

# Quality Management (QM) Program — Independence Blue Cross

## Goals and Objectives

The goals and objectives of the Quality Management (QM) Program are to promote the quality and safety of medical and behavioral health care and services provided to members. This is achieved by:

- Simplifying administrative processes and ongoing monitoring of measurable performance indicators. Performance indicators are based on high-volume, high-risk, and problem-prone-services data from customer-satisfaction and member-experience surveys, complaints/occurrences, and appeals. Other relevant sources are also evaluated to promote quality improvement. The results of monitoring activities, QM programs, barrier analyses, identified opportunities for improvement activities, and other program activities are documented and reported to the appropriate committees, operational areas, and providers.
- Distributing information about practitioner and provider performance to customers, members, and employers/purchasers to promote transparency, empowerment, and informed decision making.
- Ongoing oversight activities and regular performance assessments to ensure that (1) the quality of care and services delivered by delegates meet standards established by the Plan and relevant regulatory and accrediting agencies and (2) delegates maintain continuous, appropriate, and effective quality-improvement programs.
- Adopting, adapting, and updating practice guidelines for medical and behavioral health-related conditions, perinatal care, and member wellness — these guidelines are evidence-based and are distributed to Plan practitioners and members to facilitate decision making regarding appropriate health care.
- Identifying, developing, and improving the safety of medical and behavioral health care and services provided to members. The Plan's Member Safety Program promotes:
  - Reducing medical and medication errors through a comprehensive program of educational initiatives
  - Monitoring member-safety data over time including tracking, trending, and analyzing adverse-events data to identify system issues that contribute to reductions in member safety
  - Tracking, trending, and analyzing member complaint and satisfaction data in order to promote a safe and hazard-free clinical environment
  - Establishing the Plan as a resource for member-safety issues for members, practitioners, providers, and various departments and external organizations
- Ensuring a network of qualified practitioners and providers by:
  - Complying with all applicable accrediting bodies and regulatory credentialing/recredentialing requirements
  - Including language in the organization's contract with practitioners and providers specifically requiring participation with the Plan's QM Program and allowing the Plan to use their performance data for quality-improvement initiatives, access to medical records, and maintain the confidentiality of member information and records

- Promoting partnerships with practitioners and providers by communicating quality activities via various forms of media, providing feedback on results of Plan-wide and practice-specific performance assessments, and collaboratively developing improvement plans
- Using site-visit results from practitioner and provider credentialing to improve safe practices
- Monitoring, evaluating, and improving access and availability of primary- and specialty-care standards of service to ensure that members receive services that are appropriate and timely
- Monitoring contracted hospitals to ensure they utilize a patient-evaluation system that includes:
  - A comprehensive patient-centered hospital discharge process to improve care coordination and health care quality for each patient
  - An evidence-based initiative to improve the quality of health care, reduce preventable harm, prevent hospital readmission, and/or improve care coordination
- Promoting continuity and coordination of care:
  - Between members’ practitioners (primary care physicians and specialists) that will lead to increased patient safety, more favorable outcomes, and fewer miscommunications that cause poor outcomes and safety issues
  - Between sites of care, such as hospitals, nursing homes, and practitioners’ offices to insure timely and accurate communications that will lead to more favorable outcomes, fewer miscommunications, and inappropriate readmissions
  - Between medical and behavioral health providers
- Serving our members’ cultural and linguistic needs and preferences, including:
  - Monitoring, assessing, and adjusting, if necessary, the availability of network practitioners/providers
  - Analyzing and reducing the existence of significant health care disparities in both clinical and service areas
  - Developing and enhancing activities to meet the diverse cultural and linguistic needs of our members
  - Ensuring that all members who enter the health care system receive equitable and effective treatment that is ethical, as well as culturally-, ethnically-, and linguistically-appropriate
  - Improve network adequacy to meet the needs of underserved groups
- Providing information, training, and materials to practitioners, providers, and staff to support culturally-competent communications
- Helping members with multiple or complex conditions access care and services as well as assisting them with the coordination of their care through the Care Management Programs: Complex Case Management, Condition Management, and Perinatal Condition Management
- Complying with all regulatory requirements and maintaining accreditation and necessary certifications
- Ensuring that the appropriate resources are available to support the QM Program

### **QM Program activities**

Independence Blue Cross’s (Independence) QM Program activities include but are not limited to the following:

## **Clinical Quality Activities**

- **Preventive Health Program**

The Preventive Health Program provides education to members and providers through a variety of outreach tools, which may include direct member mailings, automated telephonic outreach, text-message reminders, Member Wellness Guidelines, website campaigns, newsletter articles, and social media. Member outreach includes, but is not limited to, efforts to increase compliance with preventive screening guidelines for influenza/pneumococcal immunization as well as, cervical cancer screening, breast cancer screening, and colorectal cancer screening.

- **Complex Case Management Program**

The Complex Case Management Program provides telephonic intervention, education, and support to members that have experienced a critical event, received a diagnosis that requires the extensive use of resources, or requires help with care coordination. These programs are open to all members in the managed care health plans.

- **Condition Management Program**

Monitoring aspects of care for members with acute and chronic conditions including, but not limited to: asthma, heart disease, chronic kidney disease, chronic obstructive pulmonary disease (COPD), diabetes, heart failure, high-risk pregnancy, HIV/AIDS, hyperlipidemia, hypertension, inflammatory bowel disease, maternity management, metabolic syndrome, musculoskeletal pain, migraine, obesity, osteoporosis, and upper gastrointestinal disease.

