

# Section 9: Medical Management and Quality Improvement and Accreditation

**MEDICAL MANAGEMENT PLAN .....177**

Mission..... 177

Goals ..... 177

Authority ..... 178

Structure..... 178

Scope..... 184

**QUALITY IMPROVEMENT PLAN.....194**

Purpose..... 194

Goals and Objectives ..... 195

Scope of Program..... 197

Clinical Programs..... 198

Service Initiatives..... 199

Coordinated Activities ..... 200

QI Program Structure..... 201

# Medical Management Plan

The 2008 Medical Management Plan provides a definition of authority and accountability for medical management activities within the Health Plan, articulates the scope and content of the Medical Management program, identifies the roles and responsibilities of individuals involved, and outlines the program evaluation process. The Health Plan's Medical Management plan is as follows:

The Geisinger Health Plan/Geisinger Indemnity Insurance Company/Geisinger Quality Options (GHP/GIIC/GQO) Medical Management Plan is structured to encompass all product lines including, but not limited to, Commercial HMO/POS, Gatekeeper PPO and Medicare product lines.

## Philosophy

It is GHP/GIIC/GQO's philosophy to assure the Medical Management Department is structured to manage the use of resources, and to maximize the effectiveness of care and services provided to Members. The Medical Management Department functions are described below.

## Mission

- To respect all Members and strive to respond appropriately to Members' care and service needs.
- To improve the health and quality of life of Members by offering quality, well-coordinated health care education and services.
- To measure, evaluate report and implement interventions that improve the health status of Members.
- To facilitate the delivery of quality care to Members in the most cost efficient manner utilizing the appropriate level of care to meet the clinical need.
- To facilitate the Member Appeal, Complaint, and Grievance process in the most cost efficient manner, when needed.

## Goals

**The overall goal of the Medical Management Plan is to assure that covered health care services are accessible, medically appropriate and cost effective.**

## Objectives include:

- To identify processes appropriate for medical management review in order to promote improvement in care delivery.
- To communicate to Providers and Members topics related to optimum use of services.
- To serve as a resource for analysis of reports of the medical management experiences, share with Providers and develop appropriate action plans.
- To encourage a "process improvement" philosophy when addressing medical management issues.
- To conduct an annual review/revision/evaluation of the Medical Management Plan, policies /procedures, and criteria.
- Evaluate new technologies and implement medical policies that reflect current medical practices

- To assure medical appropriateness is the basis for Medical Management (MM) decision- making and to assure financial incentives do not impact denials of coverage or service.
- To provide appropriate, consistent and timely MM decisions using evidenced-based medical criteria and Member benefits.
- To promote the use of mechanisms that assesses consistent adjudication of denials and appeals across all MM decision-makers.
- To assure reasonable access to covered care and service for Members throughout the network.
- To facilitate exchange of information between Medical Management, Case Management, Appeals, Medical Claims Research and Quality Improvement (QI) functions to facilitate process improvement, continuity of care, proactive services, and issue resolution.
- To analyze results of the Provider Satisfaction Survey related to Medical Management functions, identify areas of improvement, and develop any appropriate action plans.
- Comply with all state, federal and accreditation agency requirements.

## **Authority**

Medical Management personnel have the authority to review the medical record of any Geisinger Health Plan Member; to discuss findings with the physician or other providers, and to initiate appropriate actions as directed by the Vice President, Chief Medical Officer or his designee (VP Health Services, Medical Directors/Health Services, and Regional Medical Directors). This authority is documented in the GHP Subscription Certificate.

GHP has the authority to delegate MM activities to another agency. Should the Plan exercise that authority, the Medical Management Department will be responsible to assure the delegated agency is in compliance with the Plan's policies, and all applicable regulations/standards.

## **Structure**

### **1. Key Staff Responsibilities and Activities:**

- A. The Vice President, Chief Medical Officer and Vice President of Health Services hold administrative responsibility for the Health Services Department and are involved in program implementation.
  - \* *The Vice President, Chief Medical Officer* is the designated physician for providing clinical leadership in the development, implementation, oversight, continuous improvement and effectiveness of the Medical Management programs. The VP, Chief Medical Officer reports to the Board of Directors, chairs the Medical Management Administrative committee (MMAC) and serves on the Pharmacy and Therapeutics committee, and the Technology Assessment committee among others.
  - \* *The Vice President, Health Services* is the Administrator in charge of overseeing all medical management department operations. The VP, Health Services reports to the CMO and serves on MMAC and a multitude of other committees.

- B. *The Medical Directors/Health Services and Regional Medical Directors* of the Geisinger Health Plan serve as the designees for the CMO for decisions based on medical appropriateness, authorization of Referral to out of network providers, and dialogue with providers related to services and the appeal of MM denials.
- \* *Medical Director/Health Services/Medical Informatics* - Licensed physician responsible for management of day-to-day operations within the Medical Management area related to inpatient and out patient care. Works closely with the VP Health Services and reports directly to the CMO.
  - \* *Medical Director/Health Services* - Licensed physician responsible for management of day-to-day operations within the Medical Management area related to patient care. Works closely with the VP Health Services and reports directly to the CMO.
  - \* *Medical Director/VP Pharmacy* - Licensed physician designated as the lead medical authority for all Health Plan activities within the North Central Region and takes a leadership role in relationship building within the region. Also responsible for all Pharmacy activities within the Health Plan. Works closely with the VP Health Services and reports directly to the CMO.
  - \* *Medical Director/Health Services/Medical Home* - Licensed physician designated as the medical team leader for all Health Plan activities within the Western Region and takes a leadership role in relationship building within the region. Also responsible for working with the VP, Health Services to champion the Medical Home concept. Works closely with the VP Health Services and reports directly to the CMO.
  - \* *Medical Director/Health Services/Quality and Performance* - Licensed physician designated as the medical team leader for all Health Plan activities within the Eastern Region and takes a leadership role in relationship building within the region. Also responsible for all activity related to quality of care rendered to Health Plan Members and by Participating Providers. Works closely with the VP Health Services and reports directly to the CMO.

All GHP Medical Directors have authority to make MM decisions including denials. All GHP Medical Directors are board-certified physicians engaged in a variety of clinical specialties. The Medical Directors interact on a regular basis with the MM staff in the processes to support MM decision-making. The MM Nursing Staff are licensed in the State of Pennsylvania and are the initial contact for MM decision-making; however, this staff does not issue denials on the basis of medical necessity. All Medical Directors report directly to the CMO.

