

7 Health Partners Provider Manual Quality Management



Purpose: This chapter provides a description of the Quality Management standards used at Health Partners.

- Topics:**
- Quality Management principles
 - Quality management initiatives

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Overview

The Health Partners Quality Management (QM) program supports the commitment of the organization to provide quality care and service in a cost-effective manner to its members. This is reflected in the National Committee for Quality Assurance (NCQA) awarding an accreditation status of Excellent to Health Partners' Medical Assistance plan in 2006 for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

The QM program is an organization-wide, dynamic, systematic program designed to monitor and oversee all aspects and components of care and service. Monitoring activities include credentialing, utilization management, appeals and grievances, complaints, access and availability of practitioners, assessment of member satisfaction, sentinel event monitoring, medical record reviews, pharmacy service drug utilization reviews, peer review and assessment of Health Partners service improvements. Health promotion initiatives include disease management programs, promotion of preventive health screenings, pre- and postnatal case management, EPSDT and special needs case management.

Quality Management Principles

The QM program is based on the principles and concepts of continuous quality improvement.

The QM program is reviewed and approved annually by Health Partners' Quality Management Committee, Medical Affairs Committee, and Board of Directors. Implementation of all QM activities is monitored by the Medical Director for Quality Management and Vice President of Quality Management. Updates may be made as necessary throughout the year. A summary of the QM program annual description and workplan is available on request by calling the Provider Services Helpline (see Table 1: Service Department Contact Information on page 1-13).

All Health Partners/KidzPartners participating providers are expected to support and participate in the QM program as identified in the provider contracts. Participation by the provider occurs by participation in various committees and task forces, review and recommendations for draft guidelines, provision of chart copies as requested, providing access to medical records for various chart review studies or investigation of member complaints and participation in the credentialing and recredentialing process.

Goals

The primary goals of the QM program are to develop and refine monitoring systems that allow Health Partners to identify opportunities for improvement in the quality of care being delivered and to craft interventions directed at these opportunities with the ultimate goal of improving the health outcomes of our members.

The specific steps in the process include: analyzing data collected by Health Partners for selected quality of care and service indicators to assess plan performance; comparing plan performance to established benchmarks and goals; identifying opportunities for improvement as well as root causes or barriers for areas below goals; designing and implementing interventions that will increase the quality of care and service delivered to members; and re-measuring plan performance to identify the effectiveness of the quality improvement interventions and initiatives.

Program Compliance with Regulatory and Accrediting Bodies

Health Partners' comprehensive Quality Management (QM) Program is developed and administered to be in compliance with the standards established by the National Committee for Quality Assurance (NCQA), the Pennsylvania Department of Public Welfare (DPW), the Pennsylvania Department of Health (DOH), the Pennsylvania Insurance Department (PID) and the Centers for Medicare and Medicaid Services (CMS).

Annually Health Partners completes Healthcare Effectiveness Data and Information Set (HEDIS) data collection and tabulation. HEDIS is administered by the National Committee for Quality Assurance (NCQA) and is a standardized and comprehensive set of measures and reports that show how managed care plans compare regarding the care provided to members. Approximately 70 measures are reported to evaluate the effectiveness of services offered, utilization of services and member satisfaction. Some examples of these measures include use of services, accessibility of services, availability of services and how the plan manages health problems such as heart disease, cancer, diabetes, asthma and smoking. The data are an important part of measuring the quality of care provided for our members. Additionally, HEDIS scores impact Health Partners' NCQA accreditation status.

Program Components

The QM program utilizes a variety of studies, quality indicators and routine performance monitors that provide an ongoing mechanism for quality improvement. Various performance measures are utilized to evaluate the QM program.

These performance measures include:

- Topic-specific focused reviews based on established standards, parameters, or guidelines
- Comprehensive medical record and office review of all PCP, OB/GYN and high-volume specialist sites at least every 24 months
- Preventive health/health status reviews (Immunization, Childhood, Adolescent, Adult, Well Elderly, Obstetric)
- Population-based studies
- HEDIS measures
- PA Performance measures
- Internal Quality of Care measures
- Disease Management Program studies
- Clinical and/or service audits as mandated by DPW and/or PID
- Member complaints and/or grievances
- Annual Member Satisfaction Survey (CAHPS)
- Access indicators
- Availability indicators
- Annual Provider Satisfaction Surveys
- Sentinel events monitoring
- Drug utilization review
- Inpatient Quality of Care referrals
- Over and under utilization reports
- Continuity and Coordination of Care monitoring
- Credentialing and recredentialing of providers
- Evaluation and oversight of all delegations and subcontractors' Quality Management programs, including dental and vision services
- Adverse events

A summary of Health Partners' Quality Management annual program description and work plan is available on request by calling the Provider Services Helpline (see Table 1: Service Department Contact Information on page 1-13).



