EmblemHealth

Chapter 28: Quality Improvement

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Chapter Summary

EmblemHealth's Quality Improvement Program is an ongoing, objective, and systematic process of monitoring, evaluating, and improving the quality, appropriateness, and effectiveness of care. It is vital to the health of our members and our performance as a health plan.

The Quality Improvement Program addresses quality and safety of clinical care and quality of service. We maximize safe clinical practices, and enhance member experience by developing, implementing, evaluating, and reporting on the various interventionsand programs usedto improve clinical quality, and medical and behavioral health care outcomes.

Clinical Practice Guidelines

EmblemHealth adopts evidence-based clinical practice guidelines (CPGs) from nationally recognized sources for medical and behavioral health conditions. The CPGs are available to network practitioners to assist in the management of preventive and clinical care. The CPGs are reviewed at least every two years unless regulatory requirements or national guidelines require otherwise.

EmblemHealth's CPGs are not a substitute for a practitioner's clinical judgement regarding the appropriate treatment of a member. CPGs are for informational purposes only and are not meant to direct individual treatment decisions which may vary from these guidelines based on the health care practitioner's clinical judgement.

EmblemHealth's clinical practice guidelines are available in Clinical Corner's UM & Medical Management section at emblemhealth.com/providers.

Medically Fragile Children

For the Medicaid children and foster care children carve-ins, EmblemHealth incorporates the following into its guidance:

- OMH Clinic Standards of Care: https://www.omh.ny.gov/omhweb/clinic_standards /care_anchors.html
- OASAS Clinical Guidance: https://oasas.ny.gov/search/clinical_guidance_and_recommendations
- OHIP, Policy and Proposed Changes to Transition Children in Direct Placement Foster Care into Medicaid Managed Care, April 2013: https://www.health.ny.gov/health_care/medicaid /redesign/docs/policy_and_proposed_changes_fc.pdf
- OCFS Working Together: Health Services for Children in Foster Care Manual: https://ocfs.ny.gov/main/sppd/health-

services/manual.php
- Office of Health Insurance Programs Principles for Medically Fragile Children: https://www.emblemhealth.com/content/dam/emblemhealth/pdfs/provider/provider-manual/Medically_Fragile.pdf

Patient Safety

EmblemHealth is committed to patient safety through a variety of activities and programs. We are committed to:

- Promoting member safety innovations.
- Developing member safety initiatives with community agencies and other health plans.
- Encouraging the reporting of member safety issues.
- Analyzing events within organizations to identify process improvement needs.
- Educating members and physicians about medical safety issues.
- Making performance data publicly available for members and practitioners.
- Decreasing fraud, waste, and abuse by reporting suspected activities.
- Credentialing and recredentialing providers in our network.
- Addressing clinical quality complaints and appeals.
- Encouraging coordination of care.
- Encouraging members to receive the care and services needed at the appropriate time.
- Offering a network of physicians that reflects the cultures and languages of the people we serve.
- Offering a language translation line and TDD when calling EmblemHealth so that your questions can be clearly understood.

Our Neighborhood Care sites offer classes and support services to EmblemHealth members and non-members in their communities.

Cultural Competency and Equitable Access to Care

EmblemHealth recognizes the diversity and specific cultural needs of its members. Clinical and non-clinical services are provided in a culturally and linguistically competent manner and promote equitable access to all members, including people:

(i) With limited English proficiency or reading skills.

(ii) Of ethnic, cultural, racial, or religious minorities and majorities.

(iii) With disabilities.

(iv) Who identify as lesbian, gay, bisexual, or other sexual orientations.

(v) Who identify as transgender, nonbinary, and other gender identities, or people who were born intersex.

(vi) Living in rural, suburban, and urban areas with high levels of poverty.

(vii) Otherwise adversely affected by inequality or social determinants of health.

Members' needs are addressed regardless of their gender, gender identity, language, health, religion, age, culture, family traditions and beliefs, race, ethnicity, sexual orientation, and disability.