- C. *Behavioral Health Practitioner*: The Regional Medical Director and Regional QI Director of the behavioral health delegated entity; United Behavioral Health, UBH, (or their designee) is responsible for implementing the behavioral health aspects of the MM and QI Programs (in cooperation with the Health Plan VP, Chief Medical Officer). The UBH Medical Director works closely with the Health Plan CMO and the Medical Director/Health Services for overseeing and implementing programs related to Behavioral Health. The Regional Medical Director of UBH participates in both the Behavioral Health oversight committee and the Quality Improvement committee.
- D. *Medical Management Nursing Staff*: The nursing staff within the Medical Management area include: Benefit Nurse Coordinators (BNC), Medical Management nurses (MMN) and Case/Care Managers (SNF). All nursing staff are licensed nurses (LPN or RN) who have the ability to approve requests based on specified criteria. All nurses report to a MM Nurse Manager who is an RN, the Director of MM who is also an RN and to the Vice President, Health Services.
- E. *Case Management Nursing Staff*: The nursing staff including Care Coordination and Medical Home Case Managers, who provide disease management and coordination of care services.

## 2. Committee Structure

The following describes the Medical Management Administrative Committee reporting structure and responsibilities:

- A. Medical Management Administrative Committee (MMAC) meets monthly.
1. *Role*  
The MMAC is responsible for functioning as the oversight committee for the Medical Management process and activities. This committee receives and makes recommendations on information and reports received from the subcommittees.
  2. *Committee/Chairman*  
Geisinger Health Plan Vice President, Chief Medical Officer.  
Committee is comprised of Medical Directors, Administrative staff, Medical Management, Care Coordination, Pharmacy, Accreditation, Appeals, QI and Provider Network Management etc.
  3. *Reports to Geisinger Health Plan Quality Improvement Committee through the Vice President of Health Services at least semi-annually.*
  4. *Responsibilities*
    - Review/approval of the Medical Management Plan and Evaluation.
    - Review/approval of MM criteria.
    - Review/approval of Medical Policies.

- Oversight of Pharmacy & Therapeutics Committee and their activities.
- Oversight of Physician Advisory Group and their activities.
- Oversight of Technology Assessment Committee and their activities.
- Oversight of The Behavioral Health Oversight Committee and their activities related to Medical Management.
- Oversight of the Medical Management Committee and their activities.
- Oversight of the MM portion of the Provider/Member Satisfaction Surveys.
- At least semi-annual report to the GHP Quality Improvement Committee
- Oversight of any delegated MM activity
- Technology Assessment Committee reports related to approvals and denials.
- Oversight of the MM portion of the CAHPS Survey.

5. *Subcommittees of MMAC*

a. **The Medical Management Committee (MMC) meets bi-weekly.**

1. *Role*

- The MMC is responsible for coordinating operational activities throughout the Health Services department along with operational policy review/approval. MMC is also responsible for an initial review of medical policies and clinical guidelines with recommendations to MMAC.

2. *Chairperson/Committee membership*

- Director of MM  
Committee is comprised of Medical Directors, Pharmacy, Appeals, Medical Management, Care Coordination, and Medical Home etc.

3. *Reports to MMAC*

b. Pharmacy and Therapeutics (P&T) Committee Meets quarterly

1. *Role*

- The P&T committee is responsible for ensuring that procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals. This committee is also responsible for reviewing new pharmaceuticals for possible inclusion in the formulary/medical benefit determinations.

2. *Chairperson/Committee membership*

- Vice President, Chief Medical Officer  
Committee is comprised of Medical Directors, Pharmacy representatives, participating physician representation and Manager of Clinical Guidelines.

As an adjunct to this committee there are several advisory committees from multiple clinical specialty areas who provide expertise related to specific clinical issues.

3. *Reports to MMAC*
- c. Technology Assessment Committee- meets quarterly
1. *Role*
    - Responsible for evaluating new medical technologies and new applications of existing technologies for possible inclusion in the benefit package. This may include medical technologies, behavioral health procedures or other devices. (All new pharmaceuticals/pharmaceutical procedures will be taken through the P&T committee).
  2. *Chairperson/Committee Membership*
    - GHP Medical Director, Medical Management  
Committee is comprised of up to 17 physicians from multiple specialties, up to 3 lay members and support staff.
  3. *Reports to MMAC*
- d. Behavioral Health Oversight Committee- meets quarterly
1. *Role*
    - Responsible for oversight of the delegated behavioral health services to include, but not limited to, review of reporting received from the delegated entity and HEDIS data.
  2. *Chairperson/Committee membership*
    - Medical Director/ Health Services  
Committee is comprised of Administration, PNM, Pharmacy, Accreditation, QI, Medical Management, Care Coordination along with multiple representatives from the behavioral health vendor, United Behavioral Health.
  3. *Reports to MMAC and then QIC*
- e. Physician Advisory Group (Meets electronically on an ad hoc basis)
1. *Role*
    - Responsible for providing input related to clinical, service, administrative or regulatory issues.
  2. *Chairperson/committee membership*
    - One of the GHP Medical Directors or any GHP employed designee of the Medical Director  
Committee composition includes 5-10 multi-specialty physicians.

### *3. Reports to MMC and then MMAC*

#### **3. Committee Minutes**

- Minutes will be generated for all Medical Management Administrative Committee and Sub-committee meetings, with review and approval by each Committee.
- The minutes will reflect the activity, discussion, analysis and recommendations of the committees as well as follow-up and resolution of prior recommendations.
- The minutes will be dated and signed by the chairperson and the recording secretary.

#### **4. Medical Management Plan/Evaluation**

The Geisinger Health Plan Medical Management Program is designed to provide the structure and processes for continuously monitoring, analyzing and improving the clinical care and services managed through the Health Services Department. At the beginning of each year (and when necessary) the Health Services Department reviews/revise the Medical Management Plan. The Medical Management Plan defines the mission, goals, structure and scope of the Medical Management, Care Coordination, Medical Home and Appeal Departments. The Plan also outlines the committee reporting structure.

An evaluation is conducted annually by the Health Services Department and impacts the forthcoming MM plan. The annual evaluation serves to evaluate the impact of the Medical Management Program. This document describes the activities conducted by the Medical Management Department under the direction of the MMAC and evaluates (by tracking and trending) the effectiveness of these activities. The impact of the program with respect to delivery of services is monitored and evaluated through the following:

- MM Data Reporting
- CAHPS Survey
- HEDIS
- Physician Satisfaction Surveys

The Medical Management Plan and the Medical Management Annual Evaluation are reviewed and approved by the Medical Management Administrative committee, then the Quality Improvement committee.

#### **5. MM/QI Program Integration**

The Medical Management Department plays a vital role in the Quality Improvement Process. The MMAC Committee comprised of Senior Medical Management personnel oversees Medical Management processes and reports directly to the Quality Improvement Committee. The flow of information between departments goes in both directions. Opportunities identified in either area may be shared through multiple methods such as committee meetings and face-to-face interactions and may be the basis of development of a QI activity or change to a MM procedure.

## **6. Behavioral Health Aspects of the MM Program**

Management of behavioral health care is conducted by United Behavioral Health for Health Plan Members. The UBH Regional Medical Director for the St. Louis Care Advocacy Center (CAC) is the designated behavioral health practitioner responsible for providing clinical leadership to the Quality Management Program within the CAC. As such the UBH Regional Medical Director is also responsible for providing clinical leadership to the Health Plan related to all behavioral health activities. More details (including triage/referral/levels of care) are described in the UBH MM program description.

