## Managed Care Quality Management (Central Region Products)

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Overall Goals and Objectives of Quality Management

A comprehensive Quality Management (QM) Program addresses the commitment of the Organization to environments that improve clinical quality, support safe clinical practices and enhance services to members. The overall goals and objectives of the QM Program are to:

- Establish performance standards to address, at a minimum, the following areas:
  - Quality of clinical aspects of care and patient safety, including health promotion; the early detection and prevention of disease; injury prevention for all ages; and systems to identify special chronic and acute care needs at the earliest possible time.
  - Quality of service (clinical and administrative).
  - Network management, including credentialing/recredentialing, provider accessibility, provider accessibility, and continuation of care.
  - Customer satisfaction, and.
  - Oversight of delegated functions.
- Analyze data and develop interventions that result in continuous measurable improvements, as applicable.
- Achieve an effective level of administrative and clinical commitment and support for the continuous quality improvement process. This includes ensuring effective coordination of QI activities with all appropriate functional areas, including but not limited to, Healthcare Management Services, Customer Services, HealthPLACE, Provider Data Services, Healthcare Informatics, Privacy Office, Marketing Communications, etc.
- Solicit provider and member input and measures of satisfaction to identify areas where improvements are needed and to develop, implement and monitor appropriate action plans and interventions to ensure a consistent focus on priority quality issues. This may include analysis of member/provider surveys, review of trended member complaint data and PCP changes, as well as member input via focus groups, newsletters, etc., to improve care and service on an on-going basis.
- Develop methods of monitoring and evaluating clinical and service indicators relevant to membership demographics, epidemiologic data and public health goals. Incorporate public health goals (when applicable) and develop national and regional benchmarks into the QM Program.
- Demonstrate improvements in the outcomes, processes, and quality of health care and services provided to members as a result of quality improvement initiatives. Perform an annual evaluation to determine the effectiveness of the QM Program and progress toward meeting program goals and objectives.
- Ensure adequate and ongoing communication and education of participating provider and members, including the principles of preventive health care, behavioral health care, and health maintenance. This also includes mechanisms to measure and implement actions to improve continuation and coordination of care, including medical and behavioral healthcare.
- Adhere to the standards established through the Health Insurance Portability and Accountability Act (HIPAA) and the Graham, Leach, Bliley Act (GLBA) for the privacy of personally identifiable health information.
- Demonstrate and maintain full compliance with external accrediting and regulatory agencies including but not limited to the National Committee for Quality Assurance (NCQA), American Accreditation Healthcare Commission (AAHC), Pennsylvania Department of health (DOH) and others as applicable. This includes providing oversight of all delegated activities and ensuring compliance with all applicable accrediting/regulatory and internal requirements.
- Promote the accountability of organization employees, delegated entities and healthcare providers for the quality of care and service provided to Plan members.
- Maintain a corporate committee structure to ensure that all components of the QM Program are operational and that all involved stakeholders, including internal functional areas and network provider are actively involved to promote effective improvements in care and service.
Clinical Initiatives

Preventive/public health

Preventive services are available for the entire plan membership which include:

- Preventive Care: 0 – 17 years
- Preventive Care: 18 – 64 years
- Preventive Care: 65+ years
- Childhood Immunizations
- Adolescent Immunizations
- Influenza Vaccinations
- Woman’s Care (breast and cervical cancer screenings)

Preventive health guidelines are adopted annually and are appropriate for all age ranges of the membership. The guidelines are reviewed and approved by the Mid-Atlantic Quality Improvement Committee, reviewed annually and revised as needed in accordance with medical evidence based on national health maintenance guidelines. Upon approval, guidelines are distributed to network providers.

All preventive health guidelines, both new and existing, are communicated to members through written communication and/or the Highmark Blue Shield Web site: www.highmarkblueshield.com.

Clinical Practice Guidelines

On an annual basis, the Quality Management Department, along with participating network physicians, review and update the Clinical Practice Guidelines. These guidelines are distributed to the provider community via NaviNet and www.highmarkblueshield.com Web site as a reference tool to encourage and assist you in planning your patients care.

Behavioral health

The coordination of behavioral health programs is based on an analysis of the demographic, cultural, clinical and risk characteristics of Highmark Blue Shield members that utilize behavioral health services. The behavioral health programs are coordinated through the Mid-Atlantic Quality Improvement Committee.

