CHAPTER 5: CARE AND QUALITY MANAGEMENT

UNIT 6: QUALITY MANAGEMENT

IN THIS UNIT

What Is My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**

- The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.
- The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.
- The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

5.6 QUALITY MANAGEMENT PROGRAM OVERVIEW

Introduction

The Highmark Quality Management Program is designed to ensure that members receive the best quality health care, in the most appropriate setting, in the most cost-effective manner.

Quality Management follows a Continuous Quality Improvement Process model for the ongoing monitoring and analysis of relevant clinical and service quality measures. The model focuses on the early identification of problems, with the development and implementation of interventions that focus on any issues that are identified. The member is at the heart of all activities.

Purpose

The purpose of the Quality Management 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 to members.

Definitions

Quality improvement processes are those activities that the health plan undertakes to improve the quality and safety of clinical care (including behavioral health care) and the quality of service to members.

Quality management is the integrative process that links knowledge, structure, and processes together throughout the organization to assess and improve quality.

Highmark Quality Management

Highmark's Quality Management, part of the Clinical Services division of Highmark, is responsible for corporation-wide coordination of clinical and service related improvement initiatives focused on clinical care, member satisfaction, access and availability, and performance measures and outcomes for both physicians and facilities.

Quality Management is also accountable for compliance with all applicable external accrediting and regulatory entities such as the:

- Centers for Medicare & Medicaid (CMS)
- National Committee for Quality Assurance (NCQA)
- Pennsylvania Department of Health
- Pennsylvania Insurance Department
- Office of Personnel Management (OPM)

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5.6 QUALITY MANAGEMENT PROGRAM OVERVIEW, Continued

Organizational structure

The organizational structure of Highmark's Quality Management divides staff responsibilities into these distinct functional areas:

- Accreditation and Regulatory Compliance
- Clinical Performance Measurement
- Clinical and Service Quality (Medical and Behavioral Health)
- Clinical Outcomes and Guidelines

These areas work together with the support of staff from other departments in Highmark, as well as external support from primary and specialty care providers to continually assess and improve the quality of clinical care, safety and service to members.

Overall goals of the Quality Program

The goals of the Quality Program are as follows:

1. Improve client and member experience of care, as well as their health, by anticipating and evaluating their needs and proactively aligning those needs with appropriate programs and services that reduce and/or control clinical risk;
2. Support and promote the delivery of care by providing a high quality network of practitioners and providers;
3. Offer data-driven, evidenced-based, and comprehensive health care services and programs that are continuously improved based on outcomes;
4. Build effective partnerships with members and their caregivers/families, clients, providers, facilities, payers, and the community to understand their objectives and needs and adapting products and/or services accordingly to create positive and lasting change and a differentiated member and provider experience;
5. Utilize advanced analytics and proven quality improvement strategies and tools to measure and improve outcomes of care and service and achieve meaningful and sustainable improvement;
6. Enhance transparency efforts to promote member engagement, customer intimacy, and support members in making appropriate decisions about care;
7. Continue to work toward achieving health equity through reducing health care disparities, enhancing health literacy, and providing culturally and linguistically appropriate services; and
8. Identify members with complex health needs (e.g., physical or developmental disabilities, multiple chronic conditions, severe mental illness) to effectively manage their special health care needs.

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5.6 QUALITY MANAGEMENT PROGRAM OVERVIEW, Continued

Data sources

The Highmark Quality Program provides a framework for continuous assessment and improvement of all aspects of health care delivery and services for its membership. This involves the collection and quantitative/qualitative analyses of relevant data to identify barriers or causes for less-than-optimal performance, identification of opportunities for improvement, and implementation of interventions to improve results.

Examples of the various data sources that may be collected and analyzed include, but are not limited to, the following:

1. Medical/treatment records
2. Claims
3. Enrollment reports
4. Pharmacy data
5. Condition management reports
6. Health risk appraisals
7. Member service data
8. Healthcare Effectiveness Data and Information Set (HEDIS®) results
9. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) results
10. Health Outcome Survey results
11. Utilization Management (UM) statistics
12. Member/practitioner surveys
13. Current literature

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 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 Program and is reviewed and approved annually by the Highmark Board and appropriate Quality-related committee.

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.

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5.6 QUALITY MANAGEMENT PROGRAM OVERVIEW, Continued

Behavioral health activities

Behavioral health activities that have continued to 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, substance abuse, and attention deficit hyperactivity disorder (ADHD).
- New and ongoing preventive behavioral health clinical initiatives.
- Depression Condition Management Program.

5.6 HIGHMARK QUALITY PROGRAM COMMITTEES

Overview

As a way for Highmark to promote objective and systematic monitoring, evaluation and continuous quality improvement, various Highmark Program Committees have been established. The Program Committees are made up predominantly of health care professionals and are established by Highmark's Board of Directors.

Highmark Quality, Safety, and Value Committee (HQSVC)

The Highmark Quality, Safety, and Value Committee (HQSVC) is a physician-based committee that provides clinical oversight of quality program activities on behalf of the Highmark Board of Directors. The committee reviews quality assurance and improvement activities related to the health benefits administered by Highmark and its applicable wholly-owned, wholly-controlled, and/or partially-owned subsidiaries, and provides input and recommendations on such activities. The HQSVC reviews and approves the quality program description, action plan, and evaluation on an annual basis. The HQSVC also receives quality program reports and updates, as appropriate.

Care Management and Quality Committee (CMQC)

The Care Management and Quality Committee (CMQC) is a multi-disciplinary committee representing western, central, and northeastern Pennsylvania, Delaware, and West Virginia that is dedicated to continuous improvement of quality and care management services provided to members. The Senior Medical Director chairs the CMQC and Medical Directors, actively practicing physicians, and physicians in administrative positions with involvement in care management in hospitals are active members.

The CMQC has responsibility for the review and approval of the Quality, Utilization Management, and Population Health Management program descriptions, evaluations, and action plans; relevant policies and procedures; utilization core performance indicators/trends; clinical criteria sets used by the plan and its delegates; review, leadership, and direction over Highmark's care management activities and initiatives; relevant quality improvement activities; oversight/monitoring of all delegated utilization functions, credentialing policies, and desktop procedures as revised; and quality committee reports.

The CMQC is also responsible for recommending policy decisions, analyzing and evaluating the results of quality activities, ensuring provider participation in the quality program, instituting needed actions, and ensuring follow-up, as appropriate. This includes, but is not limited to, the results of quality monitoring activities completed specific to member satisfaction, health care equity, accessibility of services, practitioner and provider availability, continuity of care, credentialing and recredentialing, delegation and business arrangement oversight, and ongoing regulatory and accrediting body compliance.