## **7. Appeal Procedures for Adverse Determinations**

The Plan has a formal process for appeals and grievances to meet the standards/requirements of regulatory and accrediting bodies. Policies and procedures have been developed for Member and Provider appeals processes and are managed by the Appeals Department for Member appeals and through the MM department for the Provider appeals. More specific details are described in the associated policies.

## **8. Delegation of MM**

The Health Plan is accountable for the decisions of any entity to whom a specific MM activity is delegated. Oversight activities include a pre-delegation assessment of the delegate's ability to perform the delegated activities, an annual review of the delegate's performance, review and approval of delegate's MM program description and annual evaluation and review of quarterly reports from the delegated entity to assess the impact of activities on quality and delivery of health care to Members.

### **Scope**

The Plan's Medical Management decision process will be supported by evidence-based criteria in order to assure decisions are made in a fair, impartial, and consistent manner.

Review and selection of MM criteria will be the responsibility of the MMAC, with recommendations from the Medical Directors, PAG, MMC and MM nursing staff. The criteria will serve as a guideline, with opportunity for the Medical Director to consider all the factors in a case and determine the decision.

Evidence-based clinical criteria used to support MM decisions will be managed through MMAC using the following process:

- Criteria adoption or revisions will be supported by appropriate clinical evidence.
- Criteria are made available for input from the PAG.
- After review of all input, the MMAC will record their formal vote on acceptance of the criteria;

- The MM Department maintains a policy/procedure to define application of the criteria using clinical and psychosocial information on a given case, including specifics of the local delivery system;
- Criteria will be revised as necessary and reviewed no less than annually;
- Inter-rater reliability testing will be performed and documented at least annually for all nursing and physician staff involved in the application of the criteria; and
- The provider guide will direct as to how a participating practitioner can avail themselves of the criteria, as defined by an existing vendor copyright.

Data sources which may be used during the decision making process include but are not limited to the following:

Clinical Information from the treating physician such as: patient demographics, diagnosis, requested service, clinical findings, pertinent imaging, pertinent lab finding and pertinent treatment/medications.

In addition, individual needs and local delivery system assessments are considered. These may include age, co-morbidities, complications, progress of treatment, psychosocial situations, home environment and availability of appropriate services in the identified Health Plan service area.

Behavioral Health to include Mental Health and Substance abuse is an integral part of the Medical Management Program. This program is managed by United Behavioral Health, an accredited MBHO, as a delegated activity. The Health Plan requires routine reporting, which is reviewed at multiple levels, including Behavioral Health Oversight Committee and also the Quality Improvement Committee. Geisinger Health Plan and United Behavioral Health work cooperatively to assure the best possible outcomes for the Member.

## **1. MM Functions**

### **A. Precertification**

Precertification of non-emergency facility admissions must be initiated by the admitting physician or facility through telephone or fax contact with the Medical Management staff at the Plan. The Medical Management staff utilize InterQual® SI/IS clinical guidelines, as a basis for determinations, according to the clinical detail presented to them. The Medical Management Staff will utilize the InterQual® SI/IS guidelines to determine the following:

- Medical Necessity of the requested care
- Appropriateness of the service, location and level of care
- Appropriateness of the length of stay
- Assignment of the next anticipated review

Cases failing the InterQual® SI/IS guidelines or not meeting GHP Medical Policy, in the judgment of the nurse, are referred to a GHP Medical Director for final decision. Discussion with the requesting physician and/or an appropriate licensed specialty physician may be included in the decision making process.

Precertification provides an opportunity to intervene when any of the following are identified:

- Potential inappropriate health care services and admissions
- Complex cases appropriate for Case Management
- Discharge planning needs
- Potential quality of care issues
- Members who would benefit from Disease Management Programs.
- Clarification of par provider's availability to provide the service.

Providers are instructed to utilize their GHP Provider Guide to assist them with the pre-certification process.

Timelines for decision making are as follows:

- Pre service non-urgent (HMO, PPO)—within 15 days of receipt of the request
- Pre service urgent (HMO, PPO)—within 72 hours of receipt of the request
- Pre service non-urgent (Medicare)—within 14 calendar days of receipt of the request
- Pre service urgent (Medicare)—within 72 hours of receipt of the request

The Health Plan has a delegated Outpatient Radiology Prior Authorization Program for certain outpatient radiology services that is managed by National Imaging Associates (NIA). Prior Authorization is required for non-emergent outpatient CT scans, MRI, MRA, PET scan and/or nuclear cardiology services.

## **B. Concurrent Review**

Concurrent Review of acute, subacute, rehab, and SNF admissions are performed by the MM nurses as initiated by the physician or facility of admission. As with precertification, the Concurrent Review process is supported by InterQual® guidelines and the Plan's Medical Directors. Reviews are conducted by nurses and include the following:

- Evaluation for appropriateness (medical necessity, level of care, length of stay);
- Evaluation and coordination of discharge planning;
- Referral to Case Management or Disease Management programs;
- Referral to Transplant Management Nurses; and
- Identification of potential quality of care issues.

The MM nurses evaluate and participate in discharge planning in conjunction with the facility Medical Management Review nurse, Care Coordination and Medical Home Case Managers to facilitate the transition of the Member from an inpatient setting to a

less acute setting that is more appropriate to the Member's condition and to coordinate efficient management of benefits. The MM nurses refer appropriate facility admissions to Care Coordination and Medical Home for assessment and management.

Timelines for decision making are as follows:

- Concurrent urgent (HMO, PPO)—within 24 hours of receipt of the request

### **C. The Determination of Coverage Process**

The Determination of Coverage (DOC) process is coordinated through a Benefit Nurse Coordinator (BNC) (or Medical Management Nurse (MMN) in the cases of transplantation) in response to pre-service requests from a Member or provider for authorization of coverage. The Plan's Medical Directors are consulted in the DOC process and licensed specialty physician input is incorporated as indicated. Any denial, on the basis of medical necessity, is made by the Medical Director.

Determination of Coverage decisions are made considering these factors (other factors may also be used):

- Member's Benefit Document;
- Member's individual needs;
- The Plan's local delivery system available to the Member; participating/preferred provider's ability to provide service, availability of skilled, sub-acute, and home services and coverage of these services;
- NCQA, CMS, and other state and federal regulations;
- Standards of medical practice;
- The Plan's Medical Policies;
- Articles, literature, and research studies;
- Pertinent clinical information from other providers involved in the Member's care; and
- Recommendations from the Geisinger Technology Assessment Committee.

If coverage for the request does not require a medical necessity determination because it is addressed as a specific exclusion within the Member's Benefit Document, the BNC or MMN will generate a notice to the Member identifying the specific contract exclusion.

Timelines for pre-service determinations are noted in this Section.

