

Premier Blue*

PB-1-99

March 10, 1999

Sent to: PB PCPs, RSs

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- * Reference Guidelines for Adult Diabetes Ambulatory Care
- * Reference Guide for Preventive Medicine
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- * Office Medical Record Review Quality Indicators

Dear Participating Provider

It has been three years since Premier Blue became operational. The recent expansion of Premier Blue into Northeast Kansas gives us a presence in 31 counties, serving more than 58,000 members. In order to meet the health care needs of those members, the provider network has also expanded to include 477 primary care physicians, 1,983 referral specialists, and 40 hospitals.

Not a day goes by that the media doesn't carry news about the managed care industry. Industry standards for managed care organizations, NCQA and HEDIS, are expanding. Premier Blue must respond to this growth by evaluating our current quality improvement processes and must be prepared to discard those processes that no longer add value to the program. This evaluation is done using the industry standards as guidelines and your feedback.

In this newsletter, you will find the changes that have been made to the Quality Improvement Program for 1999. These changes have been approved by your representatives on the Medical Management Committee, who are accountable for the quality of clinical care provided to Premier Blue members.

As your partner, we continue to strive to reduce any unnecessary administrative burden so that together we can continue to focus on our ultimate goal: improving the health of Premier Blue members.

If you have any questions about these changes or suggestions, please contact your appropriate Medical Management Director Representative or the committee chairman, Dr. Ralph Weber, Vice President of Medical Affairs, Blue Cross and Blue Shield of Kansas.

| | |
|---------------------------------|-----------------------|
| Capitol Program Area: | Kent Palmberg, MD |
| Flint Hills Program Area: | Vacant |
| North Central Program Area: | Steve Schwarting, MD |
| Northeast Kansas Program Area: | Vacant |
| South Central Program Area: | Diane Nightengale, MD |
| Wichita Clinic: | Terry Merrifield, MD |
| Wichita Community Program Area: | Steve Chavez, MD |

The Premier Blue Quality Improvement Staff looks forward to working with you in 1999.

Carol Badsky, ARNP, CQAP
Director of Quality Improvement

Credentialing

* Credentialing goal for 1999: recredential PCP's

- * New shortened recredentialing form
- * Begin credentialing contracting facilities

Our main credentialing goal for 1999 is to recredential PCPs.

Currently, we are in the process of making final changes to the recredentialing application. So far, we have managed to reduce the length of the application from the initial 10 pages to 4 or 5 pages, depending on the amount of data on the recredentialing application. The new recredentialing application will include the provider's personal information, specialties, licenses, board certification, insurance, hospital privileges, educational background, and address information from our database system.

As a reminder, please review the data and answer all questions according to the instructions.

As a managed care organization, we are required to recredential providers at a minimum of every two years. Failure to complete and return the recredentialing application could result in cancellation of your contract.

In January, 1999, we will begin to credential contracting facilities. This will include hospitals, home health agencies, skilled nursing facilities, nursing homes, hospices, rehabilitation hospitals and freestanding surgical centers. The credentialing staff is responsible for establishing corporate policies and implementing procedures for credentialing and recredentialing of institutional providers for Premier Health, Inc. In order to meet NCQA standards for credentialing facilities, this process has to occur at a minimum of every three years.

We will continue to evaluate and consider ways to make the credentialing process run smoothly. We appreciate your willingness to provide the necessary information and the cooperation of your staff as well.

Office Site Assessments

- * Discontinued incentive tied to office site assessment

The Office Site Assessment (OSA) is a risk management tool conducted by the Professional Relations Representative or Quality Improvement Nurse Reviewers in the primary care physician's/referral specialist's office.

An example of the OSA form has been included with this newsletter for your reference.

It is used to evaluate key factors with regard to record keeping, accessibility, general office procedure, environment and safety, radiology, laboratory and observation of office/customer service.

The Office Site Assessment (OSA) will continue to be performed as part of the recredentialing process on all PCP's with 50 or more members, OB/GYN's and referral specialists with 75 or more members. We will continue to perform OSA's on all new applicants: MD's, DO's, DC's, and DPM's.

Providers must comply with established standards in order to be considered for the credentialing process, and for continued participation.

The provider will be notified of the OSA results at the conclusion of the initial on-site assessment and at the time of recredentialing.