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5.6 HIGHMARK QUALITY PROGRAM COMMITTEES, Continued

Clinical Policy Management Committee (CPMC) and specialty subcommittees

The Clinical Policy Management Committee (CPMC) is responsible for evaluating medical and surgical procedures and techniques, developing policy guidelines for new and evolving technology, determining the medical policy coverage positions, and recommending medical necessity guidelines for covered procedures.

Specialty subcommittees -- made up of actively practicing physicians in the areas of Cardiology, Hematology/Oncology, Musculoskeletal, Neurosciences, and Pediatrics -- evaluate existing medical policy coverage guidelines as well as new technology. The subcommittees meet quarterly and make recommendations to the CPMC regarding medical policy coverage positions.

5.6 FUNCTIONAL AREAS AND THEIR RESPONSIBILITIES

Introduction

The scope of the Clinical Services -Quality area's functions and responsibilities are described below. These functions are only one piece of the Quality Management Program. In addition, Clinical Services-Quality has established linkages to other areas within Highmark to expand the scope of the Quality Management Program throughout the organization.

Clinical Services Quality

Clinical Performance Measures

1. Annual Healthcare Effectiveness Data and Information Sets (HEDIS®) reporting to meet National Committee for Quality Assurance (NCQA), Centers for Medicare & Medicaid Services (CMS), and state regulatory requirements used to assess member utilization of preventive/chronic care services and provider compliance with national standards of care.
2. Annual NCQA HEDIS® Compliance Tool (Roadmap) completion for all applicable products, which includes a review of: record of administration, data management, and processes which serve to collect information about how the plan's information management practices comply with HEDIS® reporting requirements and associated on-site audit activities. One Roadmap and audit process will be completed for the Commercial, Medicare Advantage, and Marketplace products in Pennsylvania, West Virginia, and Delaware. Another Roadmap and audit process is required separately by the State of PA for the Children's Health Insurance Plan (CHIP) HMO and CHIP GPPO products. This audit includes a review of the health information system that is maintained to support data collection and analysis efforts for quality improvement activities.
3. Annual patient-level data submission used to calculate the summary-level data for all reported products by the required due date(s).
4. Complete Health Organization Questionnaires (HOQ) on the NCQA website by the NCQA-designated due date for all products.
5. Clinical quality of care case reviews of referred member dissatisfactions or adverse events related to deviations from standards of care to include serious reportable events and/or hospital-acquired conditions to ensure a continued network of quality focused providers and to correct all problems identified through internal surveillance, complaints, or other mechanisms**.**
6. Patient safety-related activities that demonstrate the measurement of/improvement in the quality and safety of care provided to members.
7. Quality responses for Sales-related requests for information (RFIs).

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5.6 FUNCTIONAL AREAS AND THEIR RESPONSIBILITIES, Continued

Clinical Services Quality (continued)

Clinical and Service Quality (Medical and Behavioral Health)

1. Appointment accessibility monitoring to ensure that members have appropriate access to primary care, behavioral health care, and specialty care services.
2. Telephone accessibility monitoring to ensure that members have appropriate access to organization services.
3. Member experience/satisfaction monitoring (e.g., dissatisfactions, complaints, appeals, member satisfaction surveys) and determination of service quality improvement opportunities to correct all problems identified through internal surveillance, complaints, or other mechanisms.
4. Provider satisfaction monitoring (e.g., UM process) through the review and analysis of provider dissatisfactions. Opportunities to improve provider satisfaction are identified and a plan of action implemented, if required.
5. Vendor selection/management for administration and analysis of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), behavioral health experience, and enrollee experience surveys.
6. Practitioner and provider availability monitoring to ensure an adequate network of primary care, behavioral health, and specialty care practitioners and providers is maintained, as well as how effectively the network meets the cultural, ethnic, racial, and linguistic needs and preferences of its membership.
7. Network adequacy plan maintenance and monitoring specific to the Marketplace products.
8. Quality Improvement Strategy (QIS) for Marketplace members.
9. Patient safety activity monitoring and development of targeted patient safety initiatives.
10. Continuity and coordination of care monitoring of transitions within medical care and between medical and behavioral health care, identifying opportunities for improvement and taking action as appropriate.
11. Member preventive health status assessments via claims data analysis, health-risk assessment (HRA) data, PRA-Plus™ surveys, Medicare Health Outcomes Survey (HOS) results, Personal Health Records (PHRs), etc.
12. Behavioral Health Preventive Program management, such as those components focused on alcohol use screening and depression screening post-cardiac event.
13. Collaboration with Clinical Operations on the development and reporting of Chronic Care Improvement Project(s) (CCIPs).
14. Practitioner/provider interventions designed to encourage participation in CMS and Health and Human Services (HHS) Quality Improvement initiatives as applicable.

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5.6 FUNCTIONAL AREAS AND THEIR RESPONSIBILITIES, Continued

Clinical Services Quality (continued)

15. Limited English Proficiency Project Management Office: Civil Rights Act compliance, including arrangements for language assistance services as needed; demographic analyses; Language Assistance Plan monitoring, identification of opportunities for improvement, implementation, and re-measurement.

Accreditation and Regulatory Compliance

1. Ongoing monitoring and continuous audit preparedness for all applicable regulatory and accrediting bodies:
   a. NCQA Health Plan accreditation program management for all products, in Pennsylvania, West Virginia, and Delaware.
   b. CMS quality-related activities related to Quality Improvement Program components: Quality Improvement Project (QIP) selection, monitoring, and reporting; Chronic Care Improvement Program (CCIP) selection, monitoring, and reporting in collaboration with Clinical Operations.
   c. Pennsylvania Department of Health (PA DOH) and Pennsylvania Insurance Department (PID) annual reporting/technical advisory monitoring for assigned requirements.
   d. West Virginia Insurance Commission/Bureau of Medical Services (BMS) compliance (credentialing, delegation oversight, and NCQA accreditation only).
   e. Delaware regulatory body monitoring and compliance for assigned activities.
   f. Division of Medicaid and Medical Assistance (DMMA) requirements (credentialing, delegation oversight, and NCQA accreditation only).
2. NCQA contract, project management, and audit coordination: coordinate, prepare, and submit documents for, and participate in, on-site and off-site quality reviews and audits conducted by applicable accrediting and regulatory bodies.
3. Delegation oversight assessment/monitoring: participate in centralized delegation oversight assessment process and ongoing monitoring specific to NCQA requirements.
4. Delegation oversight and reporting for Medicaid HMO products: conduct delegation oversight of non-Highmark affiliated legal entities performing functions on behalf of the Medicaid HMO products in West Virginia and Delaware and report outcomes to applicable committees.
5. Quality improvement structure, governance, maintenance, and operations to support the quality, safety, and equity of clinical care and services provided to members (including compilation of an annual Quality Program Evaluation, Description, and Action Plan; reporting matrices; meeting minutes; policies and desktop procedures, etc.).

