for Substance Use Disorder (SUD) treatment in residential facilities that met the criteria as Institutions for Mental Diseases (IMDs) and again in 2019 to include authority for inpatient services provided to Medicaid eligible beneficiaries while residing in IMDs for diagnoses of Serious Mental Illness (SMI) and/or Serious Emotional Disturbance (SED). In 2022 the GC 1115 Demonstration was renewed for an additional five-year term, through 2027.

The Global Commitment Waiver provides the State with the ability to be more flexible in the way it uses its Medicaid resources. Examples of this flexibility include new payment mechanisms (e.g. value-based payment models) rather than individual fee-for-service payments, flexibility to pay for healthcare related services not traditionally reimbursable through Medicaid (e.g. pediatric psychiatry consultation) and investments in programmatic innovations (e.g., the Vermont Blueprint for Health). It is based on a managed care model which also encourages inter-departmental collaboration and consistency across programs.

1.1 Overview

The Federally approved waiver and corresponding changes in Vermont State statute changed the administrative structures of State government to designate the Office of Vermont Health Access (OVHA), now known as the Department of Vermont Health Access (DVHA), as the country's only Medicaid Office operating under a managed care model, subject to the requirements that would be applicable to a non-risk pre-paid inpatient health plan (PIHP). The Agency of Human Services (AHS) pays DVHA a per member per month (PMPM) estimate using prospectively derived actuarial rates for the waiver year. It is believed that the use of a managed care system will allow Vermont to purchase the best value health care for Medicaid beneficiaries, improve access to services for underserved and vulnerable beneficiary populations, and protect them from substandard care.

1.2 Structure

According to the GC's Special Terms and Conditions (STCs), Vermont operates its managed care model in accordance with federal managed care regulations, found at 42 CFR 438. The Agency of Human Services (AHS), as Vermont's Single State Medicaid Agency, is responsible for oversight of the managed care model. The Department of Vermont Health Access (DVHA) operates the Medicaid program as if it were a PIHP in accordance with federal managed care regulations. Program requirements and responsibilities are delineated in a memorandum of

understanding (MOU) between AHS and DVHA. DVHA also has intra-agency agreements with other Departments that provide specialty care for GC enrollees.

Under the GC Demonstration, Vermont is authorized to provide an array of cost-effective in-home and community services. Providers of these services must meet designation, certification, and/or additional licensing requirements to be approved by the State to serve the most vulnerable of Vermont's citizens. These specialized programs are designed to support a unique group of beneficiaries, each is outlined below:

o **Choices for Care**: long-term services and supports for persons with disabilities and older Vermonters. The Demonstration authorizes HCBS waiver-like and institutional services such as nursing facility; enhanced residential care; personal care; homemaker services; companion care; case management; adult day services; and adult family care.

o **Developmental Disability Services**: provides long-term services and supports for persons with intellectual disabilities. The Demonstration authorizes HCBS waiver-like services, including service coordination, residential habilitation, day habilitation, supported employment, crisis services, clinical intervention, respite, and self-directed care.

o **Traumatic Brain Injury Services**: provides recovery-oriented and long-term services and supports for persons with a traumatic brain injury. The Demonstration authorizes HCBS waiver-like services including crisis/support services, psychological and counseling supports, case management, community supports, habilitation, respite care, supported employment, environmental and assistive technology, and self-directed care.

o **Enhanced Family Treatment**: provides intensive in-home and community treatment services for children who are experiencing a severe emotional disturbance and their families. The Demonstration authorizes HCBS waiver-like services including service coordination, flexible support, skilled therapy services, environmental safety devices, counseling, residential treatment, respite, supported employment, crisis, and community supports.

o **Community Rehabilitation and Treatment Program**: provides recovery-oriented, in-home, and community treatment services for adults who have a severe and persistent mental illness. The Demonstration authorizes HCBS waiver-like services including service coordination, flexible support, skilled therapy services, environmental safety devices, counseling, residential treatment, supported employment, crisis and community supports.