Health Employer Data and Information Set (HEDIS)

* Record review process changed

* The improvement goals are:

| | Premier Blue | Regional Average | National Average | Improvement Goals |
|---|--------------|------------------|------------------|-------------------|
| Childhood Immunization (Combo 2) | 69.3% | 60.3% | 63.6% | **40.0% |
| Adolescent Immunization | 0.2% | 3.7% | 7.9% | 5.0% |
| Breast Cancer Screening | 85.0% | 71.6% | 71.2% | 87.0% |
| Cervical Cancer Screening | 79.0% | 73.4% | 71.3% | 83.0% |
| Prenatal Care 1 st Trimester | 92.9% | 82.4% | 83.1% | 92.9% |
| Eye Exams for Diabetics | 43.4% | 37.3% | 39.0% | 47.0% |

** HEDIS reports three different "Combo" rates. The comparative results from NCQA are for Combo Rate 2. Premier Blue's goal is for Combo Rate 3, which is a more all-inclusive rate. The Plan's current performance on Combo Rate 3 is 34.8%, with an improvement goal of 40%.

BCBSKS utilizes HEDIS (Health Plan Employer Data and Information Set) to report information about its managed care products: Blue Select and Premier Blue.

As of 1999, the National Committee for Quality Assurance (NCQA) requires HEDIS reporting for NCQA accreditation, which is used as a "report card" for employers and consumers to compare managed health care plans.

Five of the HEDIS measures for 1999 require a review of a random sample of members' medical records. These reviews are to determine if a particular service, such as immunizations or eye exams for patients with diabetes, has been provided to the member population in accordance with HEDIS guidelines.

Currently, there are two ways in which this review may be conducted. One, charts may be reviewed by one of our nurse reviewers in your office, or two, you may be asked to send us a copy of the patient's record for review.

Medical record review nursing staff will be conducting on-site reviews for all sites where there are ten or more records to review. For those office sites where there are fewer than ten records to review, we will be asking offices to mail in a copy of the pertinent portion of the medical record.

The number of physicians and the geographic dispersion of offices throughout the state makes it unfeasible to conduct all of the reviews on site. We hope this approach will help to minimize the burden on physicians and their staff.

Due to the extensive number of charts that must be reviewed and the short time-line that the plan has to compile this information, your timely response and cooperation with these medical review requests is critical.

Please note that none of the charts reviewed strictly as part of the HEDIS data collection will not affect your Office Record Review.

We continue to evaluate ways that this data can be collected in our claims system, e.g., submission of special codes, in order to reduce the number of charts that need to be reviewed.

Office Medical Record Review

- * Adoption of revised office record review criteria
- * Number of review categories decreased from 7 to 2
- * Discontinued the incentive tie to office record review
- * High volume referral specialists redefined
- * Reduced medical records sample size from 10 charts to 5

The office medical record is an important clinical management tool containing current, complete, organized and detailed information. Reviews of the office medical records are performed systematically to ensure that commonly accepted documentation standards are met with consideration to the members' age, sex, health status, life style, psychosocial status, and personal and family medical histories.

Primary care physicians (PCPs) with 50 or greater Premier Blue members will undergo an office record review (ORR) every 2 years as part of the recertification process. Referral specialists with 75 or more Premier Blue member encounters will also undergo an ORR on alternate years.

Five office medical records are randomly selected from records of members who have had at least one encounter with the PCP or referral specialist. (Up to 5 additional medical records may be selected for diagnosis specific review.)

Each provider's records will be reviewed using criteria consisting of up to 21 quality indicators, depending on the providers medical practice and patient populations. (Please see attachment.) A minimum passing score of 80% is required for each quality indicator with the exception of the diagnosis specific indicators which are not currently scored.

Arrangements for ORR's are made in advance with the provider's office staff by quality improvement review staff. Once a date and time for the review is established, review staff will forward to the provider's office a confirmation letter with a list of the members' records selected for review.

To discuss pertinent findings of the review, an exit interview is scheduled to follow each review. Physicians and staff are strongly encouraged to attend. A review result letter and detailed reports of the review are provided at the time of the exit interview.

All quality indicators with less than 80% are below the minimum acceptable threshold. As a result, the provider is asked to develop and submit a quality improvement plan (QIP), within 30 days, to ensure that each of these indicators will meet the minimum acceptable score in six months when re-reviewed.

Member Satisfaction Survey

- * CAHPS 2.0H to replace individual satisfaction surveys
- * Discontinued the incentive tied to satisfaction surveys

Member Satisfaction data is collected annually through the use of the Consumer Assessment of Health Plan Study (CAHPS 2.0H) Adult and Child Surveys.

These survey instruments are standardized tools used by health plans across the nation and reflect state-of-the-art research about key components of health care quality; about how to elicit, from a broad range of consumers, their experiences with those key components; and about how to report the information in a meaningful manner.

From February through May, 1999, the study will be conducted by an independent survey research firm with a survey administration protocol designed to achieve a 60% response rate.

To assure the validity and credibility of reported data, a self-administered mail survey with telephone follow-up of non-respondents methodology is used. A random sample of 1,240 (adult survey)/685 (child survey) Premier Blue members are selected from the enrolled membership of Premier Blue.