- **Perinatal Condition Management**

Expectant mothers that are at high risk may be enrolled in our condition management program for high-risk pregnancy. This program is telephonic, with Health Coaches working with providers to cooperatively support and educate the members throughout the pregnancy continuum. All other pregnant members have access to our perinatal program, Baby BluePrints®. Members must call to self-enroll in the Baby BluePrints Program. Upon enrollment, members are assessed for risk and outreach is conducted accordingly.

- **Medicare Stars Ratings Overview**

The Centers for Medicare and Medicaid Services (CMS) rate Medicare Advantage plans on a one-to-five-star scale, with five stars representing the highest level of quality. The summary score provides an overall measure of a plan's quality and is a cumulative indicator of the quality of care, access to care, plan's responsiveness, and beneficiary satisfaction provided by the plan. The QM department collaborates with Government Markets in identifying opportunities for improvement.

- **Clinical Practice Guidelines**

Independence has developed a process for adopting, updating, and disseminating both member wellness guidelines and non-preventive (i.e., acute and chronic) Clinical Practice Guidelines for both medical and behavioral health related conditions. Clinical Practice Guidelines are divided into:

- **Clinical Practice Guidelines:**

Guidelines for clinical practice that are considered the accepted minimum standard of care in the medical profession. Guidelines are available for the following medical and behavioral health conditions: asthma, chronic obstructive pulmonary disease (COPD), coronary heart disease, diabetes, heart failure, obesity, renal disease, attention deficit hyperactivity disorder (ADHD), autism spectrum disorders, depression, and substance abuse disorders.

- **Member Wellness (Preventive Health) Guidelines:**

Guidelines that provide members with a user-friendly version of evidenced-based wellness recommendations for the average-risk person and are divided into pediatric (birth through age 17), adult (ages 18-64), and senior (ages 65 and older) recommendations.

– **Perinatal Guidelines:**

The Perinatal Guidelines are a comprehensive resource for our OB/GYN and primary care physicians. The guidelines outline perinatal care from preconception care through postpartum care with an emphasis on family planning, patient counseling, and laboratory work and testing.

• **Children’s Health Insurance Program (CHIP)**

The Plan works to with the Department of Insurance to promote quality and safety of medical care for members enrolled in the CHIP program. Current and recently completed projects have helped to reduce emergency room utilization for members with a diagnosis of otitis media, acute pharyngitis, and upper respiratory infection, as well as improve lead-screening rates.

**Network Quality Activities**

A number of activities are undertaken to foster improved communications between the Plan and the network of participating practitioners and providers and to promote improvements in the quality of services delivered by the network. These activities include, but are not limited to:

- Investigating and tracking potential quality-of-care concerns through complaint and occurrence reporting
- Maintaining medical record standards
- Monitoring access and availability
- Monitoring continuity and coordination of care
- Monitoring appropriate utilization of services
- Promoting cultural awareness
- Promoting member safety

**Service Quality Activities**

The Plan has established performance indicators and goals to monitor services provided to customers across key functional areas. When performance falls below goal, root causes are identified and initiatives implemented to improve performance. Ongoing monitoring allows management staff to assess the effectiveness of improvement activities and initiate needed follow up, as appropriate. Performance indicators include but are not limited to:

- **Claims processing** – percent processed in 30 calendar days and accuracy rates
- **Enrollment** – percent processed in eight calendar days and accuracy rates
- **Customer Services** – percent of calls answered/abandoned, average speed of answer, and average turnaround time for resolution of administrative complaints
- **Provider Services** – percent of calls answered and average speed of answer
- **Health Resource Center** – percent of calls answered, average speed of answer, complaints related to departmental staff, and results of inter-rater reliability audits
- **Member Appeals** – medical necessity and administrative appeal rates, average turnaround time, and overturn rates
- **Quality of Care & Services** – percent of member concerns resolved within 30 calendar days of receipt
- **Email Inquiries** – percent responded to within one business day of submission
- **Service Operations Escalation Dashboard** – includes executive inquiries, marketing escalations, member administrative complaints, CTMs, grievances, and corporate and service volumes

Member and provider satisfaction with the Plan, as well as, member satisfaction with primary care physicians (PCP) and specialists is assessed at least once a year.

## QM Program Outcomes

Each year, Independence evaluates the QM Program to assess its effectiveness, and the results of QM initiatives. Some of Independence's QM Program key outcomes in 2016 include:

- Reductions in overuse and inappropriate medical testing
- Increased participation and engagement in our mobile phone and email programs
- Continued high satisfaction with Case and Disease Management programs
- More engagement in critical prevention and screening measures related to weight assessments, immunizations, and cancer screenings

In addition, Independence annually seeks member input through the Consumer Assessment of Health Care Providers and Systems (CAHPS) survey. This direct mail/ phone survey asks members about their experience with their doctors and the service they receive from their health plan. Our most recent survey indicated positive changes from the prior year including:

- Members were more satisfied with how their doctors communicate:
  - Their doctor is spending enough time with them during their visit
  - Their doctor listened to them carefully and showed respect for what they had to say
- Members gave higher ratings for their personal doctor and with the coordination of medical care between the doctors and facilities they received services from.
- Members also indicated satisfaction in the ease of getting an appointment with specialists.

### For more information

For more information about our QM Program, including information about program goals and a report on our progress in meeting those goals visit our website at [Standards of Care | Providers | Independence Blue Cross](#) or call Customer Service at 1-800-ASK-BLUE (1-800-275-2583; TTY: 711).