Through a special provision as a Designated State Health Program, Community Rehabilitation and Treatment benefits can be extended to individuals with severe and persistent mental illness with incomes between 133 and 150 percent of the federal poverty level, under the Demonstration.

To that end, DVHA, in collaboration with its intra-agency agreement partners, maintains this comprehensive Quality Management Plan and an ongoing quality assurance and performance improvement (QAPI) program for the services it furnishes to Global Commitment to Health Waiver beneficiaries. This DVHA Quality Management Plan incorporates activities delegated

to all intra-agency agreement partners and includes a description of the following: quality planning, performance measurement and performance improvement.

While there are important roles for many involved with DVHA's QAPI program, much of the formal quality management work is done through various committees and teams:

Quality Committee -

The Quality Committee is made up of a cross-section of DVHA representatives and our intra-agency agreement partner quality representatives. This Committee meets monthly and is responsible for: a) development of an annual Quality Work Plan, b) reviewing performance measures regularly for improvement opportunities, c) guiding the implementation of planned improvement activities and encouraging staff to become more integrated into QI processes, d) review of DVHA and intra-agency agreement partner reporting focused on quality activities such as grievances and appeals, customer satisfaction, confidentiality and appropriateness of care.

Home and Community Based Services (HCBS) Work Group –

The HCBS Work Group is made up of Quality and Policy representatives from the Agency of Human Services, as well as Quality representatives from DVHA, DAIL and DMH. This group is responsible for direction setting, data collection and analysis of the HCBS Assurance Measure Set.

DVHA Comprehensive Risk Assessment Work Group –

Staff from DVHA's Quality, Oversight & Monitoring and Compliance Units maintain a comprehensive risk assessment process for Vermont's Medicaid program. The purposes of this work are to:

- identify, analyze, prioritize and correct compliance risks across all departments and programs responsible for Medicaid service delivery; and
- take advantage of opportunities to move beyond compliance and look for ways to improve the services we deliver to Vermonters.

The ongoing assessment entails collaboration with other Agency departments.

DVHA Quality Unit -

The Quality Unit collaborates with AHS partners to develop a culture of continuous quality improvement, maintains the Vermont Medicaid Quality Management Plan, coordinates quality initiatives including formal performance improvement projects, coordinates the production of standard performance measures, and is the DVHA lead unit for the Results Based Accountability (RBA) methodology & produces the DVHA RBA Scorecards.

DVHA Data Management and Integrity Unit –

Data management for quality measure production, as well as various performance improvement projects is performed by the DVHA Data Management and Integrity Unit.

The following positions provide special focus on Medicaid Program QAPI functions:

Vermont Medicaid Director –

This position sits in the Secretary's Office within the Agency of Human Services (AHS) to provide strategic oversight and set priorities for Vermont Medicaid. Having the Medicaid Director at the Agency level increases visibility and involvement in Medicaid programs across AHS and supports alignment among sister departments.

AHS Director of Compliance, Evaluation, and Quality

This position sits in the Secretary's Office within the Agency of Human Services (AHS) to provide strategic oversight and monitoring of compliance, evaluation, and quality priorities of the Medicaid Program. This position is the liaison between AHS and the Centers for Medicare and Medicaid (CMS) for waiver compliance, evaluation, and quality issues.

DVHA Director of Risk & Quality Management -

The Director of Risk & Quality Management oversees the DHVA Quality Unit and the implementation and progress of the annual Quality Work Plan. The Director is Chair of the Quality Committee and the Risk Assessment Work Group and is a member of the DVHA Management Team. This position also leads formal CMS performance improvement projects (PIPs), the use of Results Based Accountability scorecards within the Department and acts as a performance measures liaison between the Quality Unit and other DVHA divisions/initiatives.

DVHA Assistant Director of Risk & Quality Management –

This position within DVHA's Quality Unit provides data analysis to the Unit/Department, coordinates the annual medical record review process to produce hybrid measures, participates in and leads performance improvement projects, creates Results Based Accountability scorecards and manages home and community-based service (HCBS) quality management activities.