For behavioral health programs, Highmark Blue Shield has partnered with Magellan Behavioral Health, a national provider of behavioral health services. Magellan Behavioral Health develops and approves a Quality Improvement Program Description that outlines in greater detail activities to monitor and improve the quality and safety of behavioral health care and the quality of service provided to members. The document outlines the behavioral health aspects of the Quality Improvement Program and is reviewed and approved annually by Highmark Blue Shield and related Quality Improvement Committees.

Magellan Behavioral Health manages the inpatient utilization of behavioral health services through a delegated contractual arrangement. Outpatient behavioral health activities and services are coordinated with network providers.

Behavioral health activities that have been implemented include:

- Access to care and service availability for behavioral health services.
- Communication standards are in place to improve communication between behavioral health practitioners and primary care physicians to enhance continuity and coordination of care.
- Clinical practice guideline adoption and dissemination for treatment of depression.
- Development of a behavioral health preventive health clinical initiative.
Onsite reviews
Highmark Blue Shield conducts onsite reviews of all initial primary care physicians and ob-gyns and high-volume behavioral health specialists as part of the credentialing process. Site reviews are also conducted for all new and relocated sites of network providers. These reviews include medical record documentation standards, mechanisms to monitor and promote confidentiality, coordination and continuity of care and medical record appropriateness review.

Providers are required to submit a corrective action plan for area(s) identified that do not meet Highmark Blue Shield’s goals of 80% in medical record and 80% in environmental review. Revisits to offices are conducted at six-month intervals until such time as the provider is in compliance with Highmark Blue Shield standards.

Highmark Blue Shield will also monitor the overall aggregate onsite and medical record data for the network as a means of monitoring the organizational-wide quality of documentation and care. If a common opportunity for improvement is identified in a significant number of network providers, a quality improvement initiative is undertaken to correct the deficiency. Re-measurement will be undertaken to assess improvement.

In conjunction with the medical record review, an assessment of the provider’s office/facility is performed according to Highmark Blue Shield’s standards. Results of the onsite reviews are assessed at the time of the initial credentialing process.

Condition management
The condition management program creates an integrated approach that will concentrate on the total health care needs of members instead of focusing on one specific disease. Highmark Blue Shield will work closely with providers and members and, through provider input, will offer members the kind of services and support they need, between office visits, to more effectively follow providers’ treatment plans. Examples could include support with patient-monitoring issues like medications or blood sugar levels.

Providers will play a crucial role in helping to develop specific components of the new program. Highmark Blue Shield is seeking input and suggestions from the provider community on how to:

- Better educate patients on how to help themselves when they have diseases and other medical conditions.
- Help Highmark Blue Shield tailor activities that best support the provider-patient relationship to the most positive impact on the patient.
- Streamline the program to be more patient-centered and easier to use.

Continuation and coordination of care
Highmark Blue Shield recognizes the importance of coordination of care as part of the quality continuum. There are programs and policies in place to ensure coordination of medical, behavioral health or other community support for members. This process enables Highmark Blue Shield to inform the membership of health care needs that require follow-up, receive training in self-care and other measures to promote their health.

Systematic methods are utilized to monitor the continuation and coordination of care provided to members. Continuation and coordination of care is evaluated through treatment record/medical record reviews conducted in the offices of primary care physicians, ob-gyns and high-volume specialists, as well as through focused studies. In order to promote continuation and coordination of care for our members who have direct access to ob-gyns, communication from the ob-gyn to the primary care physician is monitored through focused studies.

Organizational providers are also monitored regarding their practices related to communication of appropriate patient information with network primary care physicians. Baseline data collection occurred in 2002 through a focused study of the presence of organizational provider communications to primary care physicians regarding members who have received services by these providers.
Highmark Blue Shield ensures continuation and coordination of care through procedures for timely communication of behavioral health information among providers. Standards for patient-approved communications between behavioral health specialists and primary care physicians will be developed and disseminated to these providers. In addition, a communication tool will be developed to assist in communication and coordination of care. Behavioral health specialists will be informed of the availability of the tool and encouraged to use this tool or other approved means of communication for sharing pertinent patient information with the primary care physicians. Evaluation of compliance with these standards will occur annually.

Quality Management policies have been developed to outline the standards and monitor methods for information exchange between network providers. Policies and procedures are also in place to address the coordination of timely access for appropriate treatment and follow-up for members with co-existing medical and behavioral health disorders. These policies and procedures are documented in this supplement.

