

Quality Program

Quality Program

The Quality Program (QP) supports Regence's commitment to ongoing quality care for our members. This is accomplished by developing standards and performance goals and continuing to monitor them to identify improvement opportunities.

Quality Program goal and objectives

The goal of the QP is to improve the care and service provided to our members. This directs us in developing our objectives, which are chosen and designed to align with Regence Core Strategies. Our objectives reflect the integration of multiple areas of the company, and our commitment to identifying opportunities to improve the experience of our members and providers. The objectives, and the activities that support them, help us develop and maintain the relationships with our members that are key to our success as a company.

Quality Program Scope

The scope of the QP includes developing improvement opportunities and activities throughout Regence. It touches divisions of Regence that directly impact the experience of our members or providers and is outlined below:

1. Develop focused quality improvement activities (QIAs) including:
 - Clinical QIAs
 - Service QIAs
2. Monitor activities throughout Regence to further the integration of our processes including:
 - Clinician performance monitoring
 - Pharmacy education programs
 - Depression disease management program
 - Coaching and wellness programs
 - Community collaboration
 - Access
 - Availability
 - Member satisfaction
 - Provider satisfaction
 - Staff qualifications
 - Under and over utilization
 - Medical record keeping
 - Advance directives
 - Quality surveys
 - Quality of Care Concerns

3. Monitor patient safety activities to fulfill our commitment to the safe delivery of care to our members.
4. Support contractual and regulatory compliance.
5. Develop and administer the Quality Program to provide an organizational structure, resources and coordination of quality processes within Regence.

Participation in the Quality Program

Participation in Regence QP activities is required in our agreements with physicians, other health care professionals and facilities. Participation may include providing data for various medical records audits such as the annual Health Plan Employer Data Information Set (HEDIS®) audit, credentialing or recredentialing, site visits and record review, or quality of care concerns or complaints. Participation may also include providing evidence of preventive health promotion and adherence to clinical standards. Providers may be asked to review and provide feedback on proposed or ongoing clinical activities, and development of clinical practice guidelines at focus groups or Medical Advisory Committees.

HEDIS Reporting

One of the most important components of the QP is the collection and reporting of HEDIS data. HEDIS is the most widely-used set of clinical measures in managed care today. Originally developed by the National Committee on Quality Assurance (NCQA) for employers to compare the quality of health plans, HEDIS now also includes Medicaid and Medicare. Regence is required to report annual HEDIS values on various populations. In Washington State, Healthy Options and the State Children's Health Insurance Plans are included in the HEDIS process. HEDIS measures general areas that:

- Affect health outcomes to the extent health plans can control or influence them
- Have significant differences between average and ideal performance
- Are useful to purchasers and consumers

Data for HEDIS measures may be collected administratively by transaction data (claims) or other administrative databases (such as state immunization registries). Regence must rely heavily on the accuracy and completeness of information submitted on claims. We may also require a review of a random sample of medical records. We will work with you to complete these necessary reviews in the most efficient way possible. Complete and specific information on claims and encounter data can reduce the number of medical record reviews required and significantly reduce our time in your office.

Site Review Standards

In order to provide a sanitary, comfortable experience, participating physicians, facilities and other health care professionals agree to adhere to the following site standards. Offices will be regularly reviewed to ensure compliance with these standards.

Physical accessibility

- The exterior is generally accessible; the office is easy to locate, parking is available, clearly identified and handicap accessible.
- The interior is generally accessible; is handicap accessible, rooms are clearly identified and office hours are communicated clearly.

Physical appearance and safety

- Exterior: The building is generally clean and well-maintained and the exterior premises are safe.
- Interior: The interior is generally clean and well-maintained, the interior premises are safe, a fire extinguish system is available, there is adequate hazardous product disposal; and if narcotics are in the office, they are securely locked.

Waiting room adequacy

- The waiting room is generally clean with adequate seating for the number of providers in the office.
- There are educational materials available.