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5.6 FUNCTIONAL AREAS AND THEIR RESPONSIBILITIES, Continued

Clinical Services Quality (continued)

6. Quality Improvement Strategy that is aligned across the integrated delivery system with common metrics and processes (where possible) and focuses on creating a culture of quality and health.
7. Highmark Population Health Management Strategy that aligns with the Highmark Health strategy.
8. Communications to members and providers regarding Quality Program goals/objectives, progress towards achieving goals, ability to provide input, etc.
9. Health services contracting monitoring to ensure compliance with NCQA requirements.
10. Compliance audits of member notification of practitioner termination and continued access to care to ensure continuity and coordination of care membership.
11. Oversight of Transition of Care (TOC) procedures to allow new enrollees of a managed care product who are currently in treatment with an out-of-network provider the opportunity to transition his/her care to a network provider.
12. Oversight of process to help inform members and providers of the potential for benefit exhaustion as well as to educate members about available alternatives for continuing care, as appropriate.
13. Process improvement lead for Quality area and support for other project teams within Clinical Services (as needed).
14. Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"): Highmark applies the same network admission and provider credentialing standards to all providers in a comparable manner regardless of whether the provider renders medical services, behavioral health services, or substance abuse treatment services. Furthermore, Highmark utilizes the same processes, standards, factors, and strategies to develop provider reimbursement rates for providers that render medical services, behavioral health services, and substance abuse treatment services.

Clinical Outcomes & Guidelines

1. Clinical outcome monitoring, analysis, and planning/design of initiatives focused on improving the care provided to members, with targeted focus on measures selected for Commercial products, Children's Health Insurance Program (CHIP) Performance Improvement Projects, and Marketplace Quality Reporting System (QRS).
2. Facilitate the Clinical Work Group (CWG): Preventive initiatives are developed and implemented by the Clinical Quality staff through the work of the Clinical Work Group (CWG). HEDIS data is reviewed, barrier analysis performed, and opportunities for improvement identified in order to identify gaps in care that need to be closed and to improve outcomes through interventions targeted toward members and providers.

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5.6 FUNCTIONAL AREAS AND THEIR RESPONSIBILITIES, Continued

Clinical Services Quality (continued)

3. Adoption and distribution of Preventive Health Guidelines that comprehensively address the characteristics and age range of the member population, using evidence-based sources and practitioner input, which are measured annually for guideline compliance. Outreach to improve compliance with Preventive Health Guidelines is also conducted by this team, with expansion of these activities anticipated in 2019.
4. Facilitate the Preventive Health Work Groups to ensure the health plan is in compliance with mandates and regulatory guidelines and complete the annual Medicare Advantage and Commercial Preventive Schedules.
5. Member and provider interventions to reduce health care disparities.

Credentialing Compliance

For Credentialing Compliance functions, please see the Highmark Provider Manual's **Chapter 3.2: Professional Provider Credentialing**.

Revenue Program Management

Revenue Program Management Functions

1. Professional reviews to determine the adequacy and safety of all professional practitioner office sites, as well as conformance to Highmark Inc. standards for medical record reviews in Pennsylvania, West Virginia, and Delaware. This includes, but is not limited to, an assessment of the following office site criteria: access for patients with physical and/or sensory disabilities, physical appearance, adequacy of waiting/exam rooms, organized/systematic clinical record system, confidentiality, 24/7 coverage, appointment access, etc. This includes, but is not limited to, assessment of medical/treatment record criteria such as: medications, allergies, signature, dated entries, preventive services flow sheet, counseling regarding an advance directive/documentation of executed Advance Directive, etc. Assessments are in response to:
    a. Specified member complaints
    b. Offices with less than twenty (20) office hours availability
    c. Annual randomly chosen sample
    d. Medical Director requests
2. Facility office site visits and medical record reviews in the absence of external accreditation to determine the adequacy and safety of all facility sites, as well as conformance to Highmark Inc. standards for medical record documentation in response to notification from Credentialing Review requests.
3. Chart abstraction for the annual Healthcare Effectiveness Data and Information Set (HEDIS®) hybrid (medical record) reporting requirement.
4. Educate provider offices relating to Office Site/Medical Record evaluations, HEDIS® medical record review, and/or relating to Revenue Program Management projects.

5.6 CASE REVIEW PROCESS FOR QUALITY CONCERNS

Overview

Highmark's Quality Management is responsible for evaluating member dissatisfactions, concerns, and issues related to clinical quality of care.

The Clinical Performance Measures area of Quality Management becomes aware of potential issues/concerns and member dissatisfactions about clinical quality of care issues through information received from a number of sources, including providers, members, and internal Highmark departments.

The initial review

A Clinical Quality Management Consultant (CQMC) completes the initial review of each case referred for potential quality of care issues. The CQMC, who is a registered nurse, reviews the case to determine whether there is potential for a quality issue referencing scientifically-based standards of care.

- When this initial review determines that the concern does not have the potential for an adverse outcome, the case is closed and filed for trending purposes.
- If the potential for an adverse outcome is identified, medical records are requested from the provider or facility involved in the case.

Analysis of medical records

Once medical records are received, the CQMC performs a second assessment of the case. If the assessment dispels any concern of potential for an adverse outcome, the case is closed and filed to track the provider for any future issues.

If the potential for an adverse outcome or a Level of Harm, as defined by the Agency of Healthcare Research and Quality (AHRQ), is identified, the case is forwarded to a Medical Director for review.

Medical Director review outcomes

When the Medical Director believes that a quality issue may be present, a written request for additional information is sent to the provider involved.

If it is determined that a quality issue is indeed present following the review of any additional information, a Level of Harm is determined by the Medical Director and a corrective action plan is implemented if warranted.

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5.6 CASE REVIEW PROCESS FOR QUALITY CONCERNS, Continued

Provider responsibilities

During the investigation of quality of care concerns, facility providers may be asked to supply any or all of the following:

- A copy of the member's medical or behavioral health record
- A response from the administrator, or the administrator's designee, to address a possible adverse outcome determined during the medical record review
- A corrective action plan (if warranted) if an adverse outcome is found during the medical record review

5.6 CORRECTIVE ACTION AND SANCTIONING

Issues leading to corrective action or sanctioning

A provider or facility is placed under corrective action or sanctioning when a treatment, procedure, or service indicates a provider is not practicing in a manner that is consistent with the standards of Highmark and/or deviates from acceptable standards of care.