Health Partners specialists choosing to leave the network or otherwise becoming unavailable to members (for example, by limiting their practice) must notify Health Partners so we can notify members under their ongoing care in advance of that change.

In keeping with NCQA quality standards, Health Partners requires that specialists provide 60 days advance notification to Health Partners when:

- The entire practice terminates its participation with Health Partners
- Any single specialist terminates participation under his/her Health Partners contract
- Any single practitioner within a group practice, or the entire specialty group, leaves or becomes unavailable to members.

Quality Initiatives

The Quality Management Committee and the Board of Directors have identified and prioritized activities on which to focus for the future. These initiatives reflect the goals and previous performance levels of Health Partners, as well as Department of Public Welfare (DPW) and/or Pennsylvania Insurance Department initiatives or requirements. The following sections describe the initiative, goals, interventions, and performance measures utilized to monitor Health Partners' success. Please feel free to contact Health Partners at the identified telephone number to ensure appropriate services are provided for members. By ensuring that the member obtains services, members will receive high quality care and Health Partners will move toward our mission of continually improving health outcomes for our members.

Baby Partners Perinatal Program

This section provides an overview of the specific goals, interventions and indicators of success used in the Baby Partners program.

Referrals related to the program can be called in to **215-991-4182** and any forms can be faxed to **215-967-4492**.

Goals

- Increase the% of women who initiate Prenatal Care in the 1st trimester or within 42 days of enrollment
- Increase frequency of prenatal care encounters
- Decrease incidence of LBW (<2500 grams) and premature infants (<36 weeks)
- Increase the% of women who receive a check-up after delivery (21-56 days)
- Create seamless transfer of mother and newborn into EPSDT task force/program or otherwise to ensure appropriate testing

Interventions

- Telephonic outreach to risk assess and facilitate prenatal care
- Member education
- Home visit after delivery
- Telephone counseling
- Targeted case management
- Referral to support services, where appropriate
- Distribution of Provider Practice Standards/Guidelines
- Smoking Cessation/Counseling

Indicators of Success

- Administrative data analysis
- Medical record review of PCP and OB/GYN
- Review of the Baby Partners Assessment form
- HEDIS measures
- PA Performance measures
- Population-based studies

EPSDT (Medicaid) & Preventive Health/Wellness Services (CHIP)

This section provides an overview of the specific goals, interventions and indicators of success used in the EPSDT and Preventive Health/Wellness Services programs.

Referrals related to the program can be called in to **215-967-4690** or **866-500-4571**.

Goals

- Increase the percentage of children who receive the recommended number of well-child visits (See indicators below)
 - Minimum of 6 well-child visits for 1-15 months old
 - One well-child visit per measurement year for 3-6 year olds
 - One well-child visit per measurement year for 12-21 year olds
- Increase percentage of children and adolescents fully immunized
- Increase percentage of children (<6 years of age) tested for lead
- Increase percentage of children (4-21 years of age) with an annual dental visit

Interventions

- Telephonic outreach
- Outreach through Case Management
- Member education

- Targeted member/provider mailings
- Reminder post-cards
- Distribution of Provider Practice Standards/Guidelines
- Distribution of Member Preventive Health Guidelines

Indicators of Success

- Administrative data analysis
- Site visit review for compliance with EPSDT site requirements
- HEDIS measures
- PA performance measures
- Population-based studies

Adult Preventive Care

This section provides an overview of the specific goals, interventions and indicators of success used in the Adult Preventive Care program.

Referrals related to the program can be called in to **215-991-4346**.

