HIGHMARK. NORTHEASTERN NEW YORK

# Overview of the Quality Improvement Program

Our Health Management Department vision and mission are aligned with the corporate mission to create a remarkable health experience, freeing people to be their best.

It is the goal of the Highmark Western and Northeastern New York Quality Program (QP) to ensure that all individuals experience the right care, at the right time, in the right way at each stage of their personal healthcare journey. This will be accomplished by keeping individuals and populations healthy and delivering safe, reliable, accessible, affordable, evidence-based care.

## + Participation in National Evidence-Based Quality Program

**National Committee for Quality Assurance Accreditation (NCQA)**

The National Committee for Quality Assurance (NCQA) provides an evidence-based framework for systematically improving health care and services. Highmark WNENY promotes quality health care delivery for our members. Improving the quality of health care enriches the lives of our members, decreases overall morbidity and mortality, and ultimately results in savings of health care dollars. Highmark WNENY undergoes a rigorous NCQA re-accreditation survey process every three years to demonstrate and maintain the highest levels of quality and service. Highmark WNENY underwent a re-accreditation survey in 2022. Standards and Guidelines for the Accreditation of Health Plans, to demonstrate continued commitment and attainment of the highest quality standards. Our Commercial HMO/POS/ PPO/EPO combined, and Marketplace/Qualified Health Plans lines of business are brought forth for review.

## + Health Care Provider Quality Programs

**Healthcare Effectiveness Data and Information Set (HEDIS®)**

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by many of America's health plans to measure performance on important dimensions of care and service. HEDIS was developed and is maintained by the National Committee for Quality Assurance (NCQA). Altogether, there are more than 90 measures across 6 domains of care, including, but not limited to:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Relative Resource Use
- Health Plan Descriptive Information

Because many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans equally.

HEDIS results are collected and reported separately for populations covered by Commercial, Qualified Health Plan (Marketplace) products The Commercial submission is a combination of HMO, POS, PPO, EPO and FEP lines of business. HEDIS results are used to identify areas for improvement in the health care provided to our members and to evaluate many of the quality programs. HEDIS clinical measures, along with consumer satisfaction survey results, contributed to the NCQA Health Plan Accreditation status for our products.

**Quality Assurance Reporting Requirements (QARR)**

The Quality Assurance Reporting Requirements or QARR are reported to the New York State Department of Health and consist of measures from the National Committee for Quality Assurance's (NCQA) HEDIS® and New York State-specific measures (Colorectal and Lead Screening measures). QARR is publicly reported for our Commercial, Medicaid and Marketplace products. QARR performance results assist our members and enrollees in choosing a health plan. These results are also used to identify opportunities for improvement of services and for evaluating existing and potential quality programs.

**Hospital Quality Incentive Program Overview**

Strategic Performance teams continue to partner in a variety of ways with hospitals and other health care facilities to identify opportunities to build health care systems and processes that promote improvement in the quality of care delivered to our members and the larger communities we serve.

The Hospital Quality Incentive Program works in collaboration with hospitals and other health care facilities by working together to achieve the following:

- Identifying 'high risk' members that have been readmitted within 30 days
- Promoting an increase in awareness and utilization of our Case and Disease Management Programs
- Promoting use of a Hospital Discharge Program that assists in follow up appointments, review of discharge medications and other treatments to prevent avoidable readmissions
- Focus on reducing the incidence of Ambulatory-Sensitive Conditions and hospital acquired conditions such as: Central Line Infections, Ventilator Acquired Pneumonia, Catheter Associated Urinary Tract Infections, and Surgical Site Infections
- Reducing Avoidable Admissions with Ambulatory Sensitive Conditions
- Hospital quality target goals that maintain or improve rates for clinical outcomes, patient safety measures, and vaccine administration
- Utilization Management/Health Care Quality Improvement teams work closely with participating facilities that qualify and seek to achieve specialty Blues Center for Distinction Designations

**Blue Distinction Centers for Specialty Care®**

Blue Distinction® is a national designation program that recognizes those facilities that demonstrate expertise in delivering quality specialty care — safely, efficiently and cost effectively. True to its original commitment as a quality-based program, Blue Distinction has evolved to include a value-based designation awarded to facilities that meet nationally established, objective quality measures focused on patient safety and outcomes, developed with thoughtful input from the medical community, as well as cost of care criteria. Its goal is to help consumers find both quality and value for their specialty care needs, on a consistent basis, while encouraging health care professionals to improve the overall quality and delivery of care nationwide.