There are two issues when a provider can be placed under corrective action/sanctioning:

1) Clinical quality of care - occurs when an episode strays from accepted medical standards (e.g., actions or omissions resulting in an adverse effect on a patient's well-being, medication errors, missed diagnosis, delaying treatment, unanticipated and unexplained death)
2) Administrative non-compliance - occurs when a provider's behavior is not consistent with their agreement with Highmark contracts and guidelines (e.g., failure to comply with contractual obligations, medical record review deficiencies, balance billing for services and unauthorized billing for services)

Notification of corrective action

Once the Medical Director makes a determination to place the provider under corrective action, the provider will be notified in writing of:

- The reason for the corrective action
- What corrective action is needed and what it involves
- The length of time the provider will remain under the corrective action

The provider can either appeal the decision of the Medical Director, elect to abide by the corrective action plan, or make the necessary improvements (if applicable).

Appeal hearing

If an appeal is requested, a hearing with the Network Quality and Credentials Committee (NQCC) will be made available. This committee will make the decision to either uphold or overturn the original decision by the Medical Director.

Sanctioning possible

After the corrective action time period has expired, the provider will be re-evaluated by the Medical Director. If the Medical Director is satisfied that all stipulations are met, the corrective action will be lifted.

If the stipulations are not met, sanctioning of the provider could occur which may result in a provider's inability to participate in certain programs.

5.6 CLINICAL QUALITY

Preventive Guidelines

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

- Adults age 65 and over
- Adults ages 19-64
- Pediatric ages 0-18
- Prenatal/Perinatal

The Outcomes and Guidelines Quality team, in conjunction with participating network providers, review and update the Preventive Health Guidelines on an annual basis. The Guidelines are placed on the applicable websites via the Provider Resource Center. A notice regarding the Preventive Health Schedule is also published in the member newsletter and made available via a microsite.

These guidelines are available to the provider community as a reference tool to encourage and assist providers in planning their patients' care.

The **Preventative Health Guidelines**, and many other valuable clinical resources are available online via the Resource Center. To access these materials, go to the Resource Center and select **EDUCATION/MANUALS**.

Condition Management Program

The Condition Management Program is designed to develop a collaborative working relationship between Highmark members, members' providers, and Highmark clinicians to support the provider's plan of care for members under their care. The purpose of the program is to identify members who are most at risk for significant care gaps and, therefore, a progression and/or worsening of their chronic condition. High-risk members are identified through a combination of inpatient and outpatient claims, pharmacy claims, and clinical risk scores that enable our clinicians to conduct outreach to those members by telephone.

Nurses providing condition management services by telephone are known as clinicians. Clinicians work collaboratively with the member and provider to establish realistic and attainable short and long-term goals and to encourage behavior and lifestyle changes that lead to better member self-management of their condition(s).

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5.6 CLINICAL QUALITY, Continued

Condition Management Program (continued)

Members are eligible to receive health coaching for these chronic conditions:

- Asthma
- COPD
- Depression
- Diabetes
- Heart disease
- Heart failure
- High-risk pregnancy
- Metabolic Syndrome
- Musculoskeletal pain
- Obesity (Pediatric)
- Tobacco use (CHIP)

Providers, members, and family members can learn about the program and refer to the program by calling the 24/7 health information line at **1-888-BLUE-428**.

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, training in self-care, and other measures to promote their health.

Clinical Services – Quality 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 behavioral health specialists is regularly monitored as part of the Highmark Quality Program, specifically through an annual provider satisfaction survey.

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.

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5.6 CLINICAL QUALITY, Continued

Patient Safety Program activities

Highmark recognizes the importance of patient safety programs; therefore, the Highmark 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.
- Development of patient safety-focused written educational offerings for member and provider communications.

Quality of care case reviews

Clinical Services – Quality is responsible for evaluating member dissatisfactions, concerns, and issues related to clinical quality of care and for initiating appropriate action in response to them.

Clinical Services – Quality 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 Clinical Services – Quality to monitor the information received over time and identify improvement opportunities.

STEP	WHO DOES IT?	WHAT IS DONE?
1	Registered Nurse from Clinical Services – Quality	Performs a preliminary review to determine whether there is potential for a quality issue. Decision made to either track the accepted case in a database of similar issues involving the provider; or requests and reviews medical records according to Clinical Services – Quality 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.
2	A Highmark Medical Director	Reviews the case. • IF this review indicates there is no quality issue, the case is closed and tracked by provider for similar issues. • IF this review indicates that a quality issue resulting in some level of harm has been identified, a written request is sent to the involved provider/practitioner for a response or further information helpful to the review.

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5.6 CLINICAL QUALITY, Continued

Quality of care case reviews (continued)

STEP	WHO DOES IT?	WHAT IS DONE?
3	A Highmark Medical Director	Reviews the case with any additional information provided by the involved provider. • IF this information satisfies the concern, the case is closed 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 by the Medical Director, depending on the severity of the issue/level of harm sustained by the member. • The involved provider is notified in writing of the decision, corrective action required, and their appeal rights.
4	Provider/ Practitioner	May choose to appeal these actions before a subcommittee of the Highmark Network Quality and Credentials Committee.
5	Clinical Services – Quality 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 Clinical Services – Quality Medical Director to take further action if needed.

HEDIS®

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of standardized performance measures designed to ensure purchasers and consumers have the information they need to reliably compare the performance of all managed health care plans. Each participating plan reports data for the same measures, so you know you are making comparisons based on similar information.

To ensure these measures encompass data from the entire calendar year, health plans are asked to evaluate and report their results from the prior year. The Plan may be required to report on members from distinct product lines as required to meet and/or maintain National Committee for Quality Assurance (NCQA) accreditation, Centers for Medicare & Medicaid Services (CMS) and/or Office of Personnel Management (OPM) requirements, and/or the Pennsylvania and/or Delaware Department of Health (PA DOH, DE DOH) requirements.

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5.6 CLINICAL QUALITY, Continued

HEDIS® (continued)

Understanding the categories in which plans are rated can help you make a choice based on what is important to you. HEDIS® determines quality and value by measuring success in the following areas:

- **Effectiveness of Care:** Assesses all types of care (preventive, early detection and screening, maternity, acute, chronic, and behavioral health) and populations (children, adolescents, adults, and seniors).
- **Access/Availability of Care:** Assesses our network providers' accessibility and timeliness of care.
- **Experience of Care:** Assesses current members' levels of satisfaction with the health plan.
- **Utilization and Risk Adjustment Utilization:** Assesses resource use, how efficiently care is provided, and whether needed services are being delivered.
- **Health Plan Descriptive Information:** Presents an overview of provider-related information and member demographics.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS

Highmark's Office/Facility Site Review Process

Highmark continually strives to enhance the quality of care and services provided to our members. Practitioner Office/Facility Site Quality and Medical/Treatment Record Evaluations are required to meet Highmark standards as well as those established by regulatory and accrediting organizations. Clinical Quality Management Analysts schedule and conduct Practitioner Office/Facility Site Quality and Medical/Treatment Record Evaluations **for any practitioner within the network** based on the following:

