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Overview

Mission

The Health Care Service Corporation (HCSC) Mission is “To promote the health and wellness of our members and communities through accessible, cost-effective, quality health care.”

Vision

HCSC Key 2010 Vision Points

HCSC has recently published an update of its long-range strategic plan, 2010 Vision, which BCBSIL has incorporated into its own strategic design. The following are the five key 2010 Vision Points for HCSC:

- Champion the non-investor-owned (NIO) model
- Be responsive to our employee, member and community needs by promoting health and wellness as evidenced by demonstrable and measurable improvements in outcomes (clinical, satisfaction, and financial).
- Provide unrivaled, differentiated customer service for members, providers, employers and producers
- Become an industry leader in providing valuable information to ourselves and our customers
- Achieve significant growth to 20 million members

In 2008, Blue Cross and Blue Shield of *Illinois* (*BCBSIL*) will continue to focus improvement efforts on business areas that are important to our customers in a manner consistent with the HCSC values and goals. The BCBSIL 2008 Quality Improvement (QI) Program and Work Plan link HCSC strategic initiatives and goals with Blue Cross and Blue Shield of *Illinois* (*BCBSIL*) performance improvement activities. The intent is to facilitate the development of corporate and leadership values within *BCBSIL*.

Philosophy

The *BCBSIL* philosophy is to provide products and services of the highest quality and value with a direct focus on meeting the needs of customers.

The *BCBSIL* Quality Improvement program is based on a view that the process for delivery of medical care and services can be continuously improved. Monitoring and evaluation are an integral part of the managed care quality improvement process by revealing opportunities for positive change that can benefit both members and health care practitioners. Through the QI program, we aim to help members achieve optimal benefits by obtaining the most appropriate care in the most appropriate setting.

The 2008 QI Program revisions focus on areas that are important to our customers and are critical to achieving corporate goals in a manner consistent with corporate values. The program integrates fundamental quality management techniques, existing improvement efforts and disciplined use of technical tools for continuous process improvement. Company leadership is the driving force behind our program. It creates and supports employee actions. It actively participates in establishing, achieving and rewarding the completion of quality objectives.

Definition of Quality

The HCSC Quality Improvement Program incorporates the definition of quality as defined by the Institute of Medicine in 1990.

“Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

Program Strategy

Purpose

The purpose of the QI program is to provide the necessary focus and structure to identify, monitor and evaluate clinical and service improvement opportunities. Through the QI Program, the plan measures performance and progress against defined goals. The QI program is a collaboration among physicians, providers, healthcare professionals, employers and plan staff who directly or indirectly influence the delivery of care and service. The QI Program supports HCSC 2010 Vision Point, "Be responsive to our employee, member and community needs by promoting member health and wellness as evidenced by demonstrable and measurable improvements in outcomes."

Scope

The Quality Improvement Program encompasses all clinical care and services provided to BCBSIL members. The scope of the quality improvement process includes a wide range of activities including process and outcomes of clinical care, behavioral health, ancillary services, pharmacy services, vendor services, member services and satisfaction, patient safety and efficient use of resources. The program is comprehensive, ongoing, and includes effective mechanisms to identify, monitor, evaluate, and resolve issues that impact the accessibility, availability, continuity, and quality of care and service provided to our members.

Goals

BCBSIL is committed to improving the value and cost effectiveness of healthcare delivery for employers, employees, and the communities we serve, and thus, have established the following goals:

- To promote the principles and commitment of continuous quality improvement throughout the Plan
- To measure, monitor, and continually improve performance of medical care in key aspects of clinical and service quality for members, physicians, providers, and customers
- To implement a standardized and comprehensive quality improvement program which will address and be responsive to the health needs of the member population
- To develop a comprehensive, meaningful, and soundly executed Quality Improvement strategy
- To demonstrate improved outcomes in medical and behavioral health care and service to members
- To ensure the QI Program is in compliance with and responsive to applicable requirements of Plan sponsors, federal and state regulators, and appropriate certification or accreditation entities
- To increase the knowledge/skill base of Plan staff across functional areas
- To foster a supportive environment that assists physicians and providers to improve the safety of their practice
- To focus continuous quality improvement efforts to those priority areas defined in the annual Work Plan which are aimed at improving member experience, member satisfaction and member health and wellness.

Program Strategy (cont.)

Objectives

The following objectives were designed to assist Plan administration in meeting quality improvement goals:

- Facilitate the achievement of public health goals for disease prevention, wellness and safety
- Identify opportunities to improve the outcomes of medical and behavioral health care and service available to members
- Develop, implement, and monitor action plans to improve medical and behavioral health care, as well as services
- Provide communication with members, physicians, and providers on issues of quality medical care to promote improvements in the health status of members and satisfaction with Plan services
- Strengthen the system of documentation of quality improvement-related information, enabling identification of opportunities and demonstrated effectiveness
- Monitor and improve compliance with accreditation standards and regulatory requirements
- Develop and distribute member information that improves knowledge regarding clinical safety, general wellness and disease prevention as it relates to self care

Continuous Quality Improvement Process

Development - The process for determining performance initiatives for BCBSIL is extensive and involves all divisions and many employees within the company. Continuous Quality Improvement principles are utilized during the process; evaluating data and current performance, selecting new or continued projects, and then prioritizing based on criteria, identifying an accountable individual, establishing timelines, measures and goals. The process of development includes a review of reliable and comparable data for selecting and conducting QI projects. This process occurs annually, unless corporate performance monitoring results identify a need to change plans and focus.