The BNC or MMN nurses coordinate a Member's care needs with both participating and non-Participating Providers in order to assure continuity of care and optimal outcomes. These nurses work closely with Care Coordination in the management of cases requiring both benefit and care coordination services. The MMNs and Medical Home nurses also work in cooperation with the Transplant Management vendor.

A list of services/procedures requiring determination of coverage is maintained by the MM department and is available to providers in their Provider guide.

## **D. Retrospective Review**

Retrospective Reviews are reviews conducted after services have been provided to the Member. Retrospective review includes a medical necessity evaluation of the care/service provided to the Member, and physician compliance with the MM program requirements. Retrospective review includes consideration of medical criteria, Member benefit information, administrative guidelines, and national coding guidelines. The individual needs of the Member as well as local delivery system availability are considered. Retrospective reviews and reconsideration of medical claims denied through claim edit or claim review processes are performed by a Medical Claims Research Coordinator. These reconsideration decisions are based on medical documentation, CPT and ICD-9 coding principles, government regulations, and current contracts along with the aforementioned criteria. The Plan's Medical Directors are consulted for medical necessity evaluation.

Timelines for decision making are as follows:

- Post service (HMO, PPO)—within 30 days of receipt of the request

## **E. Out of Network Management**

A MMN follows the care of Members admitted to a non-participating facility for emergency care. When the clinical case supports the ability of the Member to be safely transported, retrieval to a participating facility may be offered. The MMN in cooperation with the GHP Medical Director and/or triage physician at the Emergency Department of Geisinger Medical Center, Danville, coordinate this transport.

## **F. Transplant Services**

The MMN provides coordination of benefits and case management to Members approved or considered for organ and bone marrow transplantation. The GHP Medical Director oversees the transplant process and has ultimate responsibility for any decisions based on Medical Necessity. These decisions are based on the criteria noted as described in the scope section of this document.

## **G. Discharge Planning**

Health Services nursing staff evaluate and coordinate health services and care to encourage the transition of the patient from an inpatient setting to a less acute setting which is more appropriate to the patient's condition. Health Services staff participate in discharge planning to coordinate efficient management of benefits and coordination of services through discharge.

## **H. Case Management Process**

Geisinger Health Plan Benefit Nurse Coordinators provide limited case management activity in relation to requests for certain out-of-network services that are required by Members. Serious and complex medical care needs are referred to Care Coordination and Medical Home case managers for triage into case management/disease management programs.

## **I. Transition of Care**

Members identified as having exhausted a limited benefit are referred to Case Management. These nurses evaluate and assist in transitioning care to any existing alternative resources if available. This is performed through referral to local or state funded agencies, community services and/or other resources.

## **J. Continuity of Care**

The Plan is committed to ensuring the Member's continuity and coordination of care with their provider if the Member is undergoing an active course of treatment for an acute episode of a chronic illness or acute medical condition or if the Member is in the second or third trimester of pregnancy when that provider's participation agreement is discontinued. The Plan is also committed to a new Member's right to continuity and coordination of care if Member's provider is not participating with the Plan. Certain conditions must be satisfied prior to continuity being approved. These conditions are described in the established Health Plan policy. These conditions are designed to meet the needs of the Member while meeting the requirements of all external regulatory and accrediting bodies.

## **K. Emergency Services Management**

Geisinger Health Plan currently does not deny emergency service claims. All emergency service claims are adjudicated for payment without review for coverage determination.

## **L. On-site Review Process**

On-site review services may be conducted at participating facilities throughout the service areas. Functions include concurrent and retrospective review when applicable. Guidelines have been established for identification of GHP MM staff at the facility, a process for scheduling the review in advance and a process for ensuring GHP staff follow facility rules. This process is described in more detail in the policy.

## **M. Medical Policy/Technology Assessment**

Geisinger Health Plan has a formal mechanism to evaluate and address new developments in technology and new applications of existing technologies for consideration of inclusion in the benefit package. This evaluation is conducted in an effort to keep pace with changes in services which may be available to our membership. This program ensures Members have equitable access to safe and effective care. The four elements to be evaluated include:

- Medical Technologies
- Behavioral Health Procedures
- Pharmaceuticals
- Devices

The Medical Policy Manager utilizes resources such as (but not limited to) Geisinger Health Plan Technology Assessment Committee, Hayes Inc. and ECRI Technology Assessment resources, current professional literature reviews, Geisinger Health Plan Medical Directors, pharmacists, and physician consultants/experts. These policies direct informed decisions about medical care within the benefit structure. Once developed, Medical Policies are reviewed and approved by the MMAC. Final approval by the Vice President, Chief Medical Officer is required.

New pharmaceuticals are evaluated through the Pharmacy and Therapeutics committee, using specific criteria.

## **N. Disease/Case Management Program**

### **1. Disease Management**

Please note: 1). Disease/Case Management programs overlap with quality and medical management. The specific DM programs are described in more detail in the QI plan. 2). Care Coordination and Medical Home are the Health Plan departments responsible for the coordination and delivery of disease/case management services.

Disease Management is defined as the application and coordination of resources for a population of Members characterized by the presence of a chronic condition (such as diabetes, asthma, or heart failure). Resources are applied across the continuum of care and through the life cycle of disease to achieve optimum levels of wellness. The key words in disease management are “population” and “chronic illness.”

The goal of The Plan’s Disease Management Program is to promote quality health outcomes relying on Case Managers working in concert with the patient, family, provider and other members of the health care team.

The Disease Management Programs are established utilizing evidence-based Clinical Guidelines (developed from nationally accepted best practice parameters, specialty and practitioner input), Stratification and Assessment Guidelines, and internally developed Intervention Pathways. Members are eligible to receive education by Case Managers to improve self-management skills and individualized support for optimal health outcomes.

The goals of the Disease Management Programs are to:

- Improve self-management skills of Members;
- Provide quality healthcare;
- Enhance wellness;
- Coordinate appropriate utilization of services; and
- Facilitate and coordinate appropriate inpatient and emergency room utilization, as indicated.

Disease Management Programs involve voluntary participation from the Member. The Health Plan encourages active Member participation in Disease Management through direct mailings, Newsletters (*Member Updates*) and direct communication with Practitioner and Member.

Current Disease Management Programs include:

- Diabetes Care Program---NCQA accredited
- Adult and Pediatric Asthma Care Program—NCQA accredited
- Tobacco Cessation Program
- Osteoporosis Prevention and Management Program—NCQA accredited
- Hypertension Program—NCQA accredited
- Chronic Obstructive Pulmonary Disease (COPD)—NCQA accredited
- Heart Failure (HF)—NCQA accredited
- Coronary Artery Disease (CAD)—NCQA accredited
- Chronic Kidney Disease (CKD)----NCQA accredited

## 2. Complex Case Management

Complex Case Management is the coordination of care and services for Members with multiple or complex conditions. Case Management is a collaborative process of assessment, planning, implementation, coordination, monitoring, evaluation and advocacy for options and services to meet Member's health care needs and to promote appropriate, cost-effective outcomes.