Upon enrollment and thereafter, members select from a practitioner network and benefit plan services that meet their cultural, ethnic, racial, gender, age, and linguistic needs.

See the Directory chapter for available support services, including free interpretation services in over 200 spoken languages as well as sign language to meet members' communication needs.

Our Enhanced Care Prime Network providers who care for our Medicaid, HARP, and Essential Plan members are required to take NYSDOH-approved cultural competency training and demonstrate to EmblemHealth that such training has been completed. All practitioners are urged to complete this training. EmblemHealth posts additional cultural competency training materials and offers free and paid continuing medical education (CME) classes in Learning Online.

Provider's Role in Quality Improvement Program

Provider participation in the Quality Improvement Programis essential for its success.

Providers are expected to cooperate with EmblemHealth'squality improvement, patient safety, and performance improvement activities. Below are examples of how you can contribute to improving the quality of care and service, and the overall member experience:

- Review quality reports and take action to improve clinical outcomes as measured by Healthcare Effectiveness Data and Information Set(HEDIS®).
- Collaborate with EmblemHealth to resolve member complaints regarding access to care, quality ofcare, provider service, or other issues.
- Provide feedback via provider satisfaction surveys.
- Provide medical records as requested for HEDIS®, quality of care investigations, or other medical record audits in a timely manner.
- Allow EmblemHealth to collect and share quality and performance data for joint quality initiatives, including department of health-specific initiatives.
- Participate in member satisfaction initiatives, including improvements in access to care.
- Participate in quality improvement committees upon request. Your perspective as a participating provider is valuable in evaluating and improving clinical effectiveness, provider and member satisfaction, access to care and services, clinical practice guidelines, and more.
- Participate in the planning, design, implementation, and/or review of quality program activities.
- Participate, as applicable, in joint EmblemHealth and Managed Behavioral Healthcare Organization (MBHO) quality activities. Participate in medical records reviews, peer reviews, and performance improvement projects.
- Share supplemental data (additional clinical data outside of claims) from electronic medical records to support an enhanced view of our shared members.
- Continuity and coordination of care between care settings and among practitioners, including behavioral health.
- Ensure access and availability standards are met, including after-hours access.

Quality Improvement Goals and Objectives

EmblemHealth's core business strategy focuses on continuous quality improvement in medical (including pharmaceutical and dental) and behavioral health care and service provided to a complex, culturally diverse membership. We have adopted improvement methodologies from the Institute for Healthcare Improvement (IHI) and the Centers for Medicare & Medicaid Services (CMS) Triple Aim.

The following are the goals and objectives of EmblemHealth's Quality Improvement Program:

- Improve the health status of members and maintain current health status when the member's condition is not capable of improvement.
  - Systematically monitor, evaluate, and improve both the process and the outcome of care delivered to members in a culturally competent environment.
  - Monitor and improve member access to safe medical and behavioral care.
  - Monitor and improve continuity of health care for members.
  - Address members' complex needs through quality of care, coordination of care, disease management, and case management initiatives.
  - Assist members in becoming more knowledgeable and active participants in their own medical and preventive care by implementing initiatives and health management programs in a format understood by the member.
  - Monitor outcomes.
- Improve the member/provider-practitionerexperience of health care and services.
  - Evaluate and improve members' access to, and satisfaction with, clinical and administrative services.
  - Evaluate practitioner satisfaction with the health plan.
  - Communicate information related to the Quality Improvement Program, and its initiatives and progress to members and providers-practitioners.
  - Address the cultural and linguistic needs of the membership through appropriate materials and communications.
  - Investigate, correct, and resolve all problems brought to EmblemHealth's attention through internal monitoring, member/provider-practitionercomplaints/grievances, or other mechanisms related to the quality of care and services.
  - Ensure practitioner participation in quality improvement initiatives, including Department of Health-specific initiatives.
- Reduce the per capita cost of health care.
  - Develop innovative approaches to facilitate the delivery of care to diverse populations within EmblemHealth's membership.
  - Establish a climate of contractual responsibility through value-based programs to improve outcomes of care in a cost-efficient environment.