Strategic plans - All QI projects are developed with consideration to the HCSC values and goals.

Quality Improvement Work Plan - At the same time the strategic plan is developed, an analysis of the prior year's QI Work Plan is begun. The QI Work Plan is developed with consideration to the HCSC and plan strategic goals to avoid duplication and to focus efforts and resources to a manageable workload.

The process for determining QI projects for 2007 included an analysis of the following:

- a) 2007 QI Work Plan
- b) HCSC and BCBSIL Strategic Plan and corporate initiatives
- c) HEDIS Results
- d) CAHPS Results
- e) Member complaint data
- f) Provider Satisfaction Survey results
- g) Internal/external audit findings

Implementation

- a) The QI projects and associated interventions are announced prior to final approval to key management staff to obtain additional input.
- b) The managers are responsible for employee communication, and specific QI corporate projects results and goals are shared at all employee meetings.
- c) Formal CQI teams may be formed. Projects and interventions are discussed and monitoring processes put in place.

Monitoring - The QI Plan provides for ongoing monitoring for the projects listed. The monitoring of projects requires discussion at the Quality Committee, and/or within other various appropriate committees or workgroups.

Structure & Resources

Governing Body

Ultimate accountability for the management and improvement of the quality of clinical care and service provided to HCSC members rests with the Board of Directors of Health Care Service Corporation (HCSC). The Emerging Issues Committee (EIC) is a committee of the HCSC Board responsible for assisting the Board in fulfilling its oversight functions related to the Quality Improvement Program for *BCBSIL* members. The EIC has delegated certain responsibilities for management and oversight of the Quality Improvement Program to the *BCBSIL* Quality Improvement Committee (QIC) and the standing subcommittees.

Emerging Issues Committee (EIC)

Purpose

The purpose of the Emerging Issues Committee (the “Committee”) of the Board of Directors (the “Board”) of Health Care Service Corporation, a Mutual Legal Reserve Company (the “Company”) is to identify and analyze emerging issues critical to the Company including its core and non-health subsidiary operations, analyze the competitive landscape and the dynamics of the environment in which the Company operates, analyze strategic partnerships, joint ventures, and collaborations, exercise oversight authority for the Corporation’s managed care Quality Improvement Programs, identify and analyze emerging issues pertaining to providers of health care, and analyze the strategic value and impact of capital utilization. In addition, the Committee shall undertake such other responsibilities as may, from time to time, be delegated by the Board of Directors to the Committee.

Administrative

The Committee will meet at least four times a year and, additionally, hold any special meetings as may be necessary or called by the Chair of the Board, the Chair of the Committee, or at the request of the Chief Executive Officer of the Company. All Committee members are expected to attend each meeting.

Membership

The Emerging Issues Committee is composed of no fewer than three Directors and shall meet such requirements that may, from time to time, be promulgated by the Board. The Chair of the Board shall be an ex-officio non-voting member of the Committee. The Committee Chair shall present to the Board the recommendations of the Committee.

Responsibilities

In addition to such responsibilities, powers and functions as may be assigned to it from time to time by the Board, the Committee’s responsibilities, powers and functions shall include the following:

In regards to emerging issues and strategic plans of both the core and subsidiary business:

- Review and recommend for Board approval the Company’s enterprise-level long-term business objectives and strategic plans as developed by senior management to ensure that such objectives and plans are in alignment with the Company’s mission and vision.
- Provide early identification of unfolding issues and opportunities critical to the Company
- Review emerging issues and opportunities and make any necessary recommendations to the Board and Senior Management.
- Educate the Board in strategic and business areas as identified by Management and the Committee

Structure & Resources (cont.)

Emerging Issues Committee (EIC) – (cont.)

- Prioritize and evaluate enterprise risks, particularly those of an external nature, facing the Corporation and its long-term business plan.
- Specific to non-health subsidiary businesses, review and approve any strategic changes in direction or capabilities that materially change the nature of the business
- Identify and investigate emerging issues regarding technological and other developments which impact providers of health care
- Review and provide guidance regarding the Company's accreditation by third party organizations such as the National Committee for Quality Assurance, the American Accreditation Healthcare Commission/URAC, etc
- Perform periodic review of the Quality Improvement Program in order to determine whether improvements or changes should be recommended; and
- As appropriate, bring emerging issues and opportunities under the jurisdiction of other standing committees to their attention for consideration and resolution.

Committee Structure & Responsibilities

Illinois Affiliate Board

The Illinois Affiliate Board reviews the BCBSIL Quality Improvement Program Description and the annual Quality Improvement Work Plan(s) of the managed care products. The Affiliate Board receives quarterly written reports on the Quality Improvement Work Plan, including actions taken and improvements made.

The Illinois Affiliate Board is comprised of the following members:

- External members (at least 5)
- Chairman of the Board of Directors

Additional staff:

- President and CEO, HCSC
- President, BCBSIL
- Senior Vice President, Health Care Management
- Vice President, CMO, Health Care Management
- Senior Medical Director
- Medical Director, Quality Improvement

Structure & Resources (cont.)

Committee Structure & Responsibilities (cont.)

Managed Care Quality Improvement Committee

The Managed Care Quality Improvement Committee (MCQIC) is responsible for providing oversight and direction to the Quality Improvement Program. The MCQIC is chaired by the QI Medical Director. The MCQIC brings multidivisional staff together with employers, providers and members for the purpose of reflecting customer values. The Senior Medical Director of Blue Cross and Blue Shield of Illinois is responsible for ensuring the Emerging Issues Committee receives the reports from the MCQIC.