The goals of Case Management include the following:

- To assess Member/family needs and provide access to needed services;
- To coordinate care based on a strong understanding of Member's benefit (in cooperation with MM Benefit Nurse Coordinators);

- To develop a plan of care that addresses the specific care needs relevant to the Member and to implement delivery of Case Management services in a timely fashion;
- To involve the Member/family in the formulation of the Case Management plan of care and in the decision making process;
- To focus on continuity of care, minimize care fragmentation and provide a smooth transition between providers and levels of care, especially in the areas of medication reconciliation and coordination of services;
- To maximize the appropriate, efficient, and cost effective utilization of available resources.

#### A. Nursing Staff

The majority of Case Managers are Registered Nurses licensed in the state of Pennsylvania who provide support services, education, and coordination of care for serious and complex medical cases. The Case Management Program is provided directly to the Member at the practitioner's office at owned or contracted primary care sites and/or telephonically.

The Care Coordination and Medical Home staff seeks guidance when managing complicated cases by contacting the on-call Medical Director and working directly with the Member's primary/specialty care provider.

## 2. Ensuring Appropriate Utilization

Geisinger Health Plan facilitates the delivery of appropriate care and monitors the impact of the medical management program. This process is designed to assist in detecting potential under/over utilization of services. The review consists of examining utilization data against established thresholds and taking appropriate action on identified opportunities for improvement.

Over/under utilization is monitored for the GOLD population using the following HEDIS metrics.

- Inpatient days/1000
- ALOS
- Outpatient visits/1000
- Mental health ALOS

Thresholds are based on the Medicare HEDIS Means, Percentiles and Ratios report, using the 90th and 10th percentiles.

The affirmative statement regarding the MM Decision Making process is distributed to practitioners, providers, employees and Members. The statement notes:

- MM decision making is based on (1) the medical necessity and the appropriateness of care and services and (2) the Member's individual

circumstances and the applicable contract language contained within the Member's Benefit Document concerning covered services and exclusions.

- The Health Plan does not specifically reward practitioners or other individuals conducting medical management review for issuing approvals or denials of coverage or services.
- The Health Plan does not offer incentives for MM decision makers that encourage decisions that might result in under utilization.

### **3. Related Medical Management Functions**

#### **A. Drug Utilization Review**

Drug Utilization Review (DUR) will be managed through the Plan's Pharmacy Department, utilizing the processes and timeframes designated by the PA Department of Health, PA Department of Insurance, NCQA, DOL, and CMS. DUR will include precertification, retrospective review, provider profiling, formulary management, and formulary design. The Medical Directors are consulted for medical necessity issues and denials. Application of new drugs, as well as formulary status decisions will be determined by the Pharmacy and Therapeutics Committee, and then reported to the MMAC.

#### **B. Tel-A-Nurse**

Support to Members for medical information and advice on a 24/7 basis is provided through the Tel-A-Nurse program. This program is available to all Members through a toll free telephone number.

#### **C. DME, Home Health and Outpatient Rehab Services**

Management of services for DME, Home Health, and Outpatient Rehab is directed through the Medical Management Committee.

#### **D. Provider Satisfaction Survey**

Provider Satisfaction Survey is utilized by the Plan to survey Participating Providers and office managers in order to determine areas of strength and to identify opportunities for improvement. Medical Management processes are included in this survey. This survey is conducted on a yearly basis and the results are reviewed at MMC. The results are compared to those from the year before and an action plan is presented to MMAC.

#### **E. Member Satisfaction Survey**

Member Satisfaction is measured in several ways. These methods include CAHPS Survey (annual) and various focused medical management member/staff interaction

surveys (on-going) and post discharge surveys (on-going). These surveys evaluate Member satisfaction with the medical management process. The results are presented to the MMAC committee.

#### F. Notification of Review Determinations

The MM staff provides telephonic and/or written notification of benefit determinations for precertification, Concurrent Review and retrospective review. Communication and documentation of the denial are provided to both practitioner and Member as designated by the applicable regulatory bodies.

Written notification of adverse determinations (denials) include the following:

- Principle reason(s) in easily understandable language
- Reference to the benefit provision, guideline, protocol etc, which support the denial
- Clinical rationale
- Explanation of the Appeal/Grievance/Complaint procedure
- Availability of the benefit provision, guideline, protocol, etc. that was used.

#### G. Confidentiality

To ensure Member and practitioner confidentiality, staff training begins during the Medical Management orientation program. Only confidential information required for the purpose of performing Medical Management processes is collected. Access to this information is limited to those employees who have a need to know and/or those employees who have authority to receive such information. On-line confidential information is password protected. This process adheres to the Geisinger Health Plan confidentiality policy.

Medical Management employees sign a confidentiality statement on an annual basis.

#### H. Hours of Operation

Medical Management regular hours of business are Monday through Friday from 8:00 a.m. to 5:00 p.m. Medical Directors are on duty or on call 24 hours a day, seven days a week to be available for the decision processes regarding the care of the Plan's Members. This process is outlined in the MM Communications Guidelines Policy.

## Quality Improvement Plan

### Purpose

The Geisinger Health System mission is to enhance the quality of life through an integrated health service organization based on balanced patient care, education, research and community

service. Geisinger Health Plan/Geisinger Indemnity Insurance Company/Geisinger Quality Options (“Health Plan”) supports the overall mission of Geisinger Health System. The Health Plan Quality Improvement Program provides the structure and processes for continuously monitoring, analyzing, and improving the clinical care and services provided under Health Plan products in order to further that mission. The Health Plan’s Quality Improvement plan is as follows.

The Health Plan Quality Improvement program is structured to support all product lines including, but not limited to, Commercial HMO/POS and Gatekeeper PPO. Medicare product lines are described in a separate document.

## **Goals and Objectives**

The following goals and objectives of the QI program (not in any specific order) function to support the concepts of continuous quality improvement.

### **A. To promote optimum health care in a managed care environment.**

1. To conduct quality improvement activities to improve the quality of clinical care and services provided to Members.
2. To identify, through data collection and analysis, provider practice patterns, operational procedures, and other activities where improvement will enhance the quality or efficiency of health care.
3. To conduct the quality improvement program based on identification of activities through methods including, but not limited to, demographic analysis, Member feedback, and provider feedback.
4. To prioritize quality improvement activities based on high-volume, high-risk analysis.
5. To implement strong interventions for those activities identified as opportunities for improvement.
6. To conduct analysis of activity results using both a quantitative and barrier analysis methodology.
7. To assess effectiveness of interventions based on re-measurement and follow-up.
8. To promote efficient delivery of health care by evaluating the utilization of primary and specialty services.
9. To regularly assess the availability, accessibility and continuity/coordination of care provided to Geisinger Health Plan Members.
10. To provide educational opportunities based on quality improvement findings.
11. To continually strive to further integrate quality improvement into operations.
12. To incorporate behavioral health activities into the QI program through workgroup participation, adoption of clinical guidelines and quality improvement studies/activities.

