# Chapter 4

## Health Care Management

### Unit 6: Quality Management

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4.6 Quality Management Program

Purpose of the Quality Management Program

The purpose of the Highmark Quality Management (QM) Program is to provide the framework and the formal processes within which the organization continually assesses and improves the quality of clinical care, safety and service provided to members. This includes the ongoing and systematic monitoring, analysis and evaluation of the accessibility, availability and continuity of medical and behavioral health care and services provided to members in the applicable products. This approach enables the organization to focus on opportunities for improving operational performance, health outcomes and member/practitioner/provider satisfaction, as well as to change perceptions.

Overall Goals of the QM Program

• Improve the health status of the population within our service area through delivery of quality, cost effective and accessible health care service
• Anticipate the health-related needs of members and their families, and proactively match these needs with high-value programs and services
• Ensure that the right support and care is given at the right time, in the right place and for the right price
• Lead and support the advance of safe, effective patient-centered care
• Measure outcomes of care and service, and apply interventions that continuously improve the level of care and service provided to members
• Build effective partnerships with internal and external customers
• Develop and implement systems and processes within the QM Department that will function seamlessly across program components

Overall Objectives of the QM program

• Maintain updated and comprehensive documentation of plan patient safety activities
• Ensure ongoing compliance oversight of entities performing functions on behalf of the plan in either a delegation or other business related capacity
• Continue to develop and refine the QM Department’s electronic prescribing (eRx) and electronic health record (eHR) implementation assistance program that will be designed to facilitate practitioner office transition to this new technology
• Ensure ongoing compliance and continuous audit preparedness for all applicable accrediting and regulatory bodies, for all applicable products. Specific focus will be placed on compliance activities related to the Medicare Modernization Act
• Select the Quality Improvement Project(s) (QIPs) for the FreedomBlue PPO product and ensure that data collection is initiated
• Address potential health care disparity issues in clinical and service quality through continued participation in the National Health Plan Learning Collaborative to Reduce Disparities and Improve Quality and the implementation of the Highmark Health Care Disparities/Culturally and Linguistically Appropriate Services (HCD/CLAS) Committee

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4.6 Quality Management Program, Continued

- Ensure the implementation of the statewide Hospital Quality Performance Report to provide network hospitals with comparative reports of member satisfaction, patient safety activities, compliance ratings with defined clinical indicators, and various clinical measures provided through the Pennsylvania Health Care Cost Containment Council (PHC4)
- Annually evaluate the continuity and coordination of medical and behavioral health care, as well as medical care across settings or transitions in care.
- **Western Region Only:** Continue to coordinate the implementation of the Risk Adjustment Data Validation (RADV) Western Region Medicare Advantage HMO initiative that is consistent with the focus on timely submission of all relevant medical record documentation and CMS guidelines
- Demonstrate improvements in the clinical outcomes, processes and quality of health care provided to members as a result of quality improvement initiatives, based on demographic and epidemiologic characteristics of the membership
- Facilitate the collaborative efforts of various departments within Highmark towards the development of strategic clinical initiatives through the Executive/Large Clinical Planning Committee
- Establish practice guidelines for preventive health, acute and chronic care, including behavioral health, that are pertinent to the membership and measure performance against at least two important aspects of four clinical practice guidelines, two of which relate to behavioral health
- Measure availability and accessibility to care and service, including behavioral health care, at least annually to meet the specific health care needs of the Highmark membership
- Measure member satisfaction to identify and address sources of dissatisfaction through analysis of member complaint and grievance data, and analysis of annual member satisfaction surveys
- Demonstrate quality improvements that positively affect the service that members receive
- Maintain an ongoing, up-to-date credentialing and recredentialing system that is compliant with all state/federal regulations, as well as accreditation standards. Conduct regular file and directory audits at defined intervals to ensure compliance, identify opportunities for improvement and identify best practices
- Promote safety and quality in practitioner offices through office site reviews and measurement of conformance to medical record standards. Consult with practitioners regarding opportunities for improvement with record documentation and best practices to ensure that members are accessing the system appropriately for prevention and wellness, as well as chronic conditions
- Provide input and support to new corporate initiatives/programs, such as Lifestyle Returns, Pay for Performance, and Transparency
- Evaluate new technologies available to continuously improve the level of care and service provided to members (e.g., Eliza, etc.) and be a leader in promoting adoption of the new technologies to enhance corporate goals and efficiency.

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4.6 Prevention and Wellness

Preventive Health Guidelines

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

- Adults over 65
- Adults ages 19-64
- Pediatrics 0-18
- Prenatal/Perinatal

Preventive health guidelines are reviewed and approved by the Quality Improvement Committee annually and revised as needed in accordance with medical evidence based on national health maintenance guidelines.

All preventive health guidelines, both new and existing, are communicated to network providers and members through written communication and/or one of Highmark’s Regional Web sites accessible through www.highmark.com.

Behavioral Health

The coordination of behavioral health programs is based on an analysis of the demographic, cultural, clinical and risk characteristics of Highmark members who utilize behavioral health services.

Highmark developed 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 and related Quality Improvement Committees.