Those members eligible for the survey include current health plan members at the time the sample is drawn by the survey vendor, age 18 and older (adult survey)/age 12 and younger (child survey) as of December 31 of the reporting year, and who have been continuously enrolled in the health plan for the 12 months of the reporting year.

The survey tool contains questions on the following broad range of topics:

- A. Your personal doctor or nurse
- B. Getting health care from a specialist
- C. Calling doctors' offices
- D. Your health care in the last 12 months (includes accessibility)
- E. Your health plan
- F. About you (demographic and health habits information)

Once the targeted completion date of May 10, 1999, is reached, the survey vendor concludes the survey process and begins the task of aggregating and reporting the following results to Premier Blue:

1. Total number of members who satisfied the random sample requirements
2. Demographic characteristics for each member of the sample
3. Member responses to each completed survey questions
4. Aggregate responses for each survey question

Aggregate reports are provided by the Blue Cross and Blue Shield Association so managed care plans may compare their results to other BCBS plans. In addition, survey data is obtained from Quality Compass, a resource which provides comparisons of Premier Blue with their competitors as well as national and regional aggregate results.

Survey results are monitored for improved aggregate trends in the area of provider satisfaction. If negative trends are noted, individual provider surveying is implemented to determine the specific reason(s) for the dissatisfaction.

Following review of those survey results, action plans are established with providers who did not meet the standards to assure improvement in the delivery of quality health care and service to Premier Blue members.

The objective for 1999 is: improve by 3.55 percentage points the rating on Overall Satisfaction with the Plan for the 1998 NCQA/HEDIS survey [1997 National HEDIS result was 56.08 percent (Excellent/Very Good responses)].

Member Accessibility

- * Accessibility monitoring continues through CAHPS 2.0H survey
- * Incentive tied to accessibility discontinued

The ability of members to access their PCP/on-call provider or a referral specialist is of prime importance to Premier Blue. The following standards were established in 1996 to monitor the accessibility of providers.

Emergency Care: See member immediately or direct to nearest contracting provider.

Urgent Care: Schedule an appointment for the member within 24 hours.

Non-Urgent Care: Schedule an appointment for the member within 14 days.

Preventive Care: Schedule an appointment for the member within 90 days.

Obstetrical Prenatal Care: Schedule an appointment for the member within the 1st trimester of pregnancy (subject to member calling by 10th week of pregnancy and applicable only to providers providing obstetrical care).

Waiting Room Time: 30 Minutes

The standards are measured by the Office Site Assessment, trends in member complaints regarding access, and monitoring of after hours access results. In addition, the annual CAHPS 2.0H survey results are monitored for trends in overall member satisfaction with access.

Member Dismissals

All requests for member dismissal must be forwarded to your Professional Relations Representative for review and approval by the Premier Blue Intercept Committee prior to proceeding with dismissal.

For questions on the Intercept process, consult your Premier Blue Administrative Manual or Premier Blue Professional Policies and Procedures.

Member Rights and Responsibilities

* The focus of member rights and responsibilities continues with no changes

The Member Rights & Responsibilities document, as follows, is to convey to members their rights when seeking health care from their provider and responsibilities as active participants in their health care. The Member Rights & Responsibilities document is distributed with the Premier Blue contract, in the Premier Blue Handbook, the provider policy memos, and the provider administrative manuals.

Member's Rights & Responsibilities

It is the responsibility of Premier Blue and its contracting providers to treat you and/or members of your family in a manner that acknowledges and supports your basic human rights. Premier Blue assumes the role of resolving organizational problems that interfere with exercising your stated rights and responsibilities.

The extent to which these rights and responsibilities are enforceable by the member or Premier Blue is governed solely by the Premier Blue contract. These rights and responsibilities are detailed below.

1. You have the right to considerate and courteous care, with respect for personal privacy and dignity.

You have the responsibility to treat all Premier Blue personnel respectfully and courteously as partners in good health care.

2. You have the right to select your own personal primary care physician (PCP) from the list of contracting PCP's of Premier Blue. However, if your first selection is not satisfactory, you have the right to choose a different PCP.

You have the responsibility to select a PCP and to communicate openly with that PCP. You have the responsibility to develop a physician-patient relationship based on trust and cooperation. You are expected to coordinate all your care with your PCP. This continuity strengthens the positive relationship between you and your physician and enables your PCP to develop a better understanding of your needs.

3. You have the right to expect your PCP's health care team to provide or arrange for all medically necessary care, except for care not requiring PCP authorization.

You have the responsibility to seek and obtain referrals from your PCP for services received only from Premier Blue contracting professionals. Exceptions apply only to life-threatening and/or out-of-area emergencies.

4. You have the right to participate in the health care process with the professionals who can help you take charge of your health.

