Quality Improvement Program

Throughout this provider manual there will be instances when there are references unique to a particular HMO network. These network specific requirements will be noted with the network name.

The following topics are covered in this section:

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality: A Key Concept with the HMO Network</td>
<td>G — 2</td>
</tr>
<tr>
<td>Objectives of the Quality Improvement Program</td>
<td>G — 2</td>
</tr>
<tr>
<td>Quality Initiatives</td>
<td>G — 4</td>
</tr>
<tr>
<td>Support Provided to the Quality Improvement Program</td>
<td>G — 5</td>
</tr>
<tr>
<td>Medical Director Involvement</td>
<td>G — 5</td>
</tr>
<tr>
<td>Quality Improvement Committee</td>
<td>G — 5</td>
</tr>
<tr>
<td>Texas Medical Advisory Committee and Texas Peer Review Committee</td>
<td>G — 7</td>
</tr>
<tr>
<td>Facility Provider Network Representative Involvement</td>
<td>G — 8</td>
</tr>
<tr>
<td>Responsibilities of the Quality Improvement Programs Department</td>
<td>G — 8</td>
</tr>
<tr>
<td>Laboratory Services Component</td>
<td>G — 9</td>
</tr>
<tr>
<td>Radiology Services Component</td>
<td>G — 9</td>
</tr>
<tr>
<td>Introduction</td>
<td>G — 10</td>
</tr>
<tr>
<td>What is Documentation and Why is it Important</td>
<td>G — 10</td>
</tr>
<tr>
<td>How does the Documentation in Your Medical Record Measure Up</td>
<td>G — 10</td>
</tr>
<tr>
<td>Principles of Documentation</td>
<td>G — 11</td>
</tr>
</tbody>
</table>

Note:

Providers who provide services to HMO members whose PCP is contracted/affiliated with a capitated IPA/Medical Group must also contact the applicable IPA/Medical Group for instructions regarding the outpatient service preauthorization requirements. Providers who are contracted/affiliated with a capitated IPA/Medical Group are subject to the entity’s procedures and requirements for complaint resolution.

Continued on next page
Quality Improvement Program: Overview

Quality improvement is an essential element in the delivery of care and services by HMO participating Providers. To define and assist in monitoring quality improvement, the HMO Quality Improvement Program (QIP) focuses on measurement of clinical care and service delivered by HMO participating Providers against established goals.

Information regarding the Quality Improvement Program documents is available by contacting the QIP department:

800-863-9798

Objectives of the Quality Improvement Program

The HMO Quality Improvement Program is an integrated process designed to continually monitor, evaluate, and improve the care and service provided to HMO members.

The HMO Quality Improvement Program objectives are designed to assist in meeting HMO goals. Following are the objectives:

- Facilitate the achievement of public health goals for disease prevention and safety
- Identify opportunities to improve the outcomes of medical and behavioral health care and service available to HMO members
- Analyze existence of health care disparities in clinical areas, including behavioral health and supported by pharmacy and lab data, in order to reduce existing disparities
- Assess the cultural, ethnic, racial and linguistic needs of members
- Use practitioner and provider chart reviews and interviews to understand the differences in care provided and outcomes achieved
- Conduct patient-focused interventions with culturally competent outreach materials that focus on race/ethnicity/language specific risks
- Conduct focus groups or key informant interviews with cultural or linguistic minority member(s) to determine how to better meet their needs and may encompass population groups based on race, ethnicity, language, gender, education level, socioeconomic status, veteran status, disability status, and age
- Provide staff training, information, and tools that help identify cultural and linguistic barriers

Continued on next page
Quality Improvement Program: Overview

Objectives of the Quality Improvement Program, continued

- Provide information, training, and tools to staff in support of culturally competent communication
- Develop, implement, and monitor action plans to improve medical and behavioral health care and HMO services
- Provide communication to HMO members, physicians, and professional providers on issues of quality medical care to promote improvements in the health status of members and satisfaction with HMO services
- Enhance the system of documentation of quality improvement-related information, enabling identification of opportunities and demonstrated effectiveness
- Monitor and ensure compliance and improve compliance with accreditation standards and regulatory requirements
- Develop and distribute member information that improves knowledge regarding clinical safety, general wellness, and disease prevention as it relates to self-care
- Identify opportunities to improve the outcomes for populations with complex health needs which may include the following conditions: physical or developmental disabilities, multiple chronic conditions, severe mental illness, organ transplants, HIV/AIDS, progressive degenerative disorders and metastatic cancers
- Promote the delivery and effective management of quality care for members with complex health needs that include but are not limited to individuals with multiple chronic diagnosis, physical and developmental disabilities, and severe behavioral health conditions through the following objectives:
  - Identify and stratify members with multifaceted special health care needs and actively enroll these members into complex care management, as appropriate
  - Direct enrollment of members with chronic care conditions to the Condition Management programs, as appropriate
  - Provide continuity and coordination of care for members with complex health care, as appropriate
  - Promote preventive health care services for members’ complex health care needs (e.g. asthma, diabetes, hypertension, etc.) through targeted health education and other programs