Examination room adequacy

- The rooms are generally clean and of adequate size.
- There is hand washing available in each room.
- There is an exam table in each room.
- The patient's privacy is protected.
- There is educational information available.
- There is an assistant available as needed (e.g., OB/GYN).

Appropriate equipment available

- There are examination instruments – for primary care physicians this would include: stethoscope, blood pressure cuff, otoscope and ophthalmoscope.
- There are Sharps containers.
- There is resuscitation equipment or CPR-certified staff.
- If X-rays are done in the office, state certification has been obtained
- If lab work is done in the office, C.L.I.A. certification has been obtained.

Adequacy of medical record keeping

Physicians, other health care professionals and facilities must maintain a medical record-keeping system that conforms to professional medical standards, permits an internal and external medical audit, permits encounter claim review and facilitates an adequate system for follow-up treatment. All medical records must be maintained for at least ten years after the date of medical services.

Participating physicians, other health care professionals and facilities must include, at a minimum, the following in medical records:

- Identifying information of the patient
- Identification of all providers participating in the patient's care
- A problem list, including significant illnesses and medical and psychological conditions
- Presenting complaints, diagnoses and treatment plans
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- Information on allergies and adverse reactions – or a notation that the patient has no allergies or history of adverse reactions
- Information on Advance Directives
- Past medical history, physical examination, necessary treatments and possible risk factors the patient relevant to the particular treatment

The following policies and procedures are also established:

- The charts must be organized and contents secured
- Medical records must be kept from public access
- Medical records must be readily available
- Confidentiality policy
- Release of information policy
- Procedures for assessing and improving content, legibility, organization and completeness of medical records

Provider availability

To ensure that our members have services they need at any given time, the following are minimum standards for availability:

- Emergent care will be assessed, treated or referred immediately.
- Urgent, acute care appointments will be scheduled within 24 hours.
- Non-urgent, routine care appointments for symptomatic conditions will be scheduled within seven calendar days.
- Non-urgent, routine care appointments for asymptomatic conditions will be scheduled within 30 calendar days.
- Preventive care examinations will be scheduled within four weeks or within the community standard.
- Wait time for a scheduled appointment will be no more than 15 minutes.
- Physicians and other health care professionals will provide or arrange for the provision of covered services to members on a 24-hour-a-day, seven-days-a-week basis.

After-hours answering systems

In order for members to be able to access their primary care or call share physician after regular office hours, physicians and other professional providers must have an adequate telephone answering system or service available. If your office utilizes a telephone answering system after regular office hours, the following guidelines apply:

- The answering message must include the name and telephone number of the on-call physician or other health care professional (you or the callshare physician) and complete instructions on how to contact the on-call physician or other health care professional.
- The message must be checked frequently to ensure that it is clear, easily understood and contains accurate information such as telephone numbers.

Messages that only instruct a member to call 9-1-1 or go to a hospital emergency room do not meet the full requirement for 24-hours-a-day, seven-days-a-week coverage.

If your office utilizes an answering service, it is your responsibility to furnish the answering service with accurate information that includes the name of the on-call physician or other health care professional. You must also include what, if anything, the member needs to do to contact that physician or other health care professional.

Cultural Competency

Legislative requirements at both state and federal levels emphasize the importance of demonstrating cultural competency in the provision of health

services. The Balanced Budget Act of 1997 also added cultural competency requirements for managed care plans contracting for Medicare. The Centers for Medicare & Medicaid Services (CMS) interpreted these requirements to mean services should be provided in a culturally-competent manner to all enrollees who met one or more of the following criteria:

- Limited English proficiency or reading skills
- Diverse cultural or ethnic background
- Physical or mental disabilities
- Homeless individuals

It is our policy to seek physicians and other health care professionals who speak other languages in addition to English and who have an awareness of the social and cultural composition of the community.