13. To specify policies and procedures specific to QI activities for the Health Plan.

**B. To enhance our inter-disciplinary approach in the care of and service to Health Plan patients and/or Members.**

1. To include representatives of the various health care disciplines in the quality improvement process.
2. To involve both contracted and employed practitioners in various aspects of the QI program.
3. To emphasize the importance of a team effort to produce patient satisfaction and continuous quality improvement.
4. To enhance communication among health care team members.
5. To provide input into the organization and content of the Health Plan provider guide.
6. To contribute to the formal orientation of Health Plan providers and practitioners.
7. To involve lay members of the Health Plan in multiple aspects of quality improvement.
8. To assure continuity and coordination of care, including how it relates to Behavioral Health Care and services.
9. To work cooperatively with the delegated entities to promote the highest level of Member care and service.

**C. To assure initial credentialing of all qualified practitioners and providers and subsequent recredentialing of same, in compliance with regulatory requirements.**

**D. To assure the maintenance of quality medical records.**

1. To provide, through the Health Plan provider guide, guidelines for documentation of medical record information.
2. To facilitate evaluation of quality of care and continuity/coordination of care through routine medical record audits and provider site reviews, as defined by GHP policies.

**E. To improve satisfaction of Geisinger Health Plan Members and providers/practitioners.**

1. To obtain Member/provider/practitioner feedback through multiple mechanisms including but not limited to:
  - Focus groups
  - Member concerns/complaints/appeals/grievances

- Member surveys
  - Practitioner/Provider feedback surveys
2. To analyze Member/provider/practitioner satisfaction data from the above sources, identify opportunities for improvement and implement service improvement activities with strong actions and re-measurement as appropriate.
- F. To assure that preventive health services are appropriately provided to Members.**
1. To target for CQI preventive health measures required for HEDIS and NCQA standards, as well as other measures meaningful to the membership.
  2. To educate Members about available health promotion, health education and preventive health services
- G. To improve patient safety.**
1. To educate Members regarding clinical safety as it relates to their care.
  2. To assess and intervene to improve the continuity and coordination of care and safety through monitoring of return communication between PCPs and Specialists.
  3. To monitor physician medical record legibility and documentation to improve safe practices.
  4. To maintain a plan for collecting information relative to provider and practitioner safety and making this information available for Members and practitioners.

## **Scope of Program**

The scope of the quality improvement program is focused on delivering the highest level of quality care and service and to continually enhance Member satisfaction. To this end, the comprehensive program uses a wide variety of data and techniques to monitor, analyze, and evaluate proposed and ongoing improvement activities. Since the inception of the program in 1985, this process has been applied to hundreds of studies, activities, and monitors within the Health Plan. The Accreditation Department develops a separate annual QI Work Plan, which details the schedule of activities and tracks progress on these quality initiatives. An Annual Evaluation is also prepared which documents the effectiveness of the QI program and measures how well it is achieving its goals and objectives.

The QI program identifies clinical issues through review of HEDIS and other clinical data results. The QI program identifies service initiatives through Member satisfaction surveys, complaint and appeal analysis, monitoring system and Health Plan operations.

The scope of the QI program is broadly divided into three areas: Clinical programs, Service Initiatives, and Coordinated Activities. QI activities are described in detail in the annual QI Work Plan.

## **Clinical Programs**

*Preventive Health Program* – The preventive health program is structured to assist physicians in assuring Members receive the preventive services they need. Education of Members and providers occurs through the publication and distribution of recommended age-specific preventive services in newsletters and on the web site. QI specialists use targeted phone calls and surveys to reach out to Members identified as needing services. To ensure the effectiveness of the program, the QI Department measures Member compliance with recommended health services, mainly using HEDIS methodology. Measurement and improvement activities are wide in range. Examples include; cervical and breast cancer screening, childhood and adolescent immunization, influenza immunization, and prenatal care.

*Disease and Complex Case Management* – The Care Coordination Department develops and implements disease and complex case management programs. Nurses with clinical expertise proactively educate, manage and coordinate care for groups of Members with defined chronic conditions. Disease management programs that are ongoing include, but are not limited to: Diabetes, Heart Failure (HF), Chronic Obstructive Pulmonary Disease (COPD), Osteoporosis, Asthma, Coronary Artery Disease (CAD), Chronic Kidney Disease and Hypertension. Program data is reviewed at least quarterly. Programs and/or processes are revised as indicated by data results, clinical guideline revisions, and staff feedback. The need for additional disease management programs is also evaluated on a regular basis. In 2006, eight Disease Management programs were accredited by NCQA: Diabetes, HF, Hypertension, COPD, Osteoporosis, Asthma, CAD and Chronic Kidney Disease. Complex case management includes post-discharge follow-up of Members with targeted conditions and care of Members with multiple conditions.

*Clinical Guidelines* – The Medical Policy/Clinical Guidelines Manager develops, implements, and updates clinical guidelines to assist practitioners and Members in the health care decision-making process. Clinical guidelines include but are not limited to: diabetes, sinusitis, asthma, pediatric otitis media, depression, hyperlipidemia in CAD, UTI, Pediatric ADHD etc. Clinical guidelines are used as the basis for all Health Plan Disease Management programs. The Health Plan systematically assesses performance against several guidelines annually.

*Ongoing Clinical Monitors and Studies* – Based on data analysis and recommendations from the QIC and other related QI committees/work groups, relevant quality initiatives and monitors are identified for inclusion in the QI program. The QI Department is

responsible for the QI processes (quantitative measurements, implementation of interventions, etc.) relating to these initiatives. Mental Health initiatives are coordinated activities utilizing the Mental Health Carve out company, United Behavioral Health (UBH), Geisinger Health Plan Accreditation Department and multiple Health Plan committees. Active initiatives include, but are not limited to the following:

- Antidepressant Medication Management
- Follow-up After A Hospital Admission for Mental Illness—UBH
- Abnormal Pap Smear follow-up
- Breast Cancer Screening
- Cholesterol Management after a cardiac event
- Childhood Immunizations

*Other initiatives that are continuing activities include, but are not limited to:*

- Persistence of Beta Blocker treatment after a heart attack
- Ambulatory Medical Record Review

*Behavioral Health Aspects of QI* – The Health Plan works in conjunction with UBH to monitor and improve behavioral health services to our Members. UBH’s Quality Improvement Council, which is chaired by the Vice President of QI, is responsible for promoting the goals and objectives of UBH’s QI program. Health Plan direction for these activities is provided by the Behavioral Health Oversight committee and the GHP Quality Improvement Committee led by the Health Plan VP, Chief Medical Officer. Activities being conducted include but are not limited to, follow-up after mental health admission, antidepressant medication management, readmissions within 30 days of discharge from inpatient care and initiation and engagement of alcohol and other drug dependence treatment.