Highmark manages the inpatient utilization of behavioral health services for all members who have behavioral health care coverage through Highmark. Outpatient behavioral health services are authorized in accordance with the behavioral health benefits available for each product.

Behavioral health activities that have been implemented include

- Access to care and service availability for behavioral health services.
- Communication standards to improve communication between behavioral health practitioners and primary care physicians to enhance continuity and coordination of care.
- Adoption and dissemination of clinical practice guidelines for the treatment of depression.
- Development of preventive behavioral health clinical initiatives.
- Implementation of a Depression Condition Management Program.

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4.6 Clinical Quality

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 or Highmark’s Regional Web sites accessible via www.highmark.com as a reference tool to encourage and assist you in planning your patients’ care.

Condition Management Program
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.

Continuity and Coordination of Care
Highmark 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 to inform the membership of health care needs that require follow-up, receive training in self-care and other measures to promote their health.

The QM Department facilitates the continuity and coordination of medical care across the delivery system and also collaborates with behavioral health practitioners to monitor and improve coordination between medical and behavioral health care. The communication between PCPs and specialists is regularly monitored as part of Highmark’s Quality Management Program, specifically through the medical record review program and as part of the provider satisfaction survey. During medical record review, representatives will check for the practitioner’s initials on the patient’s chart and ensure that any necessary follow-up actions are addressed.

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4.6 Clinical Quality, Continued

Continuity and Coordination of Care (continued)

Network organizational providers, such as hospitals, emergency facilities, ambulatory surgery centers, home health agencies, and skilled nursing facilities must promote continuity and coordination of care for network members by communicating with PCPs when care is delivered to their patients. PCPs should expect a written description of the care given to their patients any time services have been rendered by these providers.

Patient Safety Program Activities

Highmark recognizes the importance of patient safety programs; therefore, Highmark’s Patient Safety Program focuses on the development of activities which assess and improve the plan’s patient safety efforts.

Many activities have been developed to enhance patient safety, including:

• Collaboration with other departmental areas to catalog the plan’s various patient safety activities
• Facilitation of a Patient Safety Committee that is responsible for assessing, monitoring and reporting of the plan’s patient safety activities in an effort to enhance patient safety and setting a strategic direction for the organization
• Development of a written patient safety plan for collecting and providing information on provider and practitioner safety and quality that includes:
  ▪ Activities to collect information on provider’s actions to improve patient safety
  ▪ Activities to make performance data publicly available for members and practitioners
• Development of an electronic prescribing (eRx) and electronic health record (eHR) implementation assistance program

Quality of Care Case Reviews

The Quality Management Department is responsible for evaluating member dissatisfactions, concerns and issues related to quality of care and initiating appropriate action in response to them. The Quality Management Department becomes aware of quality of care dissatisfactions through information received from a number of sources, including providers and members as well as internal Highmark departments. Tracking mechanisms enable the Quality Management Department to monitor the information received over time.

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4.6 Clinical Quality Continued

<table>
<thead>
<tr>
<th>Step</th>
<th>Who Does It?</th>
<th>What is Done?</th>
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| 1    | Registered Nurse from Quality Management | Performs a preliminary review to determine whether there is potential for a quality issue.  
• IF NO, the case is closed.  
• IF YES, accepts the case for review. |
| 2    | Registered Nurse from Quality Management | Without the review of medical records, tracks the accepted case in a database for similar issues involving the provider; or Requests and reviews medical records according to Quality Management department policy.  
• IF medical record review indicates no potential for an adverse outcome, closes the case but maintains a record of it to track the provider for similar issues.

• IF potential for an adverse outcome is identified or the provider may have contributed to an adverse outcome, passes the case to a Medical Director for review. |

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## 4.6 Clinical Quality, Continued

### Quality of Care Case Reviews (continued)

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<tr>
<th>Step</th>
<th>Who Does It?</th>
<th>What is Done?</th>
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| 3    | A Highmark Medical Director | Reviews the case.  
  • IF this review indicates there is no quality issue, the case is closed by the RN but maintained in the records so the provider can be tracked for similar issues.  
  IF this review indicates that a quality issue may be present, sends a written request for a provider/practitioner response. |
| 4    | Provider/ Practitioner | Responds to the Medical Director’s request for information |
| 5    | A Highmark Medical Director | Reviews the case with the additional information provided.  
  • IF this information satisfies the concern, the case is closed by the RN and a record of the case is maintained so that the provider can be tracked for similar issues.  
  • IF the review still indicates the presence of a quality concern, a corrective action may be initiated, depending on the severity of the issue. |
| 6    | Provider/ Practitioner | May choose to appeal these actions before a subcommittee of the Credentialing Committee. |
| 7    | Quality Management Staff | Documents the outcome of the case via the Member Dissatisfaction Tracking Database.  
  Tracks the incident(s) and providers for similar trending patterns.  
  Generates confidential reports from this database on a quarterly basis for the Quality Management Medical Director to take further action if needed. |
4.6 Network Quality

Office Site and Medical Record Documentation Reviews

Office site and medical record documentation reviews are conducted for all initial, new and relocated PCPs, ob/gyns, independently practicing certified registered nurse practitioners and nurse midwives, and for all high-volume behavioral health sites. In lieu of performing a review, we will accept practitioners that have been recognized by the National Committee for Quality Assurance’s (NCQA’s) Physician Practice Connections Program. The office must provide a copy of NCQA’s recognition letter as evidence. Reviews will continue to be conducted triennially for all dual-credentialed practitioners.