Goals

- Increase percentage of women screened for cervical cancer annually
- Increase percentage of women screened for breast cancer annually
- Increase percentage of members obtaining flu and pneumococcal vaccine annually

Interventions

- Reminder post-cards
- Member newsletter articles
- Targeted member/provider mailings
- Administrative data analysis
- Medical record review
- Distribution of Provider Practice Standards/Guidelines
- Distribution of Member Preventive Care Guidelines
- Telephone outreach
- Refer appropriate members to DM programs

Indicators of Success

- Administrative data analysis
- Medical record review
- HEDIS measures

- Population-based studies

Clinical Care Programs

This section provides an overview of the specific goals, interventions and indicators of success used in the Clinical Care program.

Referrals related to case management can be called in to **215-967-4690** or **866-500-4571**.

Goals

- Increase percentage of high risk members enrolled in the following disease management programs
 - Asthma (Adults & Children)
Increase the percentage of asthmatics with a filled prescription for an anti-inflammatory
 - CHF (Heart Failure)
Increase the percentage of members with CHF with a filled prescription for an ACE inhibitor
 - Diabetes (Adults & Children)
Increase the percentage of members with HgA1C <7.0
Increase percentage of members with dilated eye exam
Increase the percentage of members with lipid profile <100
Increase percentage of member with test for microalbuminuria

Intervention

- Early identification of appropriate members for enrollment
- Member education
- Referral to case management
- Targeted provider/member mailings
- Referral to support services, where appropriate
- Telephone counseling
- Distribution of Provider Practice Standards/Guidelines

Indicators of Success

- Administrative data analysis
- Utilization review including inpatient, emergency room and pharmacy utilization
- Medical record review
- Focused medical record audits
- Sentinel event monitoring
- HEDIS measures
- PA performance measures

- Population-based studies

High Medical Needs Members

This section provides an overview of the specific goals, interventions and indicators of success used for high medical needs members.

Goal

Ensure members with chronic diseases are seen by their physicians regularly for those diseases specified by the Chronic Disability Payment System

Intervention

Reimburse PCPs above capitation for members identified with chronic diseases who are seen at least twice a year

Indicator of Success

Absolute number of encounters received for these chronic follow-up visits billed with CPT code **99499**.

Quality Management Site Review Prior to Credentialing/Recredentialing

Health Partners staff performs site assessments of potential obstetric, high volume specialist and primary care providers prior to presenting these providers to the Health Partners Credentialing Committee. This review consists of a two-part assessment by Quality Management Coordinators. The first part is an on-site review to assess physical location, staffing, office hours and access. Also assessed are housekeeping, confidentiality and organization of records, equipment, safety measures, and availability of patient education materials. The second part includes a review of medical records to assess performance regarding overall medical record keeping practices for pediatric, adolescent, adult, well elderly and obstetric preventive care, as applicable. Once completed, the results are considered by the Credentialing Committee prior to credentialing/recredentialing.

Site review results are forwarded to each practitioner/practice. If the results in any of the categories listed fall below established target goals or expectations, the Quality Management (QM) department develops a Corrective Action Plan in cooperation with the provider. The mutually agreed upon corrective action plan is developed including a specific time frame for implementation. The results of the Corrective Action Plan are monitored by the QM department and another audit is performed. Oversight of this process is provided by the Quality Management Committee.

Member Satisfaction Survey

Health Partners commissions an outside agency to perform an annual member satisfaction survey in accordance with HEDIS criteria. Members are specifically asked to rate quality of service, quality of care, and satisfaction with their providers of care, the health plan and the Utilization Management program. After results are reviewed by the QM Committee, providers may be asked to review the results and comment, when appropriate, on their plans to address identified problem areas. Providers may also be asked to participate in initiatives aimed at increasing customer service awareness.

Provider Satisfaction Survey

Health Partners conducts an annual satisfaction survey of the provider network to assess satisfaction with the plan. The survey tool also allows for comments and recommendations from the provider network. The responses provide a catalyst for an internal review of Health Partners' programs and services, helping to identify areas of strength and opportunities for improvement. The results are reviewed by the QM Committee, a peer review committee that provides input on the findings and Health Partners strategies to improve satisfaction and services.

Provider Quality of Care Sanctions and Appeals

The following section provides an overview of possible sanctions and the appeal process associated with Quality Management initiatives and actions.

Quality of Care Sanctions

It is the goal of Health Partners to assure the provision of quality health care services in an efficient and economical setting. A provider may be subject to quality of care review and sanctions by Health Partners when a review of an individual incident or a trend of data reveals that a practitioner or provider is not in conformity with local standards of care or practice, quality management and utilization management criteria; has failed to adhere to policies and procedures established by Health Partners; or has failed to demonstrate improvement following a specific corrective action process.