You have the primary responsibility to maintain your health and prevent illness. By using the information Premier Blue provides, and by making positive health choices and seeking appropriate care when it is needed, you will be taking charge of your health.

5. You have the right to receive enough information to enable you to make a thoughtful decision before you receive any recommended treatment.

You have the responsibility to ask questions and make certain that you understand the explanations and instructions you are given.

6. You have the right to refuse to participate in experimental research.

You have the responsibility to advise your PCP and/or Premier Blue when any experimental treatment is being recommended against your wishes.

7. You have the right to be informed of your diagnosis and treatment plan in terms that you understand and to participate in decisions involving your medical care.

You have the responsibility to consider the potential consequences if you refuse to comply with treatment plans or recommendations.

8. You have the right to reasonable access to appropriate medical services.

You have the responsibility to keep scheduled appointments or to give adequate notice of delay or cancellation and to notify Premier Blue if you are unable to access appropriate medical services.

9. You have the right to a candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage. You have the right to receive the benefits of your Premier Blue membership and to be informed of available services, as well as where, when, and how you can obtain these services.

You have the responsibility to read all Premier Blue materials carefully and immediately upon your enrollment and to ask questions when necessary. You have the responsibility to follow the rules of your Premier Blue membership.

10. You have the right to receive assistance when language barriers exist between you or a member of your family and a provider of approved services.

You have the responsibility to advise your PCP and/or Premier Blue when you require assistance, to allow for adequate communication between you or your family member and a provider. Premier Blue will assist in making the appropriate arrangements.

11. You have the right for your health records to be kept confidential except when disclosure is required by law or by Premier Blue. With adequate notice, you have the right to review your medical record with your PCP.

You have the responsibility to help maintain accurate and current medical records by being honest and complete when providing information to health care professionals.

12. You have the right to express a complaint and to receive an answer to the complaint within a reasonable period of time.

You have the responsibility to express your opinions, concerns, or complaints in a constructive manner to the appropriate people at Premier Blue.

Member Concerns and Complaints

- * Member concerns and complaints processes continue
- * Incentive tied to member concerns and complaints discontinued

Premier Blue recognizes that, from time to time, members may encounter situations where the performance of the HMO or the participating Premier Blue provider does not meet their expectations.

Therefore, the member has the right to direct an inquiry, by telephone, in writing or in person, to Premier Blue management. It is the policy of Premier Blue to promptly and fairly consider all inquiries of its members.

Premier Blue monitors the number and type of complaints made by members and tracks trends and patterns of complaints regarding providers.

The Concerns & Complaints Committee meets on a weekly basis to review members' inquiries. A provider may be contacted for additional information, such as medical records, to assist in resolving the matter.

Following receipt of all the necessary information, a thorough review is conducted and a determination made. When the outcome of the case affects a provider, a representative will inform him/her of the determination.

If a member remains dissatisfied, he/she may request a formal grievance hearing, to which the provider may be asked to attend.

Health Management Programs

- * New name for Diabetes Disease Management Program
- * Implemented goals for 1999
- * Assigned new code for diabetic retinal eye exams

Since its implementation in June, 1998, Premier Blue has received 38 referrals to the Health Care Management Program, a comprehensive approach to managing diabetes through early education and intervention.

Developed by a team of Premier Blue providers and staff, pharmaceutical companies and other Kansas-based resources, the program is designed to assist providers in effectively managing the care of members who have been recently diagnosed.

The Health Management Program includes guidelines for educating patients and providers about effective diabetes management based on the American Diabetes Association national guidelines. The guidelines have been included with this newsletter for the provider's reference.

Physicians are encouraged to refer members with diabetes to a contracting American Diabetes Association recognized education center or contracting Certified Diabetic Educator where members will receive free glucose monitors. The glucose monitors will be specially selected for the member with assistance from a certified diabetes educator with respect to the individual's needs.

Members also receive a packet of material, including the book *Managing Your Diabetes* and a Premier Blue Maintenance Card, which is a reference for the member to carry in his/her wallet/purse.

As a follow-up, the Premier Blue Medical Review Case Managers contact the recently diagnosed members to answer any questions.

The Medical Review Case Managers are also available to assist physicians with members whose diabetes is not well controlled. The case managers may be contacted at 1-800-641-0972 in Wichita, or 1-800-782-4437 state-wide.

Premier Blue members who have been previously diagnosed with diabetes are being identified through a new claims service detection system. Through the Health Management Program, they also receive general information regarding balanced diet, physical activity and other preventive measures.

For additional Health Management Program information, please contact your Professional Relations Representative.

Currently, Premier Blue is working to develop a similar program for asthma management. Its implementation is expected to be completed in early 1999.

Through effective management of the disease, we can help people stay healthier and delay or even prevent severe, costly complications.