DVHA Chief Medical Officer (CMO)–

DVHA's CMO is a clinical expert for the organization and as such is responsible for providing medical leadership to the DVHA Quality Committee and the clinical expertise needed to guide the overall effort.

1.3 Scope

This Quality Management Plan sets forth specifications for certain activities that DVHA utilizes to help ensure the delivery of quality health care. The following sections are included here:

- Quality Planning
- Performance Measurement
- Performance Improvement

In conjunction with DVHA's Utilization Management and Compliance Plans, these activities encompass Medicaid Program QAPI program.

1.4 Purpose

The specific purposes of this Quality Management Plan are to:

1. Provide general context, direction and guidance for all staff in the pursuit of the QAPI goals.
2. Provide a plan for systematic, objective, ongoing monitoring and evaluation of data regarding beneficiary care and identification of areas for needed improvement.
3. Outline the Agency of Human Services' (AHS) Performance Framework.

1.5 Goals

The overarching goal of the QAPI Program is to improve future performance through the execution of effective improvement activities. These activities are driven by identified performance measures, tracking them and reliably reporting on them to decision-making and care-giving staff. More specifically, the goals of the QAPI Program are to:

1. Support improvement in the health of Vermont's population
2. Enhance efficiency of care
3. Increase effectiveness of care
4. Promote equity of care
5. Enrich patient-centeredness
6. Ensure safety
7. Assure that beneficiaries have access to high-quality health care (health care includes mental health, physical health and substance abuse treatment and services delivered in home and community-based settings)
8. Improve customer and provider satisfaction

1.6 Principles

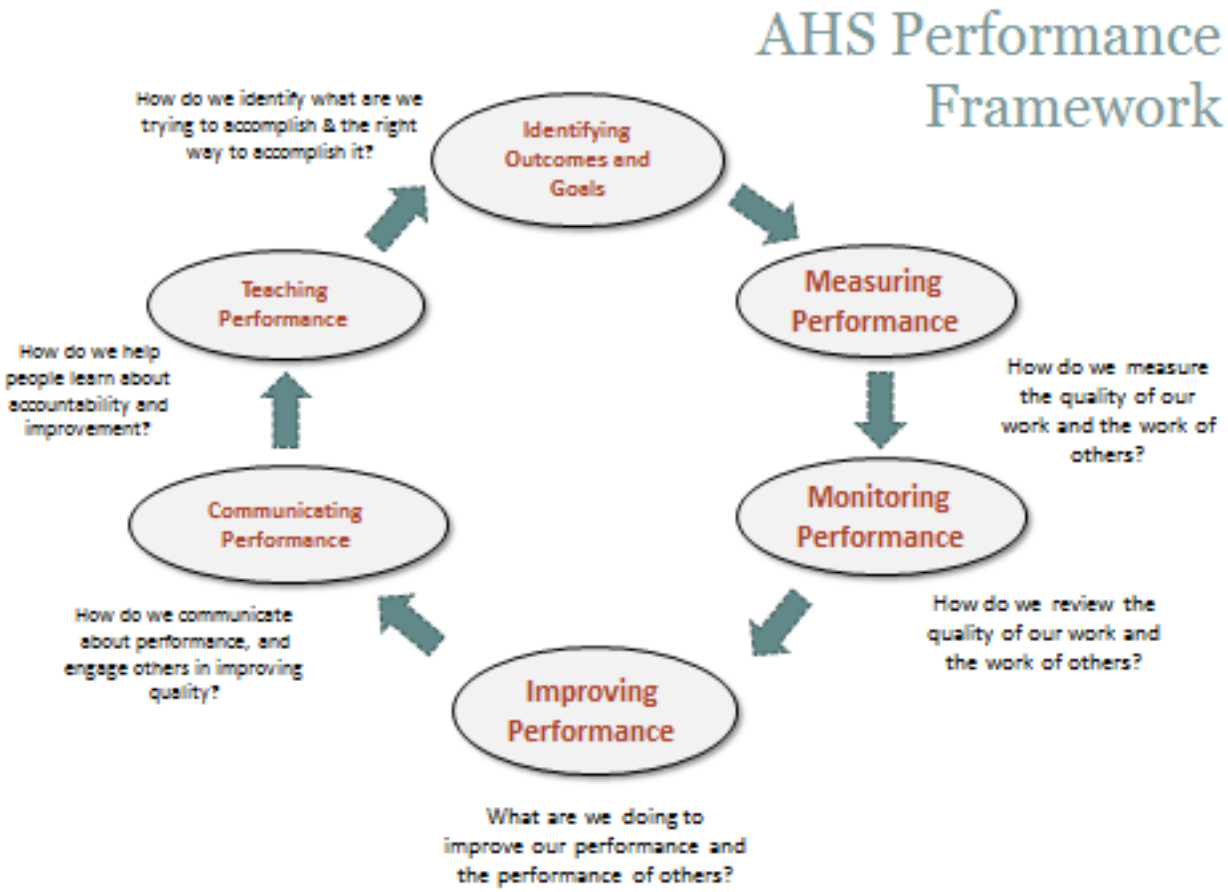
The Vermont Medicaid QAPI Program is based on the following quality principles:

1. Quality begins with a focus on the customer (our beneficiaries and their caregivers);
2. Actions should be based on facts, data, and analysis;

3. Poor processes and systems are the cause of most problems, not people;
4. Everyone needs to be involved and committed in the effort;
5. Quality Improvement is a continuous effort.

This Quality Management Plan demonstrates how DVHA and its intra-agency agreement partners work within the Agency of Human Service's Performance Framework which outlines the key components of our continuous improvement strategy to improve outcomes for the people we serve. Each component in the Performance Framework encompasses a range of strategies, practices, processes, and activities happening within each Department and across the Agency, as well as addressed here in this Plan. The AHS Performance Framework enables us to better understand and strengthen our mechanism for remaining accountable for improving conditions of well-being for the Vermonters we serve.

The Framework is based on the understanding that to pursue our mission and accomplish our goals, we must actively and continually measure our performance, monitor our progress, and improve our strategies based on what we've learned. In order to embed continuous improvement as a practice into the Agency culture, we must also communicate about our progress, and help teach others about accountability and how we can work together to improve conditions of well-being in Vermont.



4. QUALITY PLANNING

2.1 Identifying Opportunities for Improvement

Quality planning begins by identifying opportunities for improvement. These opportunities can be discovered in a variety of ways:

• Outcome data	• Contract oversight
• Participant complaints or input	• Identification of best practices / literature
• Critical incidents	• Strategic planning efforts
• Chart/program audits	• Visioning efforts
• Satisfaction data	• Professional standards
• Staff observations and ideas	• Regulatory requirements

2.2 Project Selection

DVHA follows a standard operating procedure (SOP) when selecting formal performance improvement projects. While everyone involved with DVHA has an important role in helping to identify opportunities for improvement, formal priorities for performance improvement are recommended annually by the Quality Committee. Further review is provided by DVHA clinical leadership and final formal project approval is made by DVHA's Commissioner. Priority will be based on severity, frequency, prevalence, relevance to outcomes and feasibility of implementation. In addition, 42 CFR Subpart E reserves CMS the right to specify performance improvement project topics for DVHA. Likewise, Appendix A of the AHS/DVHA MOU reserves AHS the same right.

2.3 Communication

An important part of the QAPI Program is sharing ideas, efforts, and results about quality efforts with all members of DVHA (including IGA partners, beneficiaries and their caregivers), AHS and CMS. DVHA communicates to its stakeholders through a variety of mechanisms. The following table outlines these mechanisms:

Mechanism	Stakeholder	Timeframe for Dissemination
DVHA Web Site/Scorecard	Beneficiaries, Providers, Public, Regulators	Ongoing updates and Quality Reporting
Banner Pages (printed and electronic)	Providers	Weekly
Medicaid Advisory Newsletter (printed and electronic)	Providers	Every 2 months
Medicaid & Exchange Advisory Board (meetings and minutes electronic)	Beneficiaries, Providers, Public	Monthly
Clinical Practice Standards	Providers	Periodic
Pharmacy Newsletter (printed and electronic)	Providers	Periodic – as needed
CMS Quarterly Report	CMS, AHS	Quarterly

6. 3. PERFORMANCE MEASUREMENT

Performance Measures

Performance measures are indicators or metrics that are used to gauge program performance. They provide information needed to measure the extent to which DVHA is achieving its intended results/outcomes.