All goals and objectives are in alignment with applicable regulatory and accreditation requirements.

Scope of Quality Improvement Activities

EmblemHealth has a comprehensive Quality Improvement Program that encompasses all operational areas. It establishes a framework and process for continuously improving members' health care and services. EmblemHealth routinely monitors and reviews the following areas to ensure members have access to the highest-quality medical and behavioral care and services:

- Quality of care.
- Quality of service.
- Patient safety.

- Utilization management.
- Member and physician satisfaction.
- Access and availability.
- Population health management.
- Delegation and vendor oversight.
- Member complaints, grievances, and appeals.
- Member decision support tools.
- Cultural diversity.
- Language needs.
- Network to provide services.
- Customer service.

The focus of EmblemHealth's Quality Improvement Program activities includes, but is not limited to:

- Monitoring the availability, accessibility, quality, continuity, and coordination of care.
- Developing and distributing preventive and clinical practice guidelines for physicians and members.
- Offering and promoting health management programs to improve the health status of members with chronic conditions.
- Working with community health care partners.
- Improving the continuity of behavioral health care with medical care by overseeing the quality improvement-related components of behavioral health delegates.
- Promoting a system of timely, thorough,and appropriate resolution of member quality of care and quality of service complaints, including correction of identified problems.
- Developing initiatives to enhance patient safety in various care settings.
- Providing oversight of delegated activities as defined by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS), and state regulators.
- Promoting involvement of members and their family/representative and/or caregiver and practitioners in the Quality Improvement Program and related activities. We achieve this by encouraging feedback such as member satisfaction surveys, telephone calls, and participation on committees, as applicable.
- Promoting involvement of participating providers in the Quality Committee activities.
- Developing studies and measurements to track, evaluate, and analyze quality improvement.
- Identifying and pursuing opportunities for improvement.
- Developing a work plan outlining a schedule of activities and projects to achieve improvement over time, including continued evaluation and applicable reporting of progress toward established goals.

EmblemHealth Quality Improvement Program Authority and Responsibilities

EmblemHealth's Quality Improvement Program uses an integrated and collaborative approach that involves senior management, health plan functional areas, the Board of Directors, the Board of Directors' Quality Committee, and other committees within the Quality Improvement Committee structure.

The Health Insurance Plan of Greater New York (HIP) Board of Directors and the EmblemHealth Plan, Inc. (formerly Group Health Incorporated (GHI)) Board of Directors delegated ultimate authority for the Quality Improvement Program to the Quality Improvement Committees.

The overall responsibility for the strategic and tactical management of the Quality Improvement Program resides with EmblemHealth's chief medical officer and/or designee. Operational accountability is delegated to the appropriate department heads. The Quality Improvement Committee is an internal, interdisciplinary committee with corporate-wide representation that provides oversight, leadership, and direction for EmblemHealth's Quality Improvement Program. Committees within the Quality Improvement Committee structure include representatives from plan departments

and additional membership (including participating practitioners) as designated by its charter.

In summary, the Quality Improvement Committee responsibilities include, but are not limited to:

- Providing oversight, leadership, and direction for quality improvement and management of the health plan's Quality Improvement Program This includes: annual reviews, discussions, and approvals of the program description; monitoring the progress of the activities and initiatives contained in the workplan; and the evaluation of such workplan.
- Recommending and approving policy.
- Confirming that quality activities improve the quality of care and services provided to members.
- Reviewing, planning, designing, implementing, coordinating, analyzing, and evaluating results of quality improvement activities.
- Reviewing and approving studies, standards, clinical guidelines, trends in quality and utilization management indicators, and satisfaction surveys.
- Advising and making recommendations to improve health plan operations.
- Reviewing and evaluating company-wide performance monitoring activities, including service coordination, customer service, credentialing, claims, grievance and appeals, prevention and wellness, provider relations, and quality and utilization management.
- Instituting needed improvement actions and ensuring follow-up as appropriate.
- Ensuring practitioner participation in the Quality Improvement Program.
- Implementing necessary actions related to practitioner and community participation as appropriate and needed.
- Monitoring the effectiveness of the Quality Improvement Program.