Quality of care sanctions for Health Partners providers will be determined on a case by case basis. Quality of care sanctions may apply to any service provided where a review indicates there was a deviation from the standard of care regarding diagnosis, treatment, or expected outcome.

The appeal process applies to any provider who has received a quality of care sanction from Health Partners.

Responsibility and Authority

A Health Partners Medical Director will review all potential quality of care sanctions. Sanctions for quality of care will be reported to the Medical Affairs Committee (MAC), a subcommittee of the Board of Directors, and to Health Partners' Chief Medical Officer (CMO). All sanctions that may lead to termination of a provider's Agreement with Health Partners are also discussed with the CMO, who reports to the President and Chief Executive Officer (CEO) of Health Partners, prior to any termination action being taken.

Cases where a potential for immediate harm to members is identified will be reviewed with a Health Partners Medical Director who can act immediately to terminate health plan participation if patient welfare will be compromised by delay. An investigation of the facts and circumstances will take place prior to the termination action.

Sanction Process and Appeal Procedure

If, following review of the individual circumstance, Health Partners determines that the provider's treatment and care of a member is not in conformity with local standards of care and

practice, quality management and utilization management criteria, or the provider has failed to adhere to policies and procedures established by Health Partners, then a Health Partners Medical Director may issue sanctions.

The sanction process will typically work as follows:

1. The provider will receive a letter identifying the issue(s) and will be provided an opportunity to conform to the appropriate procedures and protocols within a specified time frame.
2. Repeated instances of nonconforming behavior may subject the provider to a second letter and the provider will not be permitted to accept additional members until all issues are resolved to the satisfaction of Health Partners.
3. Failure to conform thereafter will be grounds for immediate termination of the provider's agreement with Health Partners.
4. Notwithstanding the foregoing, if, in the sole discretion of Health Partners, the provider's behavior is egregious, negligent, criminal or threatens the ability of Health Partners to ensure quality health care to members, the provider agreement may be terminated immediately. In the event of such termination, the provider will not be permitted to accept additional members and the provider's current member panel will be advised that the provider is no longer a physician authorized to provide medical services to Health Partners/KidzPartners members. Cases when there is a potential for immediate harm to members will be reviewed with the Health Partners CMO, who can act immediately to terminate health plan participation if patient welfare will be compromised by delay. An investigation of the facts and circumstances will take place prior to the termination action.

Appeal

The provider may appeal quality of care sanctions to the President and CEO of Health Partners by presenting a written appeal within 30 calendar days of notice of action or sanction. This provider quality of care appeal shall detail the reason(s) such action or quality of care sanction should not be implemented. The President and CEO will then appoint a hearing panel of at least one person to review the appeal. A hearing date will be scheduled within 60 days of notice of the appeal. The provider shall be notified at least 30 days in advance of the hearing. The hearing notice will include the date, the location of the hearing, and the name of the hearing panelist(s).

In addition, the notice will require the provider to identify his/her representatives and witnesses and provide supporting documentary evidence to Health Partners at least ten (10) business days prior to the hearing. The provider will have an opportunity to present oral and written testimony at the hearing.

At the hearing, the burden of persuasion rests with the provider to demonstrate an abuse of discretion, a factual finding not supported by substantial evidence, or a decision not in accordance with law. The panel shall make a written report of its recommendation to Health Partners' President and CEO within thirty (30) days of the hearing date. Any party may request a copy of the record at his/her own expense.

Health Partners' President and CEO shall have thirty (30) days after receipt of the record and the hearing panel's recommendation to notify the provider in writing of Health Partners final decision and a copy of the written recommendation of the hearing panel. In any case in which the hearing panel supports the original sanction decision, the provider shall assume liability to pay the reasonable costs of the appeal that were incurred by Health Partners, including, but not limited to, expert witness expenses, costs of transcripts, and costs of counsel-unless the decision is reversed by a court of competent jurisdiction or Health Partners waives such costs.

Sanctions will not be reported until all notice and hearing procedures have been completed or waived. Health Partners will then advise all requisite regulatory authorities, including but not limited to the Pennsylvania Department of Public Welfare and the National Practitioner Data Base (NPDB), that a reportable sanction has been issued.