*Pharmaceutical Management/Coordination* - The Pharmacy Department maintains a closed formulary that is reviewed at least annually. Coordination is ongoing between pharmacy and QI to identify and conduct relevant QI/Pharmacy studies. One pharmacy related activity is asthma control.

## **Service Initiatives**

*Access and Availability Standards* – Service initiatives include measuring performance against access and availability standards and implementing interventions as appropriate. Access standards have been established by the Health Plan and are monitored on an annual basis. These include access to routine care appointments, urgent care appointments and after hours care. Practitioner availability is also measured on an annual basis. Two standards are used for this measurement; practitioner to Member ratio and geographic distribution of practitioners. These findings are then tied into Provider Network Management recruitment plans, as feasible.

*Member Satisfaction Initiatives* – The QI program uses information including: data from complaints and appeals, Member satisfaction surveys (including CAHPS) and telephone interactions to identify activities for improving Member satisfaction. Ongoing initiatives include monitoring telephone access standards, tracking complaints and appeals, close monitoring of complaint and appeal turnaround times and Member satisfaction survey results analysis. The Service Improvement Committee reviews all of this information separately and in aggregate. Practitioner satisfaction is also assessed through an annual survey. Data is reviewed by the Service Improvement committee along with Member satisfaction data to determine similarities/differences. This aggregate analysis is then used for identification of opportunities for improvement.

*Patient Safety Activities* - Although the Health Plan does not administer direct patient care, the safety of Members is vital. Geisinger Health Plan encourages and promotes safety through monitoring of Member complaints and appeals, Member education, encouraging return communication between practitioners and monitoring medical record legibility and documentation. The Health Plan has developed a patient safety plan that includes monitoring on both the practitioner and provider side.

*Other Service Initiatives* – Service initiatives identified through data analysis, as opportunities for improvement will be moved forward as service activities.

## **Coordinated Activities**

*Over and Under Utilization Monitoring* –Geisinger Health Plan facilitates the delivery of appropriate care and monitors the impact through the Medical Management program. This process is designed to assist in detecting potential under/over utilization of services. Areas of focus are identified by relevancy to the Health Plan population in conjunction with high volume activities. The review consists of examining utilization data and taking appropriate action on identified opportunities for improvement.

*Continuity and Coordination of Care Monitoring* – The Continuity and Coordination of Care workgroup monitors care and services that Members receive across the continuum of care and across the delivery system. Examples include: evaluating the coordination of medical care, taking action to improve the continuity and coordination of care as appropriate, and using medical record audit data to improve practitioner continuity and coordination of care efforts.

*Continuity and Coordination of Behavioral Health Care* – This is monitored through both UBH and the Health Plan’s QI process. Examples include evaluating return communication between primary care and behavioral health care practitioners and assuring follow-up for Members who have been discharged from the hospital after a mental health admission.

*Credentialing and Recredentialing of Practitioners* – The Provider Network Management, Credentialing, Accreditation and QI Departments work closely together to

maintain a seamless process for the credentialing and recredentialing of practitioners. The Health Plan re-credentials on a thirty-six (36) month cycle.

## QI Program Structure

The Geisinger Health Plan QI reporting structure brings together work groups and committees within the network to coordinate QI activities across the continuum of care and across the organizations and facilities that deliver care. The Health Plan Board of Directors (the governing body) designates the Health Plan Quality Improvement Committee as the committee to oversee QI activities. As the governing body, the Board of Directors annually approves the QI Plan, QI Work Plan and Annual Evaluation.

The QI structure consists of one main committee (QIC), a number of subcommittees reporting to the QIC, and a number of work groups reporting to subcommittees. Each committee or group keeps minutes that reflect the activity, discussion, analysis, and recommendations/decisions, as well as, follow-up and resolution of prior recommendations. Minutes are dated and signed by the appropriate individual and available at the next meeting.

*The following describes the QI reporting structure:*

- A. **Quality Improvement Committee (QIC) Meets on a Quarterly Basis.**
1. *Role* –Provides direction and oversight to the Quality Improvement process and activities. It receives and acts on reports from subcommittees and work groups.
  2. *Chairman* – VP, Chief Medical Officer. (The chair is responsible for administrative management of the Plan’s quality improvement activities/program.)
  3. *Membership:*
    - Chair—Vice President, Chief Medical Officer/Rheumatologist
    - President and CEO
    - Manager, Pharmacy Operations
    - Vice President, Medical Operations
    - Appeals Manager
    - Director Quality Improvement/Appeals
    - Director, Care Coordination
    - Director, Medical Management
    - Manager, Provider Credentialing
    - Senior Accreditation Coordinator
    - Accreditation Coordinator
    - Manager, Clinical Guidelines

- Medical Director/VP Pharmacy, Health Plans, North Central Region-Family Practice
- Medical Director, Health Plans, Eastern Region-Family Practice
- Medical Director, Health Plans, Western Region- Family Practice
- Medical Director/ Medical Operations- Pediatrics
- Medical Director, Medical Operations--Pediatrics
- Practitioners (employed/contracted)
- United Behavioral Health representative, as needed
- Lay member for Commercial Line of Business
- Lay member for Medicare Line of Business

4. *Reports to the Health Plan Board of Directors quarterly through the Quality Improvement Committee Chairperson.*

5. *Responsibilities:*

- To establish and approve the Quality Improvement Plan annually.
- To establish and approve the annual Quality Improvement Work Plan.
- To annually review policies and procedures related to QI activities and recommend policy decisions.
- To review and evaluate the results from Quality Improvement activities.
- To review the work and action taken by various Quality Improvement sub-committees and to give advice, direction or recommendations on further action.
- To assist in instituting needed actions, as appropriate.
- To assure follow-up of open items.
- To oversee additional Quality Improvement activities unique to the managed care (Geisinger Health Plan) aspects of care, i.e., appointment access, availability of services, telephone access, HEDIS, clinical guidelines, disease management, care management programs, etc.
- To provide oversight and assure appropriate credentialing activities of practitioners contracted with Geisinger Health Plan.

- To assure practitioner participation in the QI program through committee membership and/or planning, design, implementation or review of activities related to the QI program.
- To review results and approve recommended actions of the Service Improvement Committee based on the Health Plan’s satisfaction surveys and other service data such as complaints and appeals.
- To review reports of quality issues and aggregate data on quality issues and provide oversight to recommended actions of the Medical Directors office or Peer Review Committee as applicable.
- To assure linkages between the various committees and departments of the Plan as they relate to quality activities.
- To assure adequacy of the scope of the QI program and documentation of its effectiveness.
- To assure the Plan has appropriate oversight on any delegated activities.
- To assure a planned annual evaluation of the QI Plan, Work Plan and overall QI program is conducted.