DVHA collects, analyzes and reports on quality measures to assess our success in progressing towards what the Institute of Medicine (IOM) calls six (6) domains of healthcare quality. These aims can be summarized as care that is:

- **Safe:** avoiding harm to patients from the care that is intended to help them.
- **Effective:** providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Patient-centered:** providing care that is responsive to individual patient preferences, needs and values and assuring that patient values guide all clinical decisions.
- **Timely:** reducing waits and sometimes harmful delays for both those who receive care and those who give care.
- **Efficient:** avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable:** providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socio-economic status.

3.1 Quality Measure Production - HEDIS

The Healthcare Effectiveness Data and Information Set (HEDIS) refers to a widely used set of performance measures in the managed care industry. More than 90 percent of health plans use HEDIS to measure performance. HEDIS is managed by the National Committee for Quality Assurance (NCQA) and consists of over 70 measures of process, structure, and outcomes. HEDIS addresses a spectrum of care from prevention to acute to chronic care.

Reporting and Analysis:

DVHA reports its performance to AHS using these standard HEDIS tool sets by contracting with a NCQA-certified software vendor to produce the measures. DVHA runs the full set of HEDIS administrative measures, as well as a growing number of hybrid measures, annually. AHS then contracts with an external quality review organization (EQRO) to audit and validate DVHA's performance measure production processes and results. Performance measures have recently been required and validated in the following focus areas:

- Prevention and Screening
- Utilization
- Access/Availability of Care
- Behavioral Health
- Diabetes

- Respiratory Conditions
- Cardiovascular Conditions

3.2 CMS Adult, Child & Behavioral Quality Core Measure Sets

The Centers for Medicare & Medicaid Services (CMS) published an Initial Core Set of Measures via Federal Register Notice on January 4, 2012, signifying an important step toward better understanding, at both the State and national level, the quality of health care delivered to Medicaid covered adults. This measure set is now updated annually by CMS and contains a sub-set of behavioral health measures.

The Children's Health Care Quality Measures for Medicaid and CHIP originated from the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. Ultimately, the goals of this core measure set are to provide a national estimate of the quality of health care for children; facilitate comparative analyses across various dimensions of pediatric health care quality; and help identify racial, ethnic, and socioeconomic disparities.

Reporting and Analysis:

The Mandatory Medicaid and Children's Health Insurance Program (CHIP) Core Set Reporting final rule released on August 31, 2023.

To meet this mandatory reporting requirement, states must report on all the measures on the Child Core Set and the behavioral health measures on the Adult Core Set by December 31, 2024, for FFY 2024 state reporting and annually thereafter. This data provides information for CMS and states to better identify quality improvement priorities and to plan and implement quality improvement initiatives.

DVHA completes this required Core Set reporting each year by the deadline set by CMS. Once complete, DVHA notifies the AHS Quality Manager and updates DVHA's internal Child and Adult Core Set Scorecards on DVHA's website: http://dvha.vermont.gov/quality/medicaid-performance-measures

3.3 Experience of Care Measures

DVHA is also required to calculate and report out on its beneficiaries' experience of care. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey provides an assessment of health plan performance from a consumer perspective regarding the plan's services and care delivery system.

DVHA contracts with an NCQA-certified vendor to conduct both the Children and Adult health plan surveys annually. The surveys use random samples of all *Global Commitment to Health* beneficiaries.