Various committees and subcommittees support the functions of the Quality Improvement Program and report their activities to the Quality Improvement Committee, other appropriate subcommittees, and plan departments. Network providers and practitioners, including behavioral health care practitioners and consumers, can participate in the following committees that advise the Quality Improvement Committee:

- Behavioral Health Quality Management HARP and non-HARP Subcommittee
- Mental Health Parity.
- Behavioral Health Utilization Management HARP and non-HARP Subcommittee.
- Children's Medicaid Health and Behavioral Health Advisory Committee.
- Medical Policy Committee.
- Credentialing/Re-credentialing Committee.
- Delegation and Vendor Oversight Committee.
- Pharmacy & Therapeutics Committee.
- Physician Quality Improvement Committee.
- Medical Management Committee.

The Behavioral Health Quality Management Subcommittee exists to meet the quality requirements and standards for the populations, benefits, and services for children under 21 years of age, including those in the following subpopulations: Medically Fragile Children with physical, emotional, or developmental disabilities diagnosis; behavioral health diagnosis(es); and children in voluntary foster care agencies. EmblemHealth maintains an active Behavioral Health Quality Management Subcommittee, which includes (in an advisory capacity) members, family members, youth and family peer support specialists, and child-serving providers. The Behavioral Health Quality Management Subcommittee is responsible for carrying out the planned quality activities related to individuals with behavioral health conditions who access behavioral health benefits and/or home- and community-based services (HCBS).

Activities and Evaluation

Quality improvement activities may include, but are not limited to:

- Member and provider education.
- Development, approval, and dissemination of clinical and medical practice guidelines.
- Member incentives to encourage them to seek appropriate care.
- Provider incentives and large provider group value-based programs to encourage the delivery of appropriate care.
- Ongoing medical record reviews, and coordination and continuity of care, to ensure members received appropriate medical and behavioral health care.
- Collaborative activities with internal and external colleagues, including the New York City Department of Health and Mental Hygiene (NYC DOHMH), New York State Department of Health (NYSDOH), and Centers for Medicare & Medicaid Services (CMS).
- Quality improvement programs that meet the requirements of the NYSDOH, New York State Department of Financial Services(NYSDFS), andCMSfor the lines of business for which they have regulatory oversight.
- Community outreach.
- Analysis of member satisfaction with the cultural diversity of the network, with the health plan, and as new members including availability of appropriate practitioners.
- Analysis of trends in effectiveness of care measures, claims, enrollment, and service metrics throughout the year.
- Analysis of Health Outcomes Survey (HOS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) results, Enrollee Satisfaction Survey, and other NYSDOH-and CMS-sponsored member satisfaction surveys to identify opportunities to address member needs and progress toward health and satisfaction.

EmblemHealth uses industry standard processes and methodologies for conducting and evaluating quality improvement activities. These include:

- Appropriate study design.
- Baseline measurement.
- Root cause analysis and opportunities identified.
- Development and implementation of appropriate interventions.
- Remeasurement and statistical analysis to determine the impact of interventions.

Sampling methodology and the frequency of data collection are determined based on the nature of the quality indicators and/or committee recommendations.

The Quality Management department is responsible for monitoring improvement of these activities. The staff develops and implements an annual work plan of quality improvement activities. Quality Management annually evaluates the work plan to measure the impact and effectiveness of the Plan’s quality improvement activities.

Provider Performance Evaluations

EmblemHealth maintains assessment methods and performance criteria used to evaluate the performance of network practitioners in meeting the objectives of the Quality Improvement Program.