Continued on next page
Quality Improvement Program: Overview

Objectives of the Quality Improvement Program, continued

- Evaluate member complaints and appeals by collecting valid data for each of the following categories: quality of care, access, attitude and service, billing and financial issues, quality of practitioner office site

- Performance data may be used relating to the participating practitioner’s and provider’s provision of services, including, but not limited to, data relating to quality improvement activities, publicly reported data, and other related activities, as BCBSTX deems appropriate to assist members and groups

Quality Initiatives

HMO conducts interventions/initiatives which are designed to improve the overall health of plan members. Examples include:

- Preventive Care/Wellness Guidelines

- Birthday reminder card for men 50 years of age and older to encourage preventive screenings such as prostate screenings, cholesterol screening, and colon cancer screening

- Birthday reminder card for women 40 years of age and older to encourage preventive screenings such as clinical breast examination, pap test, mammogram, cholesterol screening, and colon cancer screening

- Targeted outreach to encourage members to receive breast, cervical, and colorectal cancer screening as well as other preventive care initiatives as opportunities are identified

- Childhood immunization reminders at 4 and 14 months of age to encourage compliance with the childhood immunization schedule and well-child visits

- BCBSTX website, which provides information related to health and wellness (bcbstx.com/provider).

For additional information about the above mentioned interventions or to request samples, please contact the Quality Improvement Program Department:

Toll-free at 800-863-9798

Continued on next page
Support Provided to the Quality Improvement Program

The Quality Improvement Program is supported by the Quality Improvement Department, Medical Directors, Texas Medical Advisory Committee, Texas Peer Review Committee, Provider Relations and Provider Contracting Representatives, Office of Physician Advocacy and on-site Physician Office Review (POR) nurses.

Medical Director Involvement

- Facilitates communication of quality improvement activities with participating HMO Providers
- Serves as a liaison between HMO and participating HMO Providers
- Chairs the Texas Medical Advisory Committee and the Texas Peer Review Committee to facilitate initiatives, including credentialing and review of quality of care issues
- Participates in the Quality Improvement Committee, which supports the development and periodic review of policies, procedures, practice guidelines, clinical criteria, QI outcomes study and initiatives utilized in the HMO Quality Improvement Program

Quality Improvement Committee

The HMOs Clinical Quality Improvement Committee (CQIC) oversees the development, implementation, and evaluation of required quality improvement activities. The committee conducts regularly scheduled meetings, is composed of participating Physicians, HMO employees, and consumer members from HMO, and is usually chaired by the Medical Director. The Physicians are invited to serve on the committee for a period of two years.

The responsibilities of the committee include but are not limited to the following:

- Centralize and coordinate the integration of all quality improvement activities
- Adopt clinical practice guidelines, general standards of care, and policies of medical practice based on current medical evidence, HMO demographics, and other local/regional factors

Continued on next page
Support Provided to the Quality Improvement Program

Quality Improvement Committee, continued

- Analyze and evaluate summary data from quality improvement activities and make recommendations for improvement utilizing
  - Quality improvement studies
  - Quality improvement projects
  - Quality of care and service data including access to services
  - Member, physician, and provider satisfaction surveys
  - Physician office review
  - Pharmacy programs review
  - Utilization and case management review
  - Conditions and lifestyle management
  - Administrative services

- Recommend policy decisions
- Identifies needed actions
- Ensure follow-up, as appropriate

- Review and approve the annual QI Program Evaluation, Work Plan, and updates to the QI Program description

- Monitor QI activities of all contracted agencies to which HMO delegates quality improvement, utilization management, case management, credentialing, physician office review or claims processing, and customer service activities

- Review, approve/deny, and recommend actions and communications to delegates when a delegate is determined to be non-compliant with HMO performance requirements, regulatory, certification or accreditation requirements, and standards

- Provide an annual QI Program Evaluation and regular reports to the public policy committee

- Review outcome measurements and improvement results

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Support Provided to the Quality Improvement Program

Quality Improvement Committee, continued

- Ensure that implementation of action plans has received the support of management. Provide coordination and monitoring of the Medical Management Program including review and approval of the Medical Management Program description, goals and objectives, clinical review criteria, quality management projects, performance measures, annual program evaluation and program impact.

- Review results from population based studies to assess patterns/trends derived from statistical data, which identify opportunities for improvement.

- Reassess activities continuously to determine whether optimal results have been achieved and are sustained.

- Review and approve any recommendations/action plans provided by the sub-committees.