DVHA reports on all measures within the core health plan surveys, including measures related to:

- Getting Needed Care
- Getting Care Quickly
- Customer Service
- Overall Rating of Health Plan

DVHA's Child Health Plan survey also includes the Item Set for Children with Chronic Conditions. This set of questions produces the following measures for this population:

- Access to Prescription Medicines.
- Access to Specialized Services.
- Family-Centered Care:
    - Having a Personal Doctor or Nurse who Knows the Child.
    - Shared Decision-making.
    - Getting Needed Information.
- Coordination of Care and Services.

Additionally, DVHA and its intra-governmental agreement partners conduct the Home and Community-Based Services (HCBS) CAHPS survey. This is a cross-disability survey for adults using long term services and supports through Medicaid HCBS programs. The survey allows for the comparison across programs and different populations (e.g., older adults, persons with physical disabilities, intellectual and developmental disabilities, persons with acquired brain injuries, and persons with mental health or substance use disorders).

Reporting and Analysis

CAHPS survey results, as well as an initial analysis of the results, are compiled by the vendor and reported to DVHA. DVHA reports CAHPS health plan survey results to the AHRQ CAHPS database and to AHS annually. In addition, the Quality Committee further analyzes the results to determine whether any quality improvement projects should be initiated.

DVHA's most recent Adult and Child Health Plan Experience of Care survey results can be seen here: http://dvha.vermont.gov/quality/experience-care

DVHA reports HCBS CAHPS survey results to AHS every other year, beginning August 2025.

3.4 Home and Community-Based Assurance (HCBS) Measure Set

On November 15, 2023, CMS approved Vermont's HCBS Assurance Measure Set. The state is required to use these measures to demonstrate continued compliance with the HCBS Assurances as well as assess and improve the quality and experience of care of individuals receiving HCBS services through Vermont Medicaid-funded HCBS programs.

The measure set requires the state to report the following three types of HCBS measures:

1. Compliance - reported annually, beginning August 29, 2024.
2. Quality - reported every other year, beginning August 29, 2025.
3. Experience of Care - reported every other year, beginning August 29, 2025. (See also above, Section 3.3)

Reporting and Analysis

The collecting and reporting of Quality and Experience of Care measures will rely heavily on the use of contractors. The collection of Compliance measure data will primarily be done by DAIL and DMH staff and will be reported to DVHA, who will in turn report to AHS annually. DVHA's Quality Committee will further analyze the results to determine whether any quality improvement projects should be initiated.

Once reporting begins, the HCBS Measure Set results will be found on the Quality section of DVHA's website, along with other Quality Assurance and Performance Improvement (QAPI) program resources.

3.5 Network Adequacy Measures:

CMS has set key requirements for Medicaid managed care network adequacy and access (i.e., whether managed care plans contract with a sufficient number of providers to serve enrollees) that include the following:

- Current federal rules require states to establish network adequacy standards for specified provider types including primary and specialty care (adult and pediatric), OB/GYN, behavioral health (adult and pediatric), hospital, pharmacy, pediatric dental, and long-term services and supports (LTSS) (as applicable).
- The 2020 CMS Medicaid managed care final rule removed the requirement that states use time and distance standards to ensure provider network adequacy and instead lets states choose any quantitative standard such as minimum provider-to-enrollee ratios, maximum travel time or distance to providers, minimum percentage of contracting providers accepting new patients, maximum wait times for an appointment, or hours of operation requirements.
- Network standards must include all geographic areas covered by the managed care program; however, states may vary standards for the same provider type by geography.
- In setting network adequacy standards, states must consider the diverse needs of their Medicaid enrollees, including individuals with disabilities, special needs, or limited English proficiency.
- States must make network adequacy standards available online and network adequacy standards and access requirements must be included in the state's managed care quality strategy.

Reporting and Analysis

AHS sets Vermont Medicaid's network adequacy standards. DVHA and its intra-agency agreement partners collect data for measures that support those standards. DVHA reports its network adequacy measures to AHS annually and makes them available on the DVHA website (under the *Global Commitment to Health 1115 waiver* icon): https://humanservices.vermont.gov/about-us/medicaid-administration

AHS contracts with an external quality review organization for review of the network adequacy data collection process. AHS also incorporates the state's network adequacy standards in Vermont's Comprehensive Quality Strategy (see same link above).