Guiding principles for the selection process were developed through a balanced set of quality, cost, and access considerations, to provide consumers with meaningful differentiation in value for those specialty care facilities that are designated as Blue Distinction Centers (BDCs), including:

**Quality**

- Establish a nationally consistent and continually evolving approach to evaluating quality and safety, by incorporating quality measures with meaningful impact, including delivery system features and specific quality outcomes to which all can aspire.

**Cost**

- Establish a nationally consistent, equitable, and objective approach for selecting Blue Distinction Centers that address market and consumer demand for cost savings and affordable health care.

**Access**

- Accommodate consumer access to Blue Distinction Centers, while achieving the program's overall goal of providing differentiated performance on quality and cost of care.

**Practitioner Quality**

The Pay for Performance (P4P), Best Practice and Pay for Outcome programs are designed to reward physicians for delivering high quality of care to our members in their patient panel. We identify HEDIS measures annually that need improvement from a plan performance perspective for inclusion in the program. Providers have on-demand, real time access to their compliance so that they can self-manage their performance while maximizing their incentive. The plan benefits by increased physician engagement in Quality and improved HEDIS scores.

**Culturally and Linguistically Appropriate Services (CLAS)**

This program is designed to enhance the enrollee/provider/health plan relationship from a cultural and linguistic perspective. Language Line Services are used to assist with any language barriers that may exist to improve understanding and compliance for all parties and to ultimately improve the health and health care of our enrollees. Educational programs are provided to promote culturally competent care, and programs are planned to decrease ethnic disparities in care. Annual training of employees is completed to expand and keep current knowledge regarding how culture and language barriers affect our enrollees and how they can help to make the enrollees health care experience a positive one promoting increased compliance and wellness.

According to our 2022 Culturally and Linguistically Appropriate Services Evaluation:

- The total number of interpreter calls in 2022 was 423, a 57% decrease from the 995 interpreter calls in 2021.
- Spanish continues to be the most common language translated by the interpreter service with 90.68% of the total interpreter volume.
- Moderately used language translations, across all lines of business, consisted of Arabic (2.47%), Mandarin (2.28%), and Russian (1.14%). Total utilization for these three languages was 5.89%, still far below the volume of Spanish translation at 90.68%. The next six minimal usage languages accounted for 1.14% of the call volume. Those languages include Ukrainian, Filipino, Italian, Nepali, Punjabi, and Vietnamese. All moderately and minimal usage languages are spoken by our provider network and all but one, Nepali, are in the top twenty languages spoken.
- There was a significant increase in the number of network providers in 2022, 2,379 compared to 1,831 in 2021. There was also an increase in diversity for the provider network in 2022. The Caucasian provider race/ethnicity category decreased from 91.48% to 88.57%. All other demographics increased in 2022. Asian or Pacific Islander increased from 3.71% to 5.93%, African American from 1.86% to 2.02%, Other from 1.47% to 1.81%, Hispanic from .93% to 1.05%, and American Indian/Alaska Native from .55% to .63%.

*It is important to note that NYS law states health plans may request cultural information from providers, but that it is an optional requirement on provider credentialing applications.

**Continuity and Coordination of Care**

Continuity and Coordination of Care (C&C) between settings and transitions in care is essential to quality care across the health care system. C&C helps prevent duplication of services, improves appropriateness of care, patient safety and can lead to a reduction in medical cost.

Information sharing is essential to the effective management of a patient's overall health. Surveys and medical record review are used to assess information exchange within the health care system. In addition, other program/projects (i.e., Case and Disease Management, Continuity and Coordination of care between medical and behavioral health settings, Express Scripts Safety alerts, Poly-Pharmacy Alerts, Emergency Room Utilization etc.) measure coordination and work toward improving C&C for all our members.

Interventions are developed and implemented to improve performance. Information exchange continues to be monitored via medical record review for standards, provider surveys, and other C&C related activities.

Continuity and coordination between medical and behavioral health care is facilitated by a multi-disciplinary team approach to health care, which is demonstrated by the plan in many different arenas such as the case management model (Includes medical and behavioral health professionals), and clinical quality consultants who assist PCPs in care coordination between the medical and behavioral health practices, and

Emphasizing continuity and coordination between medical and behavioral health care reduces fragmentation of care for many illnesses such as coexisting conditions between behavioral health disorders such as depression, attention deficit hyperactivity disorder, substance abuse, and chronic medical conditions such as diabetes, heart disease, cancer, etc. This continuity of care ultimately improves overall patient safety, quality of care, and improved health outcomes.

**Medical Record Review for Standards**

Primary Care/OB-GYN medical records are reviewed and rated against established documentation standards to identify areas for improvement in the medical record documentation and to assess for quality-of-care concern, based on NYS DOH requirements.