1. **Member Dissatisfactions**: When a member dissatisfaction is received about the quality of any practitioner (PCP, specialist, allied health practitioner, or facility) office where care is delivered that is related to any of the following categories:
   a. Physical accessibility
   b. Physical appearance
   c. Adequacy of waiting room and examining/treatment room space
   d. Provider accessibility
2. **Annual Random Samples:** Annually, using a statistically valid sampling methodology, practice sites will be selected for the Practice Office/Facility Site Quality and Medical/Treatment Record Evaluations.
3. **Annual Less Than 20 Hours Per Week Sites:** In accordance with the Pennsylvania Department of Health Managed Care Organization regulations, primary care practitioners must provide office hours at each practice location accessible to members a minimum of twenty (20) hours a week at each practice site in Pennsylvania. In addition, any Delaware or West Virginia primary site providing less than twenty (20) primary care hours to members will also have Practice Office/Facility Site Quality and Medical/Treatment Record Evaluations performed.
   On an annual basis, sites identified as providing less than twenty (20) primary care hours to members will have Practice Office/Facility Site Quality and Medical/Treatment Record Evaluations performed at that site.
4. **Facility Site Quality and Medical/Treatment Record Evaluations:** Any organizational provider not accredited by a recognized accreditation agency or has not undergone a review by the Centers for Medicare & Medicaid Services (CMS) or the applicable state will have site or medical/treatment evaluations completed.
5. **Medical Director Request**:
   Provider/facility sites may have office/facility and medical record evaluations completed as requested by a Highmark Medical Director.

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5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS, Continued

Facility quality review process

Quality Management will coordinate the oversight and documentation of an onsite quality assessment visit based upon the type, size, and complexity of the health delivery organization for any facility provider not accredited by a recognized accreditation agency such as CMS or the applicable state agency. A Clinical Quality Management Analyst will schedule and complete both the Facility Medical/Treatment Record and the Facility Site Quality evaluations.

Follow-up reviews will be conducted within six (6) months of the previous evaluations for all facility sites that score below Highmark's threshold of eighty (80) percent on both the Facility Medical/Treatment Record and the Facility Site Quality Evaluations. To view these forms, please click on the links below:

- **Facility Medical/Treatment Record Evaluation**
- **Facility Site Quality Evaluation**

Note: Facilities identified with continuous opportunities for improvement for three (3) consecutive visits within a six (6) month interval will be presented to the Credentials Committee as an exception for further recommendations. Providers with deficiencies on repeated re-evaluations may be terminated from the network.

Scoring requirements

Follow-up reviews will be conducted within six months of the previous evaluations for all sites that score below Highmark's threshold of eighty (80) percent for the practitioner's office/facility site quality and medical/treatment record evaluations.

Provider office sites and facilities with continuous opportunities for improvement after three consecutive visits at six-month intervals will be presented to the Credentials Committee as exception practitioners for further recommendation. Sites with office deficiencies on repeated re-evaluations may be terminated from network participation.

Continued on next page

5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS, Continued

Review measures The following tables include the measures assessed in each component of the evaluation.

PROFESSIONAL OFFICE/FACILITY SITE QUALITY EVALUATION					
	PCP	Specialists	OB/GYN	Behavioral Health	Applies to Facility Site
The office/facility is reasonably accessible (noting the ease of entry into and the accessibility of space within the building) for patients with physical and/or sensory disabilities.	×	×	×	×	×
The physical appearance of the office/facility is clean, organized, and well maintained for the safety of patients, staff, and visitors.	×	×	×	×	×
The waiting area is well lit, has adequate space and seating, and has posted office hours.	×	×	×	×	×
There is adequacy of examining/treatment room space as well as patient interview areas and each is designed to respect patients' dignity and privacy.	×	×	×	×	×
Clinical records are filed in an organized, systematic manner, easily located, and kept in a secure, confidential location and away from patient access. Only authorized persons have access to clinical records.	×	×	×	×	×
The office/facility has a written confidentiality policy to avoid the unauthorized release or disclosure of confidential personal health information including but not limited to computer screens, data disks, emails, telephone messages/calls, fax machines.	×	×	×	×	×
The medical equipment utilized in the office/facility appears to be adequate, well maintained, up-to-date, appropriate for the patients' age, and appropriate for the specialty of the practice.	×	×	×	×	×
The office has 24-hour medical coverage that is available 7 days a week.	×	×	×	×	×
The office has a process to ensure after-hours calls are returned within 30 minutes.	×	×	×	×	×
The office has a process to ensure after-hours calls are communicated to the office by the morning of the following business day.	×	×	×	×	×
The office has mechanisms to assess behavioral health disorders, alcohol and other drug dependence (i.e., screening tool or questionnaire). (Not applicable to Retail Clinic sites.)	×		×		×

Continued on next page

5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS, Continued

PROFESSIONAL OFFICE/FACILITY SITE QUALITY EVALUATION (continued)					
MEASURE	Applies to professional office sites:				Applies to Facility Site
	PCP	Specialists	OB/GYN	Behavioral Health	
No more than 6 office visits are scheduled per hour per practitioner.	×	×	×	×	
Emergency, life-threatening medical situations are handled immediately.	×	×	×		
Urgent medical care appointments that require rapid clinical intervention as a result of an unforeseen illness, injury, or condition are available within 1 day (e.g., high fever, persistent vomiting/diarrhea).	×	×			
Regular and routine care appointments that are non-urgent but in need of attention are available within 2-7 days (e.g., headache, cold, cough, rash, joint/muscle pain, etc.).	×	×			
Regular and routine care appointments for routine wellness appointments are available within 30 days (e.g., symptomatic preventive care, well child/patient exams, physical exams, etc.).	×	×			
Patients with chronic conditions (e.g., diabetes, hypertension, CHF, depression, etc.) are proactively notified by the office and encouraged to schedule an appointment.	×				
There is a process to assure that patients who either no show or cancel their appointments are contacted and encouraged to reschedule the appointments as evidenced by documentation of such in the medical record (e.g., appointment scheduled, reminder card, etc.).	×				
A reminder call is made by the practice prior to scheduled appointments to encourage attendance with the scheduled visit.	×				
There is a process confirming that laboratory, diagnostic procedures, and/or consultation appointments were performed and results were received, reviewed, and filed in the patient's medical record. The process: a) identifies how the laboratory, diagnostic procedures, and/or consultation appointments are tracked; b) identifies staff responsible to ensure results are returned to the office; c) identifies when and how staff match test results with patient's chart; d) identifies how the reviewer (practitioner) notifies how the results should be handled.	×				