3.6 Global Commitment to Health Waiver Evaluation Measure Reporting:

AHS works with a contracted vendor to evaluate Vermont's Global Commitment to Health Section 1115 Demonstration. The principal focus of the evaluation is obtaining and analyzing data on the **process** (e.g., whether the demonstration is being implemented as intended), **outcomes** (e.g., whether the demonstration is having the intended effects on the target population), and **impacts** of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). The primary evaluation populations of interest are listed below.

- Overall waiver population – all Vermont Medicaid members
- Members with a diagnosis of SMI/SED
- Members with a SUD diagnosis
- Members receiving HCBS services
- Members receiving Maternal Health and Treatment Services
- Specialized program participants (e.g. Community Rehabilitation and Treatment, Supportive Housing Assistance Pilot)

Reporting and Analysis

AHS and its contracted vendor establish a regular reporting schedule for Evaluation measures. DVHA's Data and Quality Units collect and submit much of the regular performance measure reporting for the populations of interest listed above in support of this evaluation.

3.7 Intra-Agency Agreement Partner Performance Measure Scorecards:

DVHA's intra-agency agreement partners maintain quality measure scorecards for the Vermont Medicaid-funded services provided by their departments. The departmental scorecards focus on the following programs:

- **Choices for Care**: DAIL Adult Services Division
- **Developmental Disability Services**: DAIL Developmental Disability Services Division
- **Traumatic Brain Injury Services**: DAIL Developmental Disability Services Division
- **Enhanced Family Treatment**: Department of Mental Health
- **Community Rehabilitation and Treatment Program**: Department of Mental Health
- **Children in Foster Care & Other Residential Placement Programs**: Department of Children and Families (DCF)
- **Children's Personal Care Services:** Vermont Department of Health – Children with Special Health Needs (VDH CSHN)

Reporting and Analysis

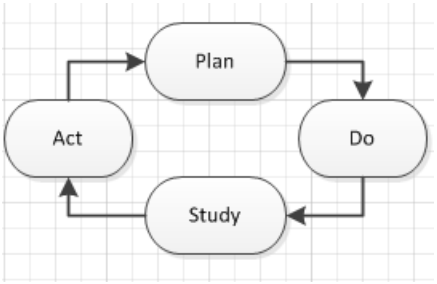
Representatives from the above programs present to DVHA's Quality Committee annually. The Quality Committee may identify improvement projects and/or request the development of new and/or the incorporation of additional performance metrics.

8. 4. PERFORMANCE IMPROVEMENT

4.1 General Quality Model and AHS Performance Framework:

Improvements in quality require change. Having a proven, sound approach is helpful in making changes more successful and enjoyable. DVHA has adopted methodologies for addressing deficiencies through performance improvement projects. These methodologies all include the key elements found in the Plan-Do-Study-Act (PDSA) model of improvement (see diagram below).

The P-D-S-A Cycle



PLAN

- Define the problem, need for change
- Establish desired outcome or goal
- Learn about the current process
- Analyze data using appropriate tools/methods as necessary
- Determine the root cause/s of the problem
- Develop action plan for change

DO

- Implement your action plan
- Pilot test as needed (small & large tests of change)

STUDY

- Continue to collect and analyze data to study effectiveness of your actions.
- Did you achieve what you wanted?
- Did you meet your target or goals?
- Did you identify other problems?
- Did your actions work? Why?
- What would you do differently?

ACT

- If your actions were successful, proceed with expansion and/or standardization of changes
- Routinely reassess to assure maintaining gains
- If not as successful as you would have liked, begin a new PDSA cycle
- Note lessons learned

4.2 Specific Approaches:

DVHA and our intra-agency agreement partners use several approaches to improve quality. Those include:

- **Formal Performance Improvement Projects (PIP's)** - All DVHA formal PIPs will be conducted in a manner that is consistent with the CMS Protocols. PIPs focus on clinical and non-clinical areas and involve:
  a. Measurement of performance using objective quality measures;
  b. Implementation of system interventions to achieve improvements in the access to and quality of care;
  c. Evaluation of the effectiveness of the interventions; and
  d. Planning and initiation of activities for increasing or sustaining improvement.