We make available (on a periodic basis and upon practitioner’s request) the information, profiling data, and analysis used to evaluate their performance. Each practitioner is given the opportunity to discuss the unique nature of their professional patient population, which may have bearing on the practitioner’s profile and the evaluation of their performance.

PERFORMANCE MEASUREMENT

EmblemHealth uses a variety of data sources and software to measure quality improvement processes and outcomes, determine and overcome barriers to improvement, and identify ways to improve quality. Data sources include, but are not limited to:

- Applicable case management and disease management.

- Behavioral health.
- Claims.
- Complaints.
- Encounters.
- Enrollment.
- Epidemiological, demographic, and census about EmblemHealth's membership.
- Grievance and appeals.
- HEDIS®/QARR (Quality Assurance Reporting Requirements).
- Laboratory.
- Medical records.
- Member and provider surveys, including but not limited to, CAHPS® [1], Access and Availability surveys, and Health Outcomes Survey.
- National and regional benchmarks from sources such as Quality Compass®, NCQA, and CMS.
- Pharmacy.
- Population-based member information.
- Quality improvement projects/studies.
- Telephone response.
- Utilization review.

EmblemHealth uses standard measures of clinical quality and customer experience to allow individuals to compare health plans and make informed choices when choosing a health plan for themselves and their family members. EmblemHealth uses the following key measure sets:

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Health Outcomes Survey (HOS)

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS®)

We use HEDIS® to measure clinical quality and customer service performance. HEDIS® is coordinated and administered by the NCQA and used by CMS for monitoring the performance of managed care organizations.

Each year between January and May, all NCQA-accredited managed care organizations like EmblemHealth perform HEDIS® reviews. It is a retrospective review of services and performance of care for the prior year. Data is collected either through claims (administrative), medical record collection and claims (hybrid), or surveys.

You play a critical role in HEDIS® scores. We look to you to promote healthy behaviors and provide the appropriate care within the appropriate time framesto members. You can improvethe health outcomes of your patientsby:

- Ensuring they receive their routine preventive services and screenings.
- Helping them manage chronic conditions such as arthritis, high blood pressure, and diabetes.
- Prescribing safe medications and only when necessary.
- Ensuring patients are continually taking their medications, especially those with chronic diseases.
- Coordinating patient care with medical and behavioral health services.
- Accurately coding claims. Coding accuracy may also reduce the number of records we need to request during the medical record collection phase of HEDIS®.

EmblemHealth-contracted providers and practitioners are required to provide medical records requested for HEDIS® data collection in a timely manner. HIPAA allows data collection for HEDIS reporting, thus no special patient consent or authorization is required to release the information.

[1]CAHPS is a program of the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services.

Member Surveys of Provider Performance

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS®) AND ENROLLEE SATISFACTION SURVEY (ESS)

We use the CAHPS® and Enrollee Satisfaction Survey (ESS) to learn about members' experiences with us and our network providers. CAHPS® and ESS also focus on factors such as getting care easily and quickly, the quality of care provided to them by their health care professionals, and overall service quality including customer service and claims experience.

We encourage our providers to improve member satisfaction by:

- Scheduling member appointments within the time frames listed in our Appointment Availability Standards During Office Hours & After Office Hours Access Standards.
- Speaking with members during each visit about their preventive health care needs and disease management goals.
- Allowing time during the appointment to be sure members understand their health conditions, the services required for maintaining a healthy lifestyle, and their treatment options and choices.
- Answering questions members have regarding newly prescribed medications.
- Ensuring members know to bring all medications and medical histories to their specialists and understand the purpose of a specialist referral.

HEALTH OUTCOMES SURVEY (HOS)

The Medicare HOS assesses how well Medicare members perceive their physical and mental health. The same members are re-surveyed two years later. HOS results are used by CMS to judge how well EmblemHealth and members' health practitioners are able to maintain or improve their physical and mental health.

Physician Incentive Program

For EmblemHealth's incentive programs, no specific payment is made directly or indirectly to a network practitioner or medical group as an inducement to reduce or limit medically necessary services offered to, or provided to, a member.