**Quality Investigations**

Ongoing monitoring of the quality of care provided by our practitioners, facilities, and vendors is performed ongoing, to identify opportunities for improvement. Quality of care concerns that may be investigated are deviations from a standard of care, and barriers to after-hours access. Issues regarding quality of care may be referred to the Health Plan Clinical Quality Team by internal departments and external vendors including Case and Disease Management, Use Management, Provider Relations, Special Investigations Unit, Grievance and Appeals unit, Advisement from Medical Directors and external physician consultants, and Behavioral Health services. All Quality Investigations are reviewed by the Medical Director and Complaint Committee.

**After Hours Access to Care Audits**

Our plan assures the provision and maintenance of appropriate access to Primary Care services, Behavioral Health services and Member services for members. All providers being credentialed or those who notify the Health Plan of a new location go through an on-site review and are expected to be in 100% compliance with the plan's access to care standards.

Credentialing and Provider Relations audit Primary Care and Behavioral Health offices to assure 24-hour access to care. If there is a provider office who does not meet our Access to Care criteria, the case is further investigated. Corrective action is required by 100% of offices not meeting this standard.

**Patient Safety Initiatives**

Patient safety activity monitored through the review of Quality-of-Care complaints.

+Care Management Programs

**Clinical and Service Quality (Medical and Behavioral Health)**

1. Vendor selection/management for administration and analysis of behavioral health experience.
2. Network adequacy plan maintenance and monitoring
3. Quality Improvement Strategy (QIS) for Marketplace members.
4. Patient safety activity monitoring through the review of Quality-of-Care complaints.
5. 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.
6. Behavioral Health Preventive Program management, such as those components focused on alcohol use screening and depression screening post-cardiac event.
7. Collaboration with Clinical Operations on the development and reporting of the Chronic Care Improvement Project(s) (CCIPs).
8. Practitioner/provider interventions designed to encourage participation in CMS and HHS QI initiatives as applicable.
9. Limited English Proficiency Project Management Office: Civil Rights Act compliance, including for language assistance services as needed; demographic analyses; Language

Assistance Plan monitoring, identification of opportunities for improvement, implementation, and remeasurement.

**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, and Marketplace Quality Reporting System (QRS).
2. Facilitate the Clinical Workgroup (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 to identify gaps in care that need closed, and to improve outcomes through interventions targeted towards members and providers.
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.
4. Facilitate the Preventive Health Workgroups to ensure the health plan follows mandates and regulatory guidelines and complete the annual Medicare Advantage and Commercial Preventive Schedules.
5. Member and provider interventions to improve health literacy.

## +Customer Satisfaction Program

**Customer Service**

To improve the accuracy of the information given to customers when they call, a Call Monitoring Program is in place. Frequent modifications to our program to improve the service we offer to our customers are made.

**Customer Satisfaction Monitoring**

We have a program that monitors the quality of our customer service department. This includes making sure that information shared by our staff is accurate and that customers do not have to wait long for a response to their question. We measure first call resolution and have quality programs in place to improve our performance. Many times, our customers contact us with quality-of-care complaints. This allows us to investigate and track issues to identify areas for improvement.

Customer satisfaction surveys are conducted to measure customer satisfaction and member experience. Results from surveys and customer complaints are monitored and data is shared with a team focusing on customer satisfaction. One of the surveys done is called the Consumer Assessment of Health care Providers and Systems (CAHPS)®. The same questions are asked to customers across the nation to measure satisfaction with their health plan and doctor. This survey allows us to compare ourselves with other health plans and to focus on specific areas of improvement.

**Quality/Access to Care Complaints:**

An analysis of Quality and Access to Care complaints is performed on a biannual basis. This reporting period is January 1, 2022, through June 30, 2022, and includes all lines of business.

~ The ranking of clinical complaint categories is unchanged from mid-year 2021:

1. Quality of Care as the largest concern for our members
2. Access to Care
3. Attitude, and
4. Quality of Provider Office Site (Environmental)

~ 98% of the member complaints were resolved to the member's satisfaction.

~ Performance goals met to date:

- Total complaints/1,000 is at less than 0.5 met at 0.18.
- 100% of member complaints met regulatory requirements determined by the Utilization Management Department, which met the goal of 95%.

This activity will be integrated into Highmark's complaint process beginning 2023.

**Pharmacy Benefits Satisfaction**

Highmark WNENY Pharmacy Benefits Manager (PBM), Express Scripts, continues to meet operation performance standards for the commercial line of business

If you would like a paper copy of this report or QI program description, or need additional information, contact us at 1-877-878-8785 Option 3 or on our web site. You may also write to us at the following address: Quality Improvement, PO Box 80, Buffalo, New York 14240

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