Chapter 28: Quality Improvement

This chapter summarizes our quality improvement programs established to improve the medical and behavioral health care outcomes of our members.

Overview

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.

Our Quality Improvement Program determines members’ clinical and service needs. We maximize safe clinical practices and enhance member experience by developing, implementing, evaluating, and reporting on the various interventions/programs we use to improve clinical quality, and medical and behavioral health care outcomes.

Provider’s Role in Supporting the Quality Improvement Program

Provider-practitioner participation in the Quality Improvement Program is essential for its success.

Providers-practitioners are expected to cooperate with EmblemHealth’s quality 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 of care, provider service, or other issues.
- Provide feedback via provider-practitioner satisfaction surveys.
- Provide medical records as requested for HEDIS®, quality of care investigations, or other medical record audits.
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. EmblemHealth has 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.
- Monitor outcomes.

- Improve the member/provider-practitioner experience 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-practitioner complaints/grievances, or other mechanisms related to the quality of care and services.
- 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 Activities**

EmblemHealth has a comprehensive Quality Improvement Program that encompasses all operational areas. It establishes a framework and process for continuously working to improve the health care and services received by EmblemHealth members. 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
- Delegation
- Member complaints, grievances, and appeals
- Member decision support tools
- Cultural diversity
- Language needs

EmblemHealth’s Quality Improvement Program activities focus on, but are not limited to, the following:

- Monitoring the availability, accessibility, quality, continuity, and coordination of patient care.

- Developing and distributing preventive care 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 to ensure successful level-of-care transitions for members, especially those with complex health needs.

- Improving the continuity of behavioral health care with medical care by overseeing the quality improvement-related components of EmblemHealth’s 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
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 Group Health Incorporated (GHI) Board of Directors have delegated ultimate authority for the Quality Improvement Program to their respective Quality Committees.

The overall responsibility for the strategic and tactical management of the Quality Improvement Program resides with EmblemHealth’s Senior Vice President, Medical Delivery 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, and 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 as designated by its charter.

The Quality Improvement Committee is responsible for:

- 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.
- 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. Network practitioners, including behavioral health care practitioners and consumers, can participate in the following committees that advise the Quality Improvement Committee:

- Behavioral Health Quality Management Subcommittee
- Care Management Committee
- Medical Policy Committee
- Behavioral Health Utilization Management Subcommittee
- Credentialing/Re-credentialing Committee
- Delegation Oversight Committee
- Pharmacy & Therapeutics Committee
- HARP Medicaid Behavioral Health Advisory Subcommittee
- Children’s Medicaid Health and Behavioral Health Advisory Committee

The Behavioral Health Quality Management Subcommittee functions 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, the following:

- Member and practitioner education.
- Development, approval, and dissemination of clinical 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 our members received appropriate 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 NYC DOHMH, NYSDOH, and CMS for the lines of business for which they have regulatory oversight.
- Community outreach.
- Analysis of member demographics to identify language, cultural, racial, and ethnic needs by geographic area and...
EmblemHealth uses industry standard processes and methodology for conducting and evaluating quality improvement activities. This includes:

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

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

The Quality Management Department is responsible for monitoring and managing the improvement of these rates. The staff develops and implements an annual work plan that lists planned quality improvement activities. Quality Management also conducts an annual evaluation based on that work plan to measure the impact and effectiveness of quality improvement activities.

**Provider Performance Evaluations**

EmblemHealth maintains methods and information used to evaluate the performance of network practitioners in meeting the objectives of the Quality Improvement Program. This includes the methods of assessment and the criteria against which the performance of the practitioner is evaluated. We disclose the process, including the profiling data and other relevant information used to perform the evaluation of the practitioner.

We make available (on a periodic basis and upon the request of the health care professional) the information, profiling data, and analysis used to evaluate the practitioner’s 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®
- National and regional benchmarks from sources such as Quality Compass® and NCQA accreditation
- 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 year prior. Data is collected either through claims (administrative), medical record collection and claims (hybrid), or surveys.

As an EmblemHealth provider-practitioner, you play a critical role in HEDIS® by promoting the health of our members
and providing the appropriate care within the appropriate time frames. You can contribute to EmblemHealth’s goal of improving the health outcomes of EmblemHealth members by:

- Ensuring members receive their routine preventive services and screenings.
- Helping members 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.
- Providing accurate coding on a claim, which is essential for EmblemHealth to continuously work on improving members’ care and services and may also reduce the number of records requested by EmblemHealth during the medical record collection phase of HEDIS®.

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

EmblemHealth uses the CAHPS® and Enrollee Satisfaction Survey (ESS) to learn about our members’ experiences with their health care, i.e., health plan, providers, and specialists. CAHPS® and ESS also focus on factors such as getting care easily and quickly, the quality of care provided to them by their primary care doctor or specialist, and overall service quality including customer service and claims.

EmblemHealth encourages providers to help improve member satisfaction. You should:

- Schedule member appointments within the time frames listed in our [Appointment Availability Standards During Office Hours & After Office Hours Access Standards](#).
- Speak with members during each visit about their preventive health care needs and disease management goals.
- Allow time during the appointment to be sure members understand their health conditions and the services required for maintaining a healthy lifestyle.
- Answer any questions members have regarding newly prescribed medications.
- Ensure members know to bring all medications and medical histories to their specialists and understand the purpose of a specialist referral.

**HEALTH OUTCOMES SURVEY (HOS)**

EmblemHealth uses the Medicare HOS for signs of how well EmblemHealth manages the physical and mental health of its Medicare members. Members who receive the HOS are asked to respond to questions that reflect their physical and mental health perception. The same members are re-surveyed two years later. HOS results are used by CMS to judge EmblemHealth’s ability to maintain or improve the physical and mental health of our members.

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1 CAHPS is a program of the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services.
EmblemHealth adopts evidence-based clinical practice guidelines (CPGs) from nationally-recognized sources for medical and behavioral health conditions. We make these CPGs 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 clinical practice guidelines 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 at emblehealth.com.

Medically Fragile Children

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

- OMH Clinic Standards of Care
- OASAS Clinical Guidance
- OASAS Clinical Guidance
- OHIP, Policy and Proposed Changes to Transition Children in Direct Placement Foster Care into Medicaid Managed Care, April 2013
- OCFS Working Together: Health Services for Children in Foster Care Manual
- Office of Health Insurance Programs Principles for Medically Fragile Children

Patient Safety

EmblemHealth is committed to patient safety. We support this by:

- 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.

Physician Incentive Program

In the event EmblemHealth elects to operate a physician incentive plan, no specific payment is made directly or indirectly to a network practitioner or group as an inducement to reduce or limit medically necessary services.
EmblemHealth recognizes the diversity and specific cultural needs of our members. We are committed to making clinical and non-clinical services available and accessible to members in a culturally competent manner. Our services accommodate members with limited proficiency in speaking and/or understanding English as well as members with limited health literacy. We also serve member needs regardless of their gender, health, religion, age, culture, 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.