  Formal PIPs have 3-year cycles and summaries are submitted annually by DVHA to AHS and our external quality review organization (EQRO) for validation.

- **Informal Quality Improvement Projects and/or Learning Collaboratives** – staff within DVHA's Quality Unit both lead and participate in quality improvement projects and/or learning collaboratives on a variety of topics. These projects are "informal" in that they do not require EQRO validation and are often shorter in duration. They do, however, follow a standard quality improvement methodology of Plan, Do, Study, Act.

- **Results Based Accountability (RBA)** – RBA is a disciplined way of thinking and taking action that can be used by agencies to improve the performance of their programs. It can also be used by communities as a whole and therefore is broken out into two parts: population accountability and performance accountability. The Agency of Human Services has adopted an RBA-based software tool that every Department within the Agency uses to present its performance measure data, as well as the narrative behind that data, the partners it works with and the improvement strategies it employs. Additionally, this methodology combined with LEAN concepts is the basis for a set of internal trainings that are actively building an Agency Improvement Network of staff who are trained to facilitate process improvement.

4.3 Performance Improvement Activities:

DVHA and its intra-agency agreement partners maintain an ongoing program of formal (PIPs) and informal performance improvement projects designed to achieve, through ongoing measurement and intervention, significant improvement sustained over time in clinical and nonclinical areas.

DVHA and its partners completes each PIP in a reasonable time period so as to generally allow information on success of the PIP in the aggregate to produce new information on quality of care every year.

Recent performance improvement efforts include:

i. Formal Performance Improvement Projects:

- *Managing Hypertension* – this formal PIP started in 2020 and the primary study measure was the HEDIS Controlling High Blood Pressure (CBP) hybrid measure. The implementation team included members from the DVHA Quality Unit and Data Units, the Vermont Chronic Care Initiative (VCCI), the Blueprint for Health, the Vermont Dept. of Health and OneCare Vermont (Vermont's Medicaid ACO). Project strategies revolved around making blood pressure (BP) cuffs accessible and affordable, encouraging patients to join educational workshops that promote the importance of self-monitoring BPs and raising awareness amongst providers about measuring, diagnosing and documenting these BP readings in patient charts.

ii. Informal QI Projects and/or Learning Collaboratives:

- *Foster Care Learning Collaborative* – this CMS-sponsored Learning Collaborative started in 2021 and ran through 2023. The AIM study measure was the rate of comprehensive health visits for children and youth entering foster care. The implementation team included members from the DVHA Quality and Data Units, the Department of Children and Families, the Vermont Department of Health and the Vermont Child Health Improvement Project (VCHIP). Project strategies included improving communication between pediatric providers, foster families and state staff, as well as implementation of a billing tool for providers.

For more information about DVHA's performance improvement efforts, please visit: http://dvha.vermont.gov/providers/quality/performance-improvement-projects

4.4 Implementation of the Vermont Medicaid Program Quality Management Plan

DVHA's Director of Risk & Quality Management, along with DVHA's Quality Committee are responsible for:

- Ensuring that all appropriate DVHA staff and intra-agency agreement partner quality representatives are involved in the development and implementation of the QAPI program.
- Facilitating the formation of QI teams to address specific quality improvement initiatives.
- Analyzing customer satisfaction reports, feedback and grievance and appeals reports and initiating action to increase satisfaction.
- In consultation with AHS, setting priorities for performance improvement considering prevalence and severity of identified problems and prioritizing improvement activities that affect beneficiaries' health outcomes.
- Continuously monitoring progress toward goals and applying improvement and problem-solving processes as necessary to ensure satisfactory outcomes.
- Creating and following the Quality Committee's Annual Action Plan, which captures the above-mentioned performance improvement initiatives, as well as many of the other required QAPI program elements mentioned in this Quality Plan.