Responsibilities of the MCQIC include:

- Review and approval of the annual BCBSIL Managed Care Product Quality Improvement Program Descriptions
- Review and approval of the annual Quality Improvement Work Plans for the Managed Care Products
- Monitoring and analysis of reports on QI activities from subcommittees
- Oversight of delegated activities
- Review and approval of annual Quality Improvement Program Evaluations for the Managed Care Products
- Review and approval of Medical Management Quality Improvement Projects
- Recommendation of policy decisions
- Analysis and evaluation of the results of QI activities
- Ensuring practitioner participation in the QI program through project planning, design, implementation and/or review
- Institution of needed actions
- Ensuring follow-up, as appropriate.

The Managed Care Quality Improvement Committee meets on a monthly basis. Its membership includes:

Subscriber/Employer members (Minimum of 2)
Physicians from BCBSIL Networks (Minimum of 2, including at least 1 behavioral health specialist)
Senior Medical Director
Counsel, Legal Department
Director, HCM Quality & Research
Director(s), Medical Management
Marketing Representative
Senior Manager, Network Management
Manager, HCM Quality & Research
Medical Director, Quality Improvement (Chair)

Additional staff include:

Director of Operations, Medical Management
Senior Manager, Health Services Programs
UM/QI Project Consultant
Medical Director, Consumer Services Management
Senior Manager, Credentialing
Managers, Subscriber Services Division
Accreditation Coordinator, Quality Administration
Assistant Manager, HCM Quality & Research
HCM Quality & Research staff as needed

Structure & Resources (cont.)

Committee Structure & Responsibilities (cont.)

Provider Selection Committee

The BCBSIL Provider Selection Committee (PSC) is responsible for the credentialing process. The PSC reviews and makes recommendations regarding participation in the networks to the management staff of each managed care network. The BCBSIL Provider Selection Committee (PSC) responsibilities include:

- Credentialing and recredentialing determinations,
- Receiving information regarding network appointment determinations,
- Reviewing and making recommendations regarding network reappointment determinations,
- Assuring appropriate exchange of information and action with respect to departicipations,
- Conducting appeals adjudications related to its actions,
- Adopting and overseeing compliance with the Policy which governs these activities,
- Reviewing the credentials of practitioners who do not meet the organization established criteria and providing information to the practitioner related to the deficiencies
- Annual signing of the non-discriminatory statement and
- Providing reports to the Managed Care Quality Improvement Committee.

The Provider Selection Committee meets on a monthly basis. Its membership includes:

- Physicians from BCBSIL networks (2-5)
- Counsel, Legal Department
- Senior Manager, Credentialing
- Senior Manager, HMO/Onsite
- Senior Manager(s), Network Management
- Medical Director II, Medical Policy
- Medical Director II, Special Investigation
- Network Administrator, Professional Network Development
- Senior Manager, Special Investigation
- Senior Medical Director, (Chair)

Additional staff include:

- Senior Supervisor, Credentialing
- Senior Supervisor, Network Contracting
- UM/QI Project Consultant

Structure & Resources (cont.)

Committee Structure & Responsibilities (cont.)

Clinical Management Committee

The BCBSIL Clinical Management Committee (CMC) is responsible for review and approval of:

- Preventive care guidelines
- Clinical practice guidelines
- Medical Management utilization review criteria
- The process used to evaluate the inclusion of new technologies and the new applications of existing technologies in the benefit package, and
- Pharmaceutical management procedures to promote appropriate use of pharmaceuticals.

The Clinical Management Committee meets at least semi-annually, or more often as needed. Its membership includes:

- Physicians from BCBSIL networks (2-4)
- Full-time BCBSIL Medical Directors (8-10)
- Counsel, Legal Department
- Representative, Illinois State Medical Society (ex-officio)
- Medical Director, Medical Management (Chair)

Additional staff include:

Director, Prescription Drug Program
Director, HCM Quality & Research
Manager, HCM Quality & Research
Senior Manager, Health Services Program
Director(s), Medical Management

Managed Care Roundtable

The Managed Care Roundtable, held semi-annually, is a vehicle for communication between BCBSIL and network practitioners regarding QI goals, activities, and projects in which the products seek practitioner involvement. QI activities and program elements such as guidelines are discussed, results are presented, and information is provided to assist practitioners in supporting the Quality Improvement Program. All network practitioners are invited.

Structure & Resources (cont.)

Committee Structure & Responsibilities (cont.)

Workgroups

The Managed Care Quality Improvement Committee delegates various aspects of the QI process to workgroups. Minutes are kept within these workgroups, and they report to the Managed Care Quality Improvement Committee on a regular basis. The workgroups include but are not limited to:

1. Quality Improvement (QI) Workgroup

The QI Workgroup has responsibility for monitoring and evaluating quality improvement measures, clinical and service quality improvement reports, member and provider satisfaction results, telephone accessibility statistics, as well as audit results from member complaints, member appeals, credentialing, case management and oversight of delegated vendors.

The Committee meets at least monthly, or more often as needed. Its membership includes:

- Medical Director, Quality Improvement
- Accreditation Coordinator(s), Quality Administration
- Quality Improvement Outcomes Specialist (Statistician), Quality Improvement
- Assistant Manager, HCM Quality & Research
- Senior Manager, Health Services Programs
- Director(s), Medical Management
- Manager, HCM Quality & Research
- Quality Review Analyst(s), HCM Quality & Research
- Clinical Quality Research Analyst(s), HCM Quality & Research
- UM/QI Project Consultant
- Senior Supervisors, Medical Management
- Director, HCM Quality & Research (Chair)

2. Medical Management Utilization Management / Case Management (UM/CM) Workgroup (This workgroup is specific to the PPO/POS and FEP products.)