Several key focuses include:

- Behavioral health: The same process exists for transition and continuity of care for behavioral health service that is in place for medical care. Highmark Blue Shield uses a tool as the communication vehicle to establish and maintain communication of member care between behavioral health providers and the member’s primary care physician.
- Transition of care: Highmark Blue Shield coordinates the medical care a member is receiving from a non-network provider at the time of his or her effective date of coverage that would not otherwise be covered prior to enrollment. The member may continue an ongoing course of treatment with that provider for a period of up to 60 days from his or her effective date.
- Continuation of care: Highmark Blue Shield offers up to 90 days continuation of care for members receiving medical care from a network provider when Highmark Blue Shield is notified that it intends to terminate or has terminated the contract of that network provider. This 90 days continuation of care period may be extended if determined to be medically necessary and appropriate by Highmark Blue Shield. In the case of a member who is in the second or third trimester of pregnancy on the effective date of coverage or at the time notice of the termination is received, care may continue with the provider through postpartum care related to delivery.

Patient safety
Highmark Blue Shield recognizes the importance of patient safety programs and will focus attention on the development of monitors for health care organizations and professionals related to patient safety. Additionally, Highmark Blue Shield will conduct specific activities to anyone influencing safe clinical practices throughout the network.

Several activities that will be developed to enhance patient safety elements and injury prevention include:

- Development of provider tools and distribution by Quality Management Department.
- Behavioral health communication study between primary care physician and behavioral health care providers.
- Initial credentialing process and recredentialing process.
- Quality flag mechanism on quality of care and service adverse events.
- Analysis of member dissatisfaction, appeals and requests to change primary care physicians.
- Potential drug interactions will be identified through the concurrent drug utilization review process and a warning message is issued to the dispensing pharmacist.
- Identification of serious/complex medical conditions through care/case management programs.

Collaboration with network providers is geared toward improving medical record legibility and timely follow-up to diagnostic testing. This is accomplished through education, development of corrective action plans and
follow-up subsequent to an onsite medical record review. Retrospective drug utilization review also identifies potential drug problems and triggers practitioner education.

Activities will be reviewed annually, or more frequently as needed, to identify opportunities for improvement in member safety. If opportunities exist, Highmark Blue Shield will establish corrective action plans and implement appropriate interventions.
Administrative Services

Customer Service

Customer Service serves as the first point of access to the plan’s members. Representatives provide information to members regarding their rights and responsibilities, the benefits and requirements of their health plan, status of their inquiries on claims and answer questions.

Customer Service also serves as the intake for members. All dissatisfactions from members related to the quality of care/service or access related to providers are entered into the inquiry tracking system and referred to the appropriate department for investigation, action and follow-up. When appropriate, due to the seriousness of the issue or to repeated administrative non-compliance, the Quality Management staff, in communication with the medical director, will suggest this information be presented to the Credentialing Committee for discussion and potential action.

Member appeals

Members have the right to appeal if they are not satisfied with decisions made by Highmark Blue Shield regarding the coverage of services. There are specific managed care regulations in place for handling appeals of managed care members. These apply to our managed care product, SelectBlue. Please see Section 10, “Managed Care Referrals and Authorizations” for more information about denials and appeals for SelectBlue members.

Member satisfaction

Annual member satisfaction surveys are conducted using a statistically valid sample of the membership. Results of the survey are reviewed by the Performance Excellence Department, Quality Management Department, and the Quality Operations Committee, and reported to the Mid-Atlantic Quality Improvement Committee. Member satisfaction is also monitored through review of member complaints, appeals and primary care physician change requests.

Resource materials available to network providers

Highmark Blue Shield’s Quality Management Department staff has a selection of resource materials that network providers may find useful. The order form found in the appendix can be used to order these materials for your office. You can photocopy this form for multiple uses. Completed order forms can be faxed to 1-717-731-2798.

Enhancing the health of our members

Highmark Blue Shield offers our members a variety of value-added services, such as:

- Health and Wellness Bus – Our mobile health screening and education facility that brings a wealth of vital health-related information and services to your Highmark Blue Shield patients where they live and work.
- Blues on Call – A health information and support service with the primary goal of fostering and facilitating a strong patient-physician relationship. Members can talk to a registered nurse 24 hours a day, seven days a week, for help with a broad range of health needs.
- Women’s health: HOPE – Our osteoporosis prevention and education program designed to help our members reduce their risks of developing osteoporosis, improve the quality of life for those diagnosed and minimize the progression of bone loss to ultimately reduce fractures.
- Dr. Dean Ornish Program for Reversing Heart Disease – Is another treatment option for your patients battling heart disease.

Information about these programs can be found in the June 2002 issue of Behind the Shield. More about these and other value-added services will be published in future issues of that newsletter.