Continued on next page

5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS, Continued

PROFESSIONAL OFFICE/FACILITY SITE QUALITY EVALUATION (continued)					
MEASURE	Applies to professional office sites:				Applies to Facility Site
	PCP	Specialists	OB/GYN	Behavioral Health	
There is a process in place to ensure patients are notified of abnormal results.	×	×	×	×	×
Urgent medical care appointments which require rapid clinical intervention as a result of an unforeseen illness, injury, or condition are available within 1 day such as: a) OB - high fever, persistent vomiting/diarrhea, bladder infection, increased swelling; b) GYN – unusual vaginal discharge or vaginal bleeding post-menopause/hysterectomy, or detection of breast mass/breast lump.			×		
Regular and routine care appointments that are non-urgent but in need of attention are available within 2-7 days: a) OB – small amount of swelling in ankles or hands, sciatica pain (including hip/leg pain), respiratory infection, UTI symptoms; b) GYN – increased menstrual cramps.			×		
Regular and routine care appointments for routine wellness appointments are available within 30 days (e.g., regular routine obstetrical and gynecological appointments).			×		
Immediate intervention for a life-threatening emergency is required to prevent death or serious harm to patient or others.				×	
Intervention within 6 hours is required for a non-life-threatening emergency to prevent acute deterioration of the patient's clinical state that compromises patient safety.				×	
Timely evaluation (within 48 hours) is needed for urgent care to prevent deterioration of the patient's condition.				×	
Routine office visits are available (within 10 business days) when the patient's condition is considered to be stable.				×	
There is a fire extinguisher that is visible, easily accessible, and the expiration date is current.					×
The exits are clearly marked.					×
A written emergency disaster and evacuation plan is posted in patient areas.					×
Used syringes, scalpels, etc. are disposed of in rigid, unpierceable, leak proof containers and the containers are accessible in the area of use.					×

Continued on next page

5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS, Continued

PROFESSIONAL OFFICE/FACILITY SITE QUALITY EVALUATION (continued)					
MEASURE	Applies to professional office sites:				Applies to Facility Site
	PCP	Specialists	OB/GYN	Behavioral Health	
Biohazard wastes are disposed in red, labeled biohazardous waste bags and contained within a labeled, rigid closeable container.					×
The facility has a contract with a licensed company to dispose of biohazard waste and/or has other adequate provisions for disposal in place. The facility files manifests from the licensed biohazard waste company indicating proper disposal.					×
Separate refrigerators are maintained and properly identified for each of the following: medications, food, lab specimens.					×
A thermometer is present in the medication refrigerator/freezer and the temperature is recorded daily. Refrigerator: 35-46 degrees F (2-8 C). Freezer: 5 degrees F (-5C).					×
Medical equipment and instruments are properly disinfected or sterilized. a) Heat temperature strips and spore testing; b) Cold disinfection (20-45 minutes); c) Cold sterilization (10 hours).					×
All medications and prescription pads are adequately protected from patient access.					×
All medications, including samples, are checked for expiration dates on a regular basis.					×
A CPR-certified staff member is present during all hours of operation. (Current CPR cards should be on file and available for review.)					×
A system for the supply of oxygen is available in the event of a medical emergency. (Not applicable for Retail Clinic sites.)					×
Emergency equipment (airway/ambu bags) and medications (i.e., epinephrine, Benadryl, NTG tablets) are available as appropriate for the type of facility. The supplies are checked on a regular basis for expiration dates. (Not applicable for Retail Clinic sites.)					×
There is a reliable emergency electrical power source available.					×
Consent forms are utilized for invasive procedures performed in the facility.					×
There is an infection control plan in place.					×

Continued on next page

5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS, Continued

PROFESSIONAL OFFICE/FACILITY SITE QUALITY EVALUATION (continued)					
MEASURE	Applies to professional office sites:				Applies to Facility Site
	PCP	Specialists	OB/GYN	Behavioral Health	
There is a process in place to ensure patients are notified of abnormal test results.					×
The facility has a written policy in effect specifying how communication to the PCP or referring provider is handled in the facility.					×
There is evidence of formal job descriptions which include education/certification requirements for each specified position.					×
There is documentation of current professional licenses/certificates on file.					×
There is evidence of outcome measurements for quality improvement which targets high volume services, consumer services, billing practices, or adverse events.					×
Patient satisfaction surveys are completed and reviewed.					×

PROFESSIONAL/FACILITY MEDICAL RECORD EVALUATION					
MEASURE	Applies to professional:				Applies to Facility
	PCP	Specialists	OB/GYN	Behavioral Health	
An individual clinical record is established, organized, easily located and data is easily retrievable for each patient.	×	×	×	×	×
Each page in the medical record contains the patient's name. Another form of patient identification (e.g., birth date, social security number, identification number, etc.) is documented on the medical record.	×	×	×	×	×
Significant illnesses and medical and behavioral health conditions are indicated on the current problem list and are updated after each office visit and hospitalization.	×	×	×	×	
Each record indicates which medications have been prescribed, the dosages of each, the date of the initial prescription and/or refill, and the date the medication was discontinued, as applicable.	×	×	×	×	×
The medical record includes notes from each visit.					×
Vital signs for each visit are documented.					×

Continued on next page

5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS, Continued

PROFESSIONAL/FACILITY MEDICAL RECORD EVALUATION					
MEASURE	Applies to professional:				Applies to Facility
Medication and other allergies, adverse reactions, and relevant medical conditions are clearly documented and dated prominently in the record. It is noted if the patient has no known allergies, no history of adverse reactions, or relevant medical conditions.	×	×	×	×	×
All entries in the record contain a valid, legible author's signature which may be a: handwritten signature with credentials; printed name and credentials accompanied by handwritten provider initials; or unique electronic identifier with credentials.	×	×	×	×	×
All entries in the record are dated and are legible to someone other than the writer.	×	×	×	×	×
The medical/treatment records have a notation regarding follow-up care, calls, or visits when indicated. The specific time of return is noted in weeks, months, or as needed.	×	×	×	×	×
For patients 12 years and older, documentation includes past and present use of cigarettes (or other tobacco), alcohol, as well as illicit, prescribed, and over-the-counter drugs or other substance abuse. (Assessed at least annually.)	×	×	×	×	×
If a consultation is requested from a medical specialist, behavioral health practitioner, and/or organizational provider, the medical record contains documentation of follow-up correspondence from the consultant. The consultant reports are filed in the chart and are signed/initialed by the ordering practitioner to signify review, with explicit notation of follow-up plans relating to abnormal results.	×	×	×	×	
Consultations, laboratory, imaging, and other studies (including mammograms and Pap smears) are ordered, as appropriate. The reports are filed in the chart and are initialed by the ordering practitioner to signify review, with explicit notation of follow-up plans relating to abnormal laboratory and imaging results.	×	×	×	×	×
There is documentation in the medical record that patients are notified of abnormal test results.	×	×	×	×	×