**B. Sub-Committees of QIC**

1. *HEDIS Steering Committee*: Meets monthly. Responsible for taking inventory of all HEDIS initiatives, prioritizing these initiatives and providing direction to the Service Improvement committee and all QI workgroups, on which initiatives to focus on. Chair is the Director of Quality Improvement/Appeals. Committee is comprised of Administrative staff and Medical Directors.
2. *Compliance and Privacy Committee*: Meets monthly. Responsible for coordinating and overseeing the implementation and completion of the Compliance Plan, including reviewing and approving policies and procedures relating to compliance and privacy issues. Chair is the Compliance Coordinator. The Committee is comprised of departmental representation within the Health Plan including legal services, accreditation, medical operations, etc.
3. *Credentialing Committee*: Meets monthly. This committee is responsible for credentialing and recredentialing of physicians for the Health Plan. Chair is the Health Plan's Western Region Medical Director. The Vice President, Chief Medical Officer is Chairman Emeritus and a permanent committee member. The Health Plans Peer Review Committee is a sub-

committee of Credentialing. The Credentialing Committee is comprised of physicians from multiple specialties.

4. *Technology Assessment Committee*: Meets quarterly. Responsible for evaluation of new medical technologies and new uses of existing technologies for inclusion in the benefit package. Chair is Medical Director, Medical Management. Committee is comprised of up to 17 physicians from multiple specialties, up to 3 lay members and support staff.
6. *Service Improvement Committee*: Meets monthly. Responsible for monitoring and analysis of all Plan satisfaction and complaint data with recommendations taken to and from the HEDIS Steering committee. The committee is also responsible for monitoring access and availability data on a routine basis. Chair is Accreditation Coordinator. Committee is comprised of representation from the Operational Reporting team, Quality Improvement reporting, Provider Network Management, Marketing, and Medical Management.
7. *Medical Management Administrative Committee*: Meets monthly. Responsible for functioning as the oversight committee for the Medical Management arena. Chair is Vice President, Chief Medical Officer. Committee is comprised of multiple physicians and Administrative personnel within the Medical Operations, Pharmacy and Provider Network Management departments.
8. *Clinical Guidelines Committee*: Meets bi-monthly. Responsible for overseeing and monitoring clinical guidelines, educating practitioners and Members and ensuring quality medical care to be measured against benchmarks. Chair is Medical Policy/Clinical Guidelines Manager. Committee is comprised of Provider Network Management, Care Coordination, Accreditation, etc.
9. *Minutes*:
  - Will be generated for each meeting and approved by the Committee.
  - Will reflect the activity, discussion, analysis and recommendations of the Committee, as well as, follow-up and resolution of prior recommendations.
  - Will be signed and dated.
10. *Work group structure*:

Work groups are structured to report through the Sub-Committees of the QIC. This provides more direction and oversight of the various activities, which then is reported to the QIC by the sub committees.

## **Quality Improvement and Accreditation Personnel**

*Role – Operational Staff for the Quality Improvement Committee*

### *Vice President, Chief Medical Officer:*

The Vice President, Chief Medical Officer is the senior executive responsible for development, implementation and management of the Plan's Quality Improvement program. The Chief Medical Officer has direct management responsibility for the QI department and the Accreditation department as well as management responsibilities for the Medical Management Program including the MM Staff, Network Management, Health Plan Pharmacy and Care Coordination. The Chief Medical Officer is ultimately responsible for implementation of all aspects of the QI program.

### *Vice President, Medical Operations:*

The Vice President, Medical Operations holds administrative responsibility for the Quality Improvement and Accreditation Departments, in conjunction with the Medical Management and Care Coordination Departments. The VP, Medical Operations reports directly to the Chief Medical Officer to coordinate the vision and direction for all Quality Improvement activities.

### *Behavioral Health Practitioner:*

The Regional Medical Director and Regional QI Director of the behavioral health delegated entity, United Behavioral Health, UBH, (or their designee) are responsible for implementing the behavioral health aspects of the QI Program (in cooperation with the Health Plan VP, Chief Medical Officer). The UBH Medical Director and Regional QI Director work closely with the Health Plan CMO and the Behavioral Health Oversight committee for overseeing and implementing programs related to Behavioral Health.

The Regional Medical Director and Regional QI Director of UBH participate in both the Behavioral Health oversight committee and the Quality Improvement committee.

### *Staff:*

1. *Director of Quality Improvement and Appeals* reports directly to the Vice President Medical Operations; functions to facilitate coordination of activities in order to assure successful

implementation and ongoing evaluation of processes, which support the QI Plan, QI Work Plan and Annual Evaluation. Responsible for staffing and equipment and overall management of the QI and appeals departments. Interfaces with other operational departments to assure appropriate processes that are critical to quality and service measures.

2. *Geisinger Health Plan Quality Improvement Nurse Manager* reports to the Director of QI and is responsible for coordinating and supporting the Health Plan Quality Improvement activities. The activities include, but are not limited to data maintenance, preventive health initiatives, chart reviews, work group participation, and any relevant education (i.e., Preventive Health, HEDIS, Care Coordination) to Members and practitioners. There is feedback on all quality improvement activities at the appropriate levels.
3. *Health Plan Senior Accreditation Coordinator:* The Health Plan Senior Accreditation Coordinator works under the direction of the Vice President, Medical Operations, to assure ongoing compliance with all external regulatory standards. The Senior Accreditation Coordinator has responsibility for education of all departments on an ongoing basis to assure understanding and compliance with applicable standards/regulations.
4. *Health Plan Accreditation Coordinator:* The Health Plan Accreditation Coordinator works under the direction of the Senior Accreditation Coordinator. Is responsible for assisting with ongoing compliance with external regulatory standards and education of departments to assure understanding and compliance with applicable standards/regulations.
5. *Regional QI Nurses (5)*
6. *Quality Improvement Specialists (9)*
7. *QI Service/Data Coordinator*
8. *HEDIS coordinator*

*Support Staff:*

1. *Information Technology staff*
2. *Care Coordination staff*

3. *Clinical and Operational reporting team staff*
4. *MM Department*
5. *Provider Network Representatives*
6. *Credentialing*

*Tasks:*

1. Responsible for all inventory, tracking and follow-up of Health Plans QI activities. To obtain, assess, and act upon Quality Improvement data, including Quality Improvement Committee minutes and Quality Improvement Plans.
2. To assure completion of chart audits and other data gathering activities required by the Quality Improvement Committee.
3. To attend continuing education programs in Quality Improvement to provide expertise to the Quality Improvement Committee.
4. To facilitate Quality Improvement accreditation processes and to meet regulatory agency requirements.
5. To meet standards set for compliance with applicable law.

### **Quality Improvement at Geisinger Health Plan Contracted Facilities**

Geisinger Health Plan contracts with multiple facilities. To assure quality care for our Members, these facilities/providers are assessed and monitored using established criteria prior to the signing of a contract and at least every three years thereafter.

### **Delegated Activities**

The Health Plan has the ability to delegate activities as described within the NCQA standards. Specific criteria must be met for delegation to occur.