Members with visual impairments

The following information may assist you in providing services to visually impaired patients:

- Assign a person in your office to assist your visually impaired patients. It is helpful to develop a process to identify what to do if a patient needs assistance from their vehicle to your office, with form completion, or to and from the restroom or exam room.
- If your office is located in a newer building, Braille signs should be posted on restrooms and elevators to meet ADA requirements. Older buildings, may also add Braille signs to assist visually impaired patients. Contact the Washington State Department of Services for the Blind at 1 (800) 552-7103 for a vendor near your office.
- Guide dogs must be permitted to accompany visually impaired patients to all areas of your facility where patients are allowed. An individual with a guide dog may not be segregated from other patients.

Non-English speaking and hearing impaired members

- To ensure accurate interpretation and translation, Regence strongly encourages utilization of an interpreter service or staff person who is trained in translating medical terminology. Asking family members or friends to act as an interpreter is not appropriate for these situations as they may not be familiar with medical terms and translation errors may occur, or information overlooked or withheld.
- Regence members who are hearing impaired have access to the TTY line in Customer Service. Members may access the TTY line at 1 (800) 382-1003.
- Onsite interpreter services are available for our managed Medicare members. Please see the Medicare Advantage Plans section of this manual for more information on how to request this service from Regence.

Advance directives

To ensure our members' wishes are met concerning the provision of health care if the member becomes incapacitated and is unable to make those wishes known, physicians, other health care professionals and facilities should comply with the following:

- The office or facility should have copies of Advance Directives available for their patients to complete, or advise the patient how to obtain one from the hospital or their attorney.
- If the office has received a signed Advance Directive, a copy of the document must be prominently displayed in the patient's chart so that it is easy to see.

We request that all physicians, other health care professionals and facilities review these standards carefully. If your office or facility is currently not meeting these standards, please take the steps necessary to ensure that members have access to quality care by complying with these standards.

Provider Advisory Groups

Provider Advisory Groups are charged with the responsibility to:

- Ensure appropriate clinical standards of practice are incorporated in clinical policies, guidelines, quality activities, medical and pharmacy programs;
- Provide advice and input on utilization, costs, practice patterns, reimbursement, patient safety, and survey results such as HEDIS, CAHPS, and provider and practice manager surveys;
- Provide input on quality initiatives.

Membership is composed of:

- Plan physicians, including primary care and specialty
- Other health care professionals
- Selected medical consultants
- Chief Medical Officer
- Medical Services staff
- Provider Services staff

Advisory panels meet at least semi-annually and provide information to QPC and others.

Board of Directors and Health Care Services Committee

Participating providers serve on the Regence BlueShield Board of Directors and its sub-committee, the Health Care Services Committee. This committee meets quarterly to discuss issues surrounding the health care delivery system and provider-related quality improvement activities.

Radiology Quality Initiative

The Radiology Quality Initiative, effective June 1, 2009, is a clinical and quality review program for advanced diagnostic imaging procedures performed in outpatient, non-emergent settings.

Physicians and other health care professionals are required to obtain an order identification (ID) number from our vendor, American Imaging Management® (AIM®) before scheduling one of the advanced diagnostic imaging procedures listed below if they will be performed on an outpatient basis in a physician's office, free-standing imaging center or in an outpatient hospital setting.

- Computerized tomography (CT) and computerized tomography angiography (CTA)
- Nuclear cardiology
- Magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA)
- Positron-emission tomography (PET)

Obtain an order ID number by contacting AIM:

- Online at **www.americanimaging.net/goweb** or
- By phone at 1 (877) 291-0509

Note: Imaging procedures performed in conjunction with emergency room services, inpatient hospitalization, outpatient surgery or 23-hour observations are excluded from this requirement.

Imaging providers are strongly encouraged to verify that an order ID number has been obtained before scheduling and performing diagnostic imaging procedures.

Additional information

For more information about our Quality Program and current initiatives, please contact your provider consultant.