Continued on next page

5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS, Continued

PROFESSIONAL/FACILITY MEDICAL RECORD EVALUATION (continued)					
MEASURE	Applies to professional:				Applies to Facility
	PCP	Specialists	OB/GYN	Behavioral Health	
There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure. Possible risk factors for the member, relevant to the particular treatment, were documented, as applicable.	×	×	×	×	×
There is a current flow sheet for preventive services, in accordance with the health plan's guidelines, as applicable to practice specialty.	×	×	×	×	
Past medical history (patients seen 3 or more times) is updated every 3 years and includes serious accidents, surgeries, and illnesses. For patients 18 years and younger, past medical history relates to prenatal care, birth history, surgeries, and childhood illnesses.	×	×	×		×
The history and physical exam identifies appropriate subjective and objective data for each visit relevant to the patient's presenting complaints.	×	×	×		×
The assessments or diagnostic impressions (working diagnoses) are consistent with the findings.	×	×	×		×
The treatment or therapy plans are consistent with the diagnoses.	×	×	×		×
The records contain documentation that the patient/caregiver received and understood instructions regarding the plan of care.					×
There is evidence of 6 well care visits in the first 15 months of life to include the following: a) a health and developmental history (physical and mental); b) a physical exam; c) health education/anticipatory guidance.	×				
A lead screening test is performed prior to the child's second birthday.	×				
Children ages 3-17 have a yearly well exam which includes documentation of: a) developmental assessment; b) anticipatory guidance; c) BMI and BMI percentile; d) counseling for diet/nutrition; e) counseling for physical activity.	×				
Infants (starting at birth) and children up to 17 years of age should have a complete childhood immunization record with dates of service. Parental refusal of immunization is documented, if applicable.	×				

Continued on next page

5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS, Continued

PROFESSIONAL/FACILITY MEDICAL RECORD EVALUATION (continued)					
MEASURE	Applies to professional:				Applies to Facility
	PCP	Specialists	OB/GYN	Behavioral Health	
A complete adolescent immunization record with dates of service include: a) meningococcal vaccine (prior to age 13); b) Tdap/Td (between 10-13 years of age). Parental refusal of immunization is documented, if applicable.	×				
Adults have routine health screenings that include: a) up-to-date recommended immunizations/vaccinations; b) BMI documented at least every 2 years; c) a physical exam every 1-2 years for patients 19-49 years; d) a yearly physical exam for patients 50 years and older.	×				
Patients with chronic conditions (e.g., diabetes, hypertension, CHF, depression, etc.) were seen and the chronic illness is evaluated at least annually.	×				
Adults 65 years of age and older are assessed annually for comprehensive pain screening (i.e., Multidimensional Pain Inventory, Faces Pain Scale, etc.)	×				
Adults 65 years of age and older are assessed annually for a functional status assessment including ADL's, fall risk, and level of physical activity.	×				
Adults 65 years of age and older are assessed for medication reconciliation – medications should be reviewed at least annually and within 30 days after each hospital discharge.	×				
Adults 65 years of age and older are assessed annually for discussion of bladder control issues.	×				
The medical record notes colorectal cancer screening for patients 50-75 years of age by any of the following: a) fecal occult blood test – yearly; b) flexible sigmoidoscopy every 5 years; c) double contrast barium enema every 5 years; d) colonoscopy every 10 years.	×	×			
Adults with diagnosis of hypertension have their blood pressure measured at each office visit. Any blood pressure 140/90 or higher is addressed by the provider as evidenced by documentation on the medical record.	×	×			
Adults diagnosed with a cardiovascular condition receive an LDL-C screening annually. (Target LDL-C is less than 100.)	×	×			

Continued on next page

5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS, Continued

PROFESSIONAL/FACILITY MEDICAL RECORD EVALUATION (continued)					
MEASURE	Applies to professional:				Applies to Facility
	PCP	Specialists	OB/GYN	Behavioral Health	
Patients diagnosed with diabetes mellitus have yearly: a) BP monitoring (<140/90); b) HBA1C and lipid profile; c) nephropathy screening or ACE/ARB prescription; d) dilated retinal eye exam; e) if also diagnosed with hypertension, treated with ACE/ARB.	×	×			
Any adult 40 years of age or older that has a new diagnosis or newly active COPD had appropriate spirometry testing to confirm the diagnosis.	×	×			
Patients diagnosed with rheumatoid arthritis were prescribed a disease modifying anti-rheumatic drug.	×	×			
Female patients 65 years of age and older who suffered a fracture received either a bone mineral density test or a prescription to treat or prevent osteoporosis within 6 months of the fracture, if testing had not been done within the previous 2 years.	×	×			
The medical record has evidence of a Chlamydia screening for sexually active women ages 16-24 years of age.	×		×		
The medical record has evidence of a Pap test every 3 years for women 21-64 years of age.	×		×		
The medical record has evidence of mammogram screening every 2 years for women 40-69 years of age.	×		×		
There is documentation in the medical record that the patient 65 years of age and older was counseled regarding an Advance Directive. (Assess annually.)	×				
There is documentation in the medical record as to whether or not the patient has executed an Advance Directive and, if so, the Advance Directive or documentation is placed in a prominent part of the patient's record. (Assess annually.)	×				
If an Advance Directive is filed or documented in the medical record, a surrogate has been identified. (This question will be answered N/A in the event there is no Advance Directive in the medical record and if there is no surrogate identified.)	×				
There is evidence of communication and collaboration (letters, reports, etc.) from the OB/GYN or Facility site to the primary care physician, including documentation that a copy of the patient's exam with pertinent information has been sent to the primary care physician.			×		×

Continued on next page

5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS, Continued

PROFESSIONAL/FACILITY MEDICAL RECORD EVALUATION (continued)					
MEASURE	Applies to professional:				Applies to Facility
	PCP	Specialists	OB/GYN	Behavioral Health	
A medical and psychiatric history is documented including: previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data, and relevant family information. For children and adolescents, past medical and psychiatric history includes prenatal and peri-natal events along with a complete developmental history (physical, psychological, social, intellectual, and academic).				×	
Presenting problems, along with relevant psychological and social conditions affecting the patient's medical and psychiatric status, and the results of a mental status exam are documented in the clinical record.				×	
The mental status exam documents: a) affect/mood; b) speech; c) appearance; d) thought content; e) judgment; f) insight; g) attention; h) memory; i) impulse control.				×	
Special status situations, when present, such as imminent risk of harm, suicidal ideation or elopement potential, are prominently noted, documented, and revised in compliance with written protocols.				×	
The DSM-IV diagnoses are identified and are consistent with the presenting problems, history, mental status examination, and/or other assessment data.				×	
Treatment plans are consistent with diagnoses, have both objective and measurable goals, have an estimated time frame for goal attainment or problem resolution, and include a preliminary discharge plan, if applicable.				×	
It is noted that the office receives communication from the specialist/organizational provider which assures continuity and coordination of care activities between the primary clinician, consultants, ancillary providers, and health care institutions.				×	

Continued on next page

5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS, Continued

Practice Site Resources

Highmark is committed to promoting quality education and care to members and practitioners. Practice Site Resources is a resource for network participating office sites to assist in promoting quality health care to their patients and members.