General Elements Assessed During a Review

CPR Certification

Office Site Evaluation
- Handicapped parking
- Adequate waiting rooms
- Physical appearance of the office
- Adequate exam rooms
- Fire extinguishers
- Emergency/evacuation plan
- Handicapped accessibility
- Secure medical/treatment records
- Marked exits
- Proper handling of biohazardous waste
- Proper sterilization of equipment
- Properly secured medication and prescription pads
- Emergency drugs and airway equipment availability
- Proper storage of medications and lab specimens
- Confidentiality

Office Accessibility
- Physician availability at least 20 hours per week
- Availability of emergent, urgent, routine and preventive appointments
- Guidelines for phone triage, advance directives, disclosure of confidential information
- Coverage availability 24 hours a day, seven days per week

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4.6 Network Quality, Continued

<table>
<thead>
<tr>
<th>General Elements Assessed During a Review, (continued)</th>
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<tbody>
<tr>
<td><strong>Medical Records Documentation</strong></td>
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<tr>
<td>• Personal biographical data</td>
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<tr>
<td>• Problem lists</td>
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<tr>
<td>• Preventive services flow sheet</td>
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<tr>
<td>• All entries dated</td>
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<tr>
<td>• Past medical history</td>
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<tr>
<td>• Vital signs at each visit</td>
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<tr>
<td>• Coordination of care and notation of follow-up plans</td>
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<tr>
<td>• History &amp; Physical identifies pertinent subjective and objective data</td>
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<tr>
<td>• Immunizations as recommended for age</td>
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<tr>
<td>• Preventive health services as recommended for age and sex</td>
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<tr>
<td>• Medication flow sheet</td>
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<tr>
<td>• Medication allergies and adverse reactions</td>
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<tr>
<td>• All entries contain author identification</td>
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<tr>
<td>• Use of cigarettes, alcohol and substance abuse</td>
</tr>
<tr>
<td>• Discussion of advance directives</td>
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<tr>
<td>• Growth and development appropriate for age</td>
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<tr>
<td>• The Plan’s Primary Medical Record Standards shall reflect:</td>
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<tr>
<td>➢ all services provided directly by a PCP</td>
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<tr>
<td>➢ all ancillary services and diagnostic tests ordered by a practitioner</td>
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<tr>
<td>➢ all diagnostic and therapeutic services for which a member was referred by practitioners, such as:</td>
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<tr>
<td>• home health nursing reports</td>
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<td>• specialty physician reports</td>
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<tr>
<td>• hospital discharge reports</td>
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<td>• physical therapy reports</td>
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**Treatment Record Documentation** (for behavioral health practitioners)

Personal biographical data
• Psychiatric history
• Developmental history
• Mental status exam
• Risk factors
• Identification of DSM-IV diagnoses
• Treatment plan and goals

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4.6 Network Quality, Continued

Other indicators are also reviewed. A detailed list is available by calling 717-302-3353. All office site reviews will be scored in the aggregate for each component of the comprehensive site visit tool used by Highmark: Environmental Assessment, Medical/Treatment Record Documentation and Preventive Services Review. A score of at least 80 percent on the Environmental Assessment, Medical Record Documentation and Preventive Services evaluation must be met.

Assessments may also be conducted in response to information obtained from quality improvement activities, including member complaints. To monitor the network for ongoing compliance, a statistically valid random sample of practice sites will undergo an evaluation using selected components of the elements listed on this page. These evaluations require an aggregate visit score of 80 percent.

Practices not meeting PremierBlue Shield compliance standards on office site, medical/treatment record or preventive services evaluations are expected to correct the deficiencies and will be re-evaluated within six months. The re-evaluation will be a reassessment of the non-compliant elements from the previous site review. (Practices failing to correct deficiencies may be sanctioned and become ineligible for QualityBLUE bonus payments. Practices with office deficiencies on repeated re-evaluations may be terminated from network participation.)

Highmark’s Quality Management Department staff has a selection of resource materials that network providers may find useful. NaviNet-enabled providers can find the Partners in Quality Toolkit on NaviNet under the Clinical Reference Materials link in the Provider Resource Center. Non-NaviNet providers may obtain a CD of the Partners in Quality Toolkit by faxing a request to 1-412-544-2619.
### 4.6 Service Quality

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<thead>
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<th>Member Satisfaction Monitoring</th>
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<td>Annual member satisfaction surveys are conducted, using a statistically valid sample of the membership, to ensure that the plan identifies potential areas for service quality improvements. Results of the survey are reviewed by the Quality Management Department, the Survey Analysis Committee, the Quality Operations Committee, and are reported to the Quality Improvement Committee and Quality Management Council. Member satisfaction is also monitored through review of member dissatisfactions, complaints and appeals.</td>
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