The Medical Management UM/CM Workgroup is responsible for the following functions:

- Reviewing UM/CM policies and procedures
- Reviewing and revising member and provider UM/CM communications
- Monitoring and evaluating UM/CM processes
- Monitoring member complaint and service issues
- Evaluating performance for UM/CM/DM indicators
- Analyzing member and provider UM/CM satisfaction survey results
- Annual evaluation and updating of the utilization management/case management/ wellness disease management program.

The Medical Management UM/CM Workgroup meets on a monthly basis, or more often as needed. Its membership includes:

- Director(s), Medical Management
- Manager, Accreditation and Auditing, Operations Medical Management
- Unit Manager, Training, Operations Medical Management
- Accreditation Coordinator, Quality Administration
- Medical Director, Consumer Services Management
- Medical Director, Medical Management (Chair)

Structure & Resources (cont.)

Committee Structure & Responsibilities (cont.)

Additional staff includes:

Clinical Quality Research Analyst, HCM Quality & Research
Director of Marketing, FEP Program
Appeal Supervisor, Consumer Services Management
Quality and Audit Coordinator(s), Operations Medical Management

3. HMO UM Workgroup

(This workgroup is specific to the HMO product.)

The HMO UM Workgroup performs an important role in the HMO UM Program. The UM Workgroup's responsibilities include, but are not limited to, the following:

- Annual review and revision of HMO UM goals and UM Program documents, including the HMO UM Plan and UM sections of the HMOs Medical Service Agreement (MSA);
- Oversight of HMO UM policies and procedures to ensure compliance,
- Annual review and revision of UM policies, if appropriate;
- Oversight of IPA UM Plans, UM adherence audits, utilization case files, including components related to behavioral health, and MG/ IPA corrective action;
- Oversight of IPA complaint, denial/appeal, and referral processes;
- Review of annual HMO PCP and Member survey results with specific reference to referrals, and review of interventions for any identified issues;
- Review of IPA UM data to identify potential utilization issues;
- Annual evaluation of the HMO UM program; and
- Review and analysis of UM information collected for QI purposes.

The HMO UM Workgroup meets on a monthly basis, or more often as needed. Its membership includes:

Senior Manager, Health Services Program
Senior Manager, Network Management
Accreditation Coordinator, Quality Administration
UM/QI Project Consultant
HMO UM Nurse Liaison
HMO Behavioral Nurse Liaison
Network Consultant(s)
Senior Medical Director (Chair)

Ad hoc staff representation may include:

HMO Nurse Liaison(s)
BCBSIL Medical Director(s)
HCM Quality & Research representative
Health Informatics representative

Structure & Resources (cont.)

QI Program Resources

BCBSIL has sufficient resources to meet the QI Program objectives, carry out the scope of activities to be conducted, and complete annual and ongoing activities.

BCBSIL supports the Quality Improvement program by devoting a variety of resources to the program. These resources include but are not limited to employees (such as Medical Directors, registered nurses, auditors, health information staff, and statistician), data, and budget for activities such as accreditation, HEDIS, and surveys.

Within BCBSIL, reporting relationships have been established which foster communication and facilitate the implementation of quality improvement initiatives. The Quality Improvement Medical Director is the individual responsible for directing the Quality Improvement Program. The Quality Improvement Medical Director reports to the Senior Medical Director. Details related to reporting relationships are outlined on the BCBSIL Organization Charts.

The BCBSIL Medical Directors support the implementation of the Quality Improvement Program through the following activities:

- Chairing the Managed Care Quality Improvement Committee
- Chairing the HMO UM Workgroup
- Chairing the UM/CM Workgroup
- Chairing the Provider Selection Committee
- Chairing the Clinical Management Committee
- Membership on the Quality Improvement Workgroup
- Membership on the Managed Care Steering Committee
- Chairing the Clinical Quality Improvement Project Workgroups
- Review of Professional History Occurrences for physician credentialing
- Direct oversight of the delegated HMO UM process
- Responsibility for provider and member appeal processes.
- Chairing the Appeals Committee
- Ensuring that quarterly reports and the annual QI Program evaluation are presented to the Illinois Affiliate Board and the Emerging Issues Committee.

Conflict of Interest

Plan physicians or non-physician reviewers may not review a case in which he/she has a conflict of interest. Conflicts of interest may be either personal or financial in nature.

Confidentiality

BCBSIL has established both internal and external policies and procedures to ensure the confidentiality of patient information. Internal policies on confidentiality are outlined in employee and management handbooks, corporate policy manual and HIPAA Privacy policies. Employees receive training upon hiring and must also sign a confidentiality statement during corporate orientation and annually thereafter. QI Committee members also sign a confidentiality statement and a declaration of potential conflicts of interest statement annually.

All practitioners contracting and re-contracting with *BCBSIL* receive policies and procedures on confidentiality of medical information with their contract materials. The information is also included in the Provider Manuals.

In addition to the core confidentiality policies and procedures, *BCBSIL* ensures that all medical records, including mental health records, are protected to meet state and federal requirements.

Program Activities

Quality Monitoring Activities

Ongoing monitoring of specific quality indicators is an important component of the Quality Improvement Program. Indicators are selected based on important aspects of care for *BCBSIL* members. These indicators are relevant to the enrolled population, are reflective of high volume or high risk services, encompass preventive, acute and chronic care, and span a variety of delivery settings. Categories of indicators may include the following:

- HEDIS® Measures
- Clinical Quality Improvement Project data
- Service Quality Improvement Project data
- Hospital performance indicators
- Survey data
- Utilization data, including behavioral health data
- Complaint data
- Access and availability data
- Credentialing/ Recredentialing data
- Membership Data

Quality indicators are selected on the basis of their objectivity, measurability and validity. Performance goals or benchmarks may exist or be established, after baseline measurements have been completed.

Data Collection and Reporting

A variety of internal and external data sources may be utilized in quality indicator monitoring. In part, they include:

- Claims
- Medical Records
- Surveys
- Administrative databases
- Inquiry Reporting and Information System (IRIS)
- Systems Support databases
- Clinical documentation systems

BCBSIL is committed to ongoing involvement in clinical and non-clinical quality improvement initiatives. The Managed Care Quality Improvement Committee is responsible for the evaluation of all projects. The Clinical Management Committee is responsible for the development and approval of all preventive and clinical practice guidelines disseminated throughout the managed care networks. The Managed Care Quality Improvement Committee reviews data regarding HMO, *BlueChoice*, PPO and FEP-specific initiatives. A comprehensive report of clinical and non-clinical quality improvement projects is made to the Emerging Issues Committee and Illinois Affiliate Board on at least an annual basis. This evaluation of the Quality Improvement Program includes:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service.
- Analysis of the results of QI initiatives, including barrier analysis.
- Evaluation of the overall effectiveness of the Quality Improvement Program, including progress toward influencing network-wide safe clinical practices.

Program Activities (cont.)

Quality Monitoring Activities (cont.)

The following are general criteria or characteristics considered in the selection of clinical quality improvement projects:

- Clinical issues for study reflect the population served by BCBSIL.
- Projects may be drawn from a spectrum of clinical specialties, including primary care and behavioral health.
- Projects may include preventive, acute, and chronic conditions
- Projects may span the spectrum of care in various delivery settings, such as inpatient and ambulatory care, skilled nursing and home health.
- Projects may seek to evaluate both potential over-utilization and under-utilization of clinical services.
- Topics that reflect public health issues may be considered in developing clinical projects.

The following are general criteria or characteristics considered in the selection of service quality improvement projects:

- Studies reflect issues relevant to the population served by the BCBSIL.
- Projects reflect significant issues or concerns identified through member satisfaction survey results or member complaint data.
- For the PPO, projects may address opportunities for improvement identified through the utilization management and case management process.

The design of quality improvement projects encompasses the principles of continuous quality improvement. They include:

- The project must have a purpose, which is compatible with the goals of the Quality Improvement Program.
- Goals are enumerated which set forth expected, measurable results.
- A rationale must be presented as to why the study is important and how targeted results have been derived from guidelines, benchmarks, product-specific goals or historical controls.
- The methodology for the study should incorporate a quality improvement cycle
- Quantifiable results are required for baseline and post-intervention periods.
- The study must provide for a barrier analysis and a conclusion related to goals and objectives, effectiveness of interventions, and decisions related to “next steps” or further improvements.

For each project, including behavioral health, there is a project-specific plan. The project plans contain the purpose of the project, the identified opportunities, the indicators for the project and associated goals and the interventions or objectives. Additional project goals may also be included in the annual Quality Improvement Work Plan.

Clinical and non-clinical quality improvement projects revolve around the collection of data relevant to desired outcomes and/or the processes that directly or indirectly lead to desired outcomes. In reviewing data, hypotheses are generated related to critical processes, and potential interventions likely to bring about improvement are planned and implemented.

Program Activities (cont.)

Quality Monitoring Activities (cont.)

Strategies for interventions may be directed at the provider, practitioner, the member, and/or the contracted entity. Interventions may include:

- Adoption and dissemination of clinical practice guidelines and preventive care guidelines
- Performance-based QI Fund compensation for meeting performance goals for the HMOs
- Performance-based compensation related to Clinical Quality Indicators as part of tiered reimbursement for *BlueChoice*
- Physician education and training sessions
- Member education
- Feedback providers and practitioners about their performance in comparison to the network
- Direct mailings to targeted groups regarding wellness, preventive care and/or management of chronic conditions
- providing lists of at-risk members to IPAs and/or practitioners
- system changes (e.g. provisions of new member tools)
- Revised policies and/or procedures
- Feedback to internal staff

Ongoing evaluation of interventions is performed so that overall effectiveness is assessed and sustained improvement in the related processes can be demonstrated.

Because of the importance of behavioral health, additional efforts have been directed to monitor and improve behavioral health care for HMO members. Examples include:

- Behavioral health practitioner involvement as a voting member of the Managed Care Quality Improvement Committee
- Regular meetings with Behavioral Health vendor(s)
- Reporting of behavioral health telephone statistics
- Monitoring of activities delegated to Behavioral Health vendor(s)
- Additional activities related to behavioral health as outlined in the Quality Improvement Work Plans.

Network Practitioner Selection and Provider Selection and Monitoring

Practitioner Credentialing and Recredentialing

HCSC has established a standardized approach to credentialing and recredentialing. BCBSIL has implemented criteria for the selection and retention of network practitioners and providers. All contracted practitioners and providers must meet the applicable selection criteria, which includes both business and professional competence criteria.

The selection and retention of providers is an important element of the BCBSIL Quality Improvement Program. BCBSIL staff perform quality improvement site visits, following the Quality Site Visit Standards Policy, for each HMO primary care physician at the time of initial credentialing. The site visits are conducted in accordance with IDPH regulations and accreditation requirements. Site visits are also performed for HMO, high-volume behavioral health practitioners.

The Provider Selection Committee (PSC) is responsible for the credentialing process. The PSC reviews and makes recommendations regarding participation in the networks to the management staff of each managed care network. The procedures and criteria for credentialing and re-credentialing applied by the PSC are set forth in the BCBSIL Credentialing, Recredentialing, Appointment, and Re-appointment Managed Care Policy. Network Management makes the final decisions regarding practitioner and provider participation in the HMO and *BlueChoice* network.

Program Activities (cont.)

Network Practitioner Selection and Provider Selection and Monitoring (cont.)

In selecting professional providers BCBSIL follows the procedures set forth in its Credentialing Policy in making appointments to the networks.

To remain in the network, each HMO and BlueChoice practitioner will be recredentialed according to the state mandated recredentialed cycle. The criteria used in determining whether or not to recredentialed a practitioner are set forth in the credentialing policy.

Upon being recredentialed by the Provider Selection Committee, Network Management makes the final determination related to reappointment of the practitioner to individual networks.

Provider Credentialing and Recredentialed

In selecting institutional and ancillary providers, BCBSIL requires evidence of accreditation by a recognized accrediting agency, or if there is not such an agency, other indications that the provider meets acceptable standards of quality. BCBSIL then follows the procedures set forth in the Ancillary and Hospital Credentialing/Recredentialed Requirements policy in making decisions related to participation in the network.

Access and Availability

BCBSIL evaluates practitioner and provider accessibility within the HMO and PPO Networks based on established standards. Acute Care Hospitals, Behavioral Health/Chemical Dependency facilities, Home Health Care Agencies, Skilled Nursing Facilities, and Surgicenters comprise the categories of facilities within the HMO and PPO Networks. Service areas are identified as Urban/Suburban or Rural.

At least annually, an assessment of the HMO and PPO practitioner and provider networks against the established standards is performed to determine compliance. Ad hoc reports are prepared on an as needed basis.

If it is determined that the access standards are not met, the availability of additional practitioners or providers is evaluated. Contracting with additional available practitioners or providers is considered.

Member's Rights and Responsibilities

BCBSIL is committed to ensuring that enrolled members are treated in a manner that respects their rights as individuals entitled to receive health care services. The Plan is committed to cultural, linguistic and ethnic needs of our members. BCBSIL policies address the issues of members participating in decision making regarding their treatment; confidentiality of information; treatment of members with dignity, courtesy and a respect for privacy; and members' responsibilities in the practitioner-patient relationship and the health care delivery process.

BCBSIL also holds forth certain expectations of members with respect to their relationship to the managed care organization and their individual health care practitioners. These rights and responsibilities are reinforced in member and provider communications, including the BCBSIL Web site.

Various components of the Quality Improvement Program incorporate elements of member rights which may include:

- Policies on inquiries and complaints
- Policies on appeals
- Policies on quality of care complaints
- Access standards
- Member involvement in satisfaction surveys.

In addition, the policy on Member Rights and Responsibilities further defines the relationship between the member, the practitioner, and BCBSIL.

Program Activities (cont.)

Patient Safety

The role of BCBSIL in improving patient safety involves fostering a supportive environment to assist physicians and providers in maintaining a safe practice. The Plan's commitment of patient safety includes but is not limited to the following:

- Distributing information to members and providers which improves knowledge regarding clinical safety as it relates to self-care
- Focusing on improving patient safety in existing quality improvement activities
- Distributing information to members, physicians, and other providers which facilitates informed decisions based on safety.

Activities to Improve Safe Clinical Practice

BCBSIL collaborates with network physicians and providers to improve the safety of clinical care. These activities may include but are not limited to:

- Conducting initiatives to improve continuity and coordination of care between physicians/providers
- Providing performance data to members and physicians/providers
- Evaluating clinical practices against aspects of practice guidelines related to patient safety
- Investigating quality of care issues
- Encouraging the use of office-based systems, such as preventive flow sheets/stickers to promote the provision of care in a timely manner
- Encouraging the use of electronic health record systems and e-prescribing

Adverse Event Monitoring:

In addition to fostering an environment which promotes safe clinical care through the establishment of performance standards and expectations and conducting systematic compliance monitoring, BCBSIL is also responsible for the identification and evaluation of individual instances of potential quality of care concern. The concerns may be identified by any functional unit within BCBSIL. The Plan is responsible for initiating the investigation and evaluation of the facts surrounding the event as well as the facilitation of peer review and follow-up actions by the appropriate committee or individual. Examples of situations which may be considered for review include, but are not limited to:

- Potential quality of care issues
- Physician or provider concerns about previous medical management
- Evidence of inappropriate medical care identified during case review for medical management programs, or other clinical review
- Questionable conduct on the part of a physician or provider

The investigation of an issue focuses on the identification of the potential cause of the adverse event, such as over or under-utilization of services, practicing in a manner inconsistent with current medical knowledge, breakdown in continuity or coordination of care, lack of access or availability of services, etc.

BCBSIL will also investigate and take action on concerns raised by members or by internal review related to potential quality of care issues on a case-by-case basis. Quality review of individual cases may result in significant interventions depending on severity, including termination from the network, reporting to State licensing agencies, the National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB).

Program Activities (cont.)

Patient Safety (cont.)

Pharmacy Programs

HCSC's Pharmacy Benefit Manager (PBM) uses software to identify potential drug to drug interactions and classify their severity. For potential drug to drug interactions that meet severity criteria, the PBM notifies pharmacists in the participating pharmacies at the point of dispensing of the potential drug to drug interaction. In addition, if the FDA recalls a drug for a safety reason, the PBM notifies physicians through the mailing of a Drug Safety Alert of the withdrawal along with a list of patients having recently filled a prescription for the medication. Ongoing retrospective claims analysis targets physicians about a different medication management issue quarterly. One component of the retrospective claims analysis alerts physicians whose patients are identified as receiving multiple prescriptions for a controlled drug substance to assist in appropriate pharmaceutical management of these members.

BCBS Association Blue Distinction Hospital Measurement and Improvement Program

HCSC Plans participate in the Blue Cross and Blue Shield Association Hospital Measurement and Improvement Program. This national program is designed to evaluate hospital performance based on standardized measures. Key components of the Hospital Measurement and Improvement Program include:

- Leapfrog survey results
- Agency for Healthcare Research and Quality (AHRQ) Indicators
- Accreditation status
- Hospital Quality Alliance (HQA) indicators

BCBS Association Blue Distinction Centers

The Blue Cross and Blue Shield companies, including HCSC, in partnership with the Blue Cross and Blue Shield Association, have developed national Blue Distinction Centers for bariatric surgery, cardiac care, and transplant services. Each Center has been selected through a rigorous evaluation of clinical data that provides insight into the facility's structures, processes and outcomes of care. These nationally established criteria were developed with input from medical experts and organizations and support the consistent, objective assessment of specialty care capabilities.

BCBSIL Hospital Profile

On an annual basis, a BCBSIL Hospital Profile is developed for each contracted, non-specialty Illinois hospitals. The Hospital Profiles allow goals to be selected for individual hospitals to target improvement in indicators for which the hospital is below average. Key components of the Hospital Profile include:

- Leapfrog
- AHRQ indicators
- Member survey indicators
- Structural indicators
- Administrative efficiency indicators
- Utilization efficiency indicator
- Physician survey indicators
- Hospital Quality Alliance indicators
- Participation in selected state and/or national initiatives
- Patient Safety

Member Education

BCBSIL features information in member publications and on the BCBSIL Web site, (www.bcbsil.com), to improve member knowledge about methods by which members may reduce the likelihood of errors in their care.

Program Activities (cont.)

Member Satisfaction

The monitoring, evaluation and improvement of member satisfaction are important components of the QI Program. This is accomplished through the use of surveys, as well as through the aggregation, trending and analysis of member complaint data. In addition to the administration of surveys, *BCBSIL* encourages members to offer suggestions and express concerns utilizing customer service telephone lines and request for comments in survey instruments.

The following surveys are utilized in the assessment of member satisfaction.

- Continuous Tracking Program (CTP): population based member satisfaction survey which is administered on an ongoing basis to a sample drawn from the entire enrolled population.
- FEP Case Management Survey
- Behavioral Health Survey (if applicable)

Other Customer Satisfaction

In addition, member expectations are assessed using a variety of member satisfaction survey instruments which include questions related to various aspects of care and service. These include:

- Member Satisfaction Survey by Medical Group (HMO)
- CAHPS Survey (HMO)
- Hospital Patient Survey (HMO, *BlueChoice*, PPO)

In addition to assessment of member satisfaction, practitioners are surveyed to assess their satisfaction with various aspects of the BCBSIL program including Utilization Management and Case Management. In addition, practitioner needs and expectations are voiced at regular open meetings including HMO Administrative Forums and Managed Care Roundtables. BCBSIL uses information from practitioner surveys in ongoing program evaluation.

HMO IPAs are surveyed to assess their overall satisfaction with the networks' administration. For example, they are asked about their satisfaction with HMO support staff (e.g., Provider Network Consultants, Nurse Liaisons) as well as other questions related to network support. Information obtained through IPA surveys is utilized in network development and planning.

BCBSIL also solicits input from employers, providers, and facilities by the following means:

- Adhoc advisory groups
- Face-to-face meetings
- Telephonic encounters
- HMO Consumer Advisory Committee

HEDIS

Healthcare Effectiveness Data & Information Set (HEDIS®) Performance Measures results are evaluated on an annual basis to monitor improvement. HEDIS data is collected from claims, encounters, and may be supplemented with medical chart review. HEDIS data submitted to NCQA, the Blue Cross and Blue Shield Association (BCBSA) and other entities, are audited by an NCQA certified HEDIS auditor.

Continuity and Coordination of Care

Continuity and coordination of care are important elements of care and as such are monitored through the QI Program. Opportunities for improvement in the continuity and coordination of medical care are selected across the delivery system, including settings, transitions in care and patient safety. In addition, coordination between medical and behavioral healthcare is also monitored.

Program Activities (cont.)

Practice Guidelines

Development and Updates

BCBSIL has developed and implemented preventive and clinical practice guidelines and criteria to assist clinical decision making by patients and practitioners; provide standards and measures to assess and improve the quality of care; and to encourage uniformity and consistency in the provision of care. Clinical practice guidelines and clinical criteria are developed and derived from a variety of sources, including recommendations from specialty and professional societies, consensus panels and national task forces and agencies; review of medical literature and recommendations from ad hoc committees.

The BCBSIL Clinical Management Committee is responsible for reviewing and as necessary updating clinical criteria annually and practice guidelines at least every two years.

Dissemination and Implementation

Clinical criteria and preventive and clinical practice guidelines are disseminated to practitioners through the BCBSIL Provider Manual posted on the BCBSIL Web site. The clinical practice guidelines are applicable to all BCBSIL products.

Service Quality Improvement

The ability to provide valuable health care correlates strongly with services which support the managed care organization and healthcare delivery system. Further, satisfaction with HCSC is often derived from the quality of service the members receive. Service standards have been established to prevent issues, whenever possible, and provide consistent, timely, and accurate information and assistance to members, physicians, providers, and other customers. The standards are routinely monitored and reported to the appropriate committees. Satisfaction surveys and complaints are monitored to ensure the standards established are appropriate and meet the needs of the organization and customers. Service indicators include:

- Inquiry and complaint rates
- Telephone access standards
- Results from member and provider appeals
- Compliance with provider and practitioner access standards
- Results from member and provider surveys

Each of the monitors allows member satisfaction with key service indicators to be assessed and interventions implemented as necessary. The key areas of focus include:

- Customer service
- Claims payment

Program Activities (cont.)

Care Management Programs

The Plan's Utilization Management and Case Management activities are outlined in the Medical Management Program Description(s).

BCBSIL Case Management indicator summary results are tracked, trended and reported monthly at the Medical Management UM/CM Workgroup to identify opportunities for improvement. Results are also used to target individual and/or team training needs. (BlueChoice, PPO and FEP only)

For the HMOs, all utilization management functions are delegated to its contracted IPAs. The HMOs retain responsibility for assuring that the functions are performed appropriately. A detailed description of the HMO Utilization Management Program, including the process for monitoring oversight, is found in the HMO Utilization Management Plan. HMO Utilization Management standards, including Quality Review standards, are incorporated in the Utilization Management Plan. HMO Nurse Liaisons conduct annual onsite Utilization Management/Quality Review audits of each IPA.

Technology Assessment and Medical Policy Reviews

HCSC has a unified process for development, review and update of Medical Policies. These Medical Policies are used by the Blue Cross and Blue Shield plans that are part of HCSC: Illinois (IL), New Mexico (NM), Oklahoma (OK) and Texas (TX).

A medical director from each of the four HCSC state divisions is assigned primary responsibility for the HCSC Medical Policy process. The medical directors work collaboratively to review and discuss both new and established policies, then reach a consensus on coverage recommendations for each Medical Policy. The Medical Policy Medical Directors (MPMDs) meet weekly by telephone conference call. They also meet in person for several day sessions at least four times a year.

Review of Medical Policy is an ongoing process. New technology is evaluated on a regular basis to determine the appropriateness of benefit coverage for advances in medical procedures, drugs and devices. Medical Policies include a review of the scientific knowledge for the technology, product, device, procedure or drug currently available in the English language.

Resources for technology assessment and medical policy review may include, but are not limited to:

- Blue Cross and Blue Shield Association (BCBSA) Medical Policy Reference Manual
- BCBSA Technology Evaluation Center (TEC) Assessments
- Reporting on new and established technology in scientific and medical peer reviewed journals (preferably randomized controlled trials)
- Statements on medical practice standards from professional organizations
- Medicare coverage policy
- Suggestions from participating physicians and other providers
- Issues arising from unique claims or appeals trends
- Publicly available medical policies from other health plans

Draft medical policies are submitted electronically to all HCSC medical directors and, along with claims data, to an internal review committee comprised of departments within HCSC that may be impacted by the medical policy. Drafts are also posted in a dedicated area of the Provider page of the Internet Web site that allows direct comment from external physicians, other practitioners, and other stakeholders.

The draft policy is presented for approval to the Corporate Consistency Oversight Board (CCOB). Medical policies are considered to be final and in force when approved by CCOB.

Program Activities (cont.)

Delegation

The plan may authorize an outside entity to perform a function on behalf of the plan. Although the responsibility for performing some activities may be delegated to a contracted provider of services or a vendor, *BCBSIL* always retains accountability for these activities. Delegation may include the functions of Credentialing, Quality Improvement, Utilization Management, Case Management and/or Disease Management. The performance of the delegated entity is monitored according to the delegation agreement and state or accrediting standards.

At the time of delegation, BCBSIL executes a mutually agreed upon document which clearly defines the performance expectations for the delegated agency. At a minimum, the document:

- Defines the delegate's specific duties and responsibilities
- Describes the delegate's activities
- Describes the requirements for the delegate's reporting to BCBSIL
- Defines the process by which BCBSIL will evaluate the delegate's performance
- Specifies the remedies available to BCBSIL, including revocation of the delegation, in the event the delegate does not fulfill its obligations

A detailed description of the procedure for monitoring delegated activities is in the Oversight of Contracted Vendor policy.

External Accountability

External Accountabilities

The BCBSIL QI Program is designed to meet all applicable state and federal requirements (e.g. HIPAA etc.). Plan staff, in cooperation with the HCSC Compliance and Legal Departments, monitors state and federal requirements related to quality improvement and reviews program activities to assure compliance. In addition, if the Plan achieves external accreditation/certification, maintenance of such accreditation/certification is monitored through the QI program.

Accreditation Matrix

BCBSIL maintains accreditation for the products identified from the listed accrediting bodies:

	NCQA	URAC UM	URAC CM
HMO	X		