The resources include a variety of educational resource materials, such as age-specific progress records, preventive health records, and sample office policies to assist the practitioner in meeting Highmark standards, including medical record documentation. Member-specific educational materials are also available for physicians to assist their patients with preventive health care.

The Practice Site Resources materials are used by Highmark Clinical Quality Management Analysts to educate the practitioner office designees when performing office site and medical record documentation reviews.

*The Practice Site Resources section is available on Highmark's online Provider Resource Centers via the Highmark website and NaviNet®. From the main menu, select **EDUCATION/MANUALS**, and then **Practice Site Resources**.*

Why blue italics?

5.6 SERVICE QUALITY

Member satisfaction monitoring

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 Clinical Services - Quality and internal ad-hoc workgroups. The findings are then reported to the Care Management and Quality Management Council. Member satisfaction is also monitored through review of member dissatisfactions, complaints, and appeals.

CAHPS® & QHP EES survey results

Highmark contracts with SPH Analytics, an independent research firm certified by the National Committee for Quality Assurance (NCQA) and the Centers for Medicare & Medicaid Services (CMS), to conduct the annual Commercial and Medicare Advantage Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey and the Qualified Health Plan Enrollee Experience Survey (EES).

The surveys are used to find out about the overall experiences of our members and to identify areas of improvement. The results of the 2018 surveys revealed that members continue to rate the health plan highly when compared to other commercial health plans nationally.

The 2018 CAHPS® and QHP EES survey results are available on the Provider Resource Center. Select **EDUCATION/MANUALS** from the main menu on the left, and then **CAHPS®/QHP EES Survey Results**.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

5.6 HIGHMARK QUALITY INITIATIVES

Shared effort

Highmark considers the pursuit of quality improvement in health care to be a shared effort. While each facility must assess its own needs, establish meaningful goals, and monitor its own progress, Highmark can assist by providing data and opportunities for analysis. Highmark appreciates the cooperation of facilities in collecting data and making good use of it toward improvement of quality in health care services.

The initiatives described here represent just some of the efforts Highmark has made to be a partner with facilities and providers in improving quality in health care.

What Is My Service Area?

Medicare Advantage Quality Improvement Project

Medicare Advantage Organizations (MAOs) are required to initiate one self-selected Quality Improvement Project per year; this Centers for Medicare & Medicaid Services (CMS) project is called the Chronic Care Improvement Project (CCIP). A report on this project is to be submitted in advance of the MAO's routine audit by CMS.

Quality Management selects and implements an annual Quality Improvement Project as determined by CMS. An example of such a project is: "Improving the percentage of diabetic members who are receiving an annual diabetic retinal eye exam." Representatives from key areas of the Plan meet throughout the year to conduct a quantitative and qualitative analysis on the selected measure. Interventions are then implemented to improve results.

Safety initiatives

Highmark continuously works to improve the safety of clinical care and services provided to its members. A variety of safety initiatives are conducted at Highmark that focus on both members and providers. One of those initiatives is ensuring that hospitals with over fifty (50) beds implement an evidence-based initiative that improves healthcare quality through the collection, management and analysis of patient safety events that reduces all cause preventable harm, prevents hospital readmissions, and/or improves care coordination.

Hospitals with over fifty (50) beds can comply with this initiative by meeting at least one of the following criteria:

- Hospitals in the Commonwealth of Pennsylvania must already comply with the Patient Safety Requirements of Act 13, which includes Department Of Health review and approval of Patient Safety Plans to ensure compliance with State-required elements, as well as oversight on an ongoing basis. A hospital in Pennsylvania may submit verification of meeting this state requirement to Highmark in order to show compliance.

Continued on next page

5.6 HIGHMARK QUALITY INITIATIVES, Continued

Safety initiatives (continued)

- Obtaining/maintaining accreditation by JCAHO or another accrediting agency acceptable to Highmark that includes compliance with a Patient Safety Standard as a required component for obtaining accreditation. Highmark will verify this information at the time of a hospital's initial assessment (prior to contracting) and at least every three (3) years thereafter.
- Producing evidence of participation with a Patient Safety Organization (PSO) and/or a Patient Safety Plan to Highmark as part of the assessment site visit that is conducted for hospitals that are not accredited. Providing evidence of a CMS Certification Number (CCN) at the time of the assessment and renewal is also required.

Member outreach initiatives

The Clinical Outcomes and Guidelines team coordinates the development of member communication activities such as mailings, articles, and outreach to share health information and reminders for clinical services. Monthly mailings are sent to identified members to encourage them to schedule important preventive health screenings, such as for breast, cervical, and colon cancer.

Health care disparities activities

Highmark has made reducing health care disparities a priority.

Training to Meet the Needs of Diverse Patients
Highmark offers cultural competency training to network physicians, nurses and office staff through partnerships with medical societies, network hospitals and our provider website. These training opportunities are meant to increase cultural awareness through computer-based, self-learning courses, and "live" presentations to clinicians.

Member Outreach
Highmark continuously seeks information about our members, even after they enroll. We collect voluntary, self-identified information on race, ethnicity, language preference, and education level. These outreach efforts have led to the development of focused initiatives and interventions, which help to close the health care gap for our diverse members.

5.6 PEER REVIEW PROTECTIONS

Protected activities

Activities of the Highmark Quality Program, including activities of the staff, medical directors, and the Network Quality and Credentials Committee, are afforded protections as peer review activities under state and federal law. Such protected activities include:

- Evaluating and improving the quality of health care rendered;
- Reducing morbidity and mortality;
- Evaluation by health care professionals of the quality and efficiency of services ordered or performed by other health care professionals (including inpatient hospital and extended care facility utilization review and ambulatory care review); and
- Actions or recommendations of a professional review body, based on the competence or professional conduct of a physician, which could adversely affect the health or welfare of a patient, and which could affect the clinical privileges or plan membership of the physician.

Accordingly, network providers and other peer review bodies (such as hospital quality review committees) may furnish information requested by the Highmark Quality Program and know that the confidentiality of such information will be maintained and protected.

What Is My Service Area?

West Virginia Code

Generally, the proceedings and records of a peer review organization are confidential, privileged, are not subject to subpoena or discovery proceedings, and are not to be admitted as evidence in any civil action arising out of the matters that are subject to evaluation and review.

However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any civil action merely because they were presented during proceedings of such organization. Please see W.Va. Code §30-3C-1 et seq. for additional information.