Texas Medical Advisory Committee and Texas Peer Review Committee

The Texas Medical Advisory Committee and the Texas Peer Review Committee serve in an advisory capacity to the Medical Director and HMO regarding health care delivery issues that affect members and participating Providers. The Committees participate in the development, implementation, and evaluation of required peer review activities. The responsibilities include but are not limited to the following:

- Review and act upon completed credentialing files of applicants that have been recommended for participation.

- Make recommendations regarding continued Provider participation in the HMO network.

- Access, monitor, and evaluate utilization, quality of care, and service issues related to specific Providers.

- Recommend corrective action plans when opportunities to improve care or service are identified for specific Providers.

- Review Provider appeals regarding credentialing/recredentialing determinations.

- Review quality of care issues.

- Review preventive guidelines.

- Review quality improvement activities.

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Support Provided to the Quality Improvement Program, continued

Facility Provider Network Representative Involvement

- Facilitate adequate access for members to a full continuum of appropriately credentialed Providers
- Coordinate the Provider recruitment, servicing and credentialing activities
- Communicate policies, procedures, and guidelines established by HMO to participating Providers and disseminate information regarding the results of Quality Improvement Program activities

Responsibilities of the Quality Improvement Programs Department

The Quality Improvement Programs Department responsibilities include, but are not limited to the following:

- Initiate quality of care investigation and resolution
- Perform HEDIS data collection analysis, and interventions
- Develop and maintain QI studies/interventions for clinical and service issues
- Perform analysis and develop interventions related to member/Provider satisfaction
- Maintain compliance with state, federal, and other regulatory requirements periodic assessment

Continued on next page
Provider Review Program

Laboratory Services Component

The primary issue concerning provision of lab services is the accuracy of test results, which can be affected by such factors as training of personnel, equipment maintenance and calibration, and expiration date of testing reagents.

The Clinical Laboratory Improvement Amendment (CLIA) requires that all laboratories be certified by the Department of Health and Human Services as meeting minimum performance specifications. Evidence of CLIA certification is required to meet HMO review criteria as well as state of Texas requirements.

Radiology Services Component

Issues associated with radiology services include calibration and maintenance of equipment, exposure to radiation, film quality and staff training. The state of Texas requires inspection of radiology equipment every three years and documentation of the training for operation of the equipment. The Provider is required to register the equipment with the state, which grants a certificate of registration. Following each inspection, a letter of compliance is issued.

This review is limited to the radiology services component.
Principles of Medical Record Documentation

Introduction
The following Principles of Medical Record Documentation were developed jointly by representatives of the American Health Information Management Association, the American Hospital Association, the American Managed Care and Review Association, the American Medical Association, the American Medical Peer Review Association, the Blue Cross and Blue Shield Association, and the Health Insurance Association of America. Although their joint development is not intended to imply either endorsement of or opposition to specific documentation requirements, all seven groups share the belief that the fundamental reason for maintaining an adequate medical record should be its contribution to the high quality of medical care.

What is Documentation and why is it Important?
HMO requires medical records to be maintained in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review.

How does the Documentation in Your Medical Record Measure Up?

1. Is the reason for the patient encounter documented in the medical record?

2. Are all services that were provided documented?

3. Does the medical record clearly explain why support services, procedures and supplies were provided?

4. Is the assessment of the patient’s condition apparent in the medical record?

5. Does the medical record contain information on the patient’s progress and on the results of treatment?

6. Does the medical record include the patient’s plan for care?

7. Does the information in the medical record, describing the patient’s condition, provide reasonable medical rationale for the services and the choice of setting that are to be billed?

8. Does the information in the medical record support the care given in the case where another Provider must assume care or perform medical review?

9. Does the information in the medical record include communication between providers?

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Principles of Medical Record Documentation, continued

1. The medical record should be complete and legible.

2. The documentation of each patient encounter should include: the date; the reason for the encounter; appropriate history and physical exam; review of lab, X-ray data and other appropriate ancillary services; assessment; and plan for care (including discharge plan, if appropriate).

3. Past and present diagnoses should be accessible to the treating and/or consulting Physician.

4. The reasons for and results of X-rays, lab tests and other ancillary services should be documented or included in the medical record.

5. Relevant health risk factors should be identified.

6. The patient’s progress, including response to treatment, change in treatment, change in diagnosis and patient non-compliance, should be documented.

7. The written plan for care should include, when appropriate: treatments and medications specifying frequency and dosage; any referrals and consultations; patient/family education; and specific instructions for follow-up.

8. The documentation should support the intensity of the patient evaluation and/or the treatment, including thought processes and the complexity of medical decision-making.

9. All entries to the medical record should be dated and authenticated.

10. The Revenue Codes/CPT/ICD9 codes or their successors as required reported on the health insurance claim form or billing statement should reflect the documentation in the medical records.

Such documentation is expected in all medical records, to include electronic medical records, of all members for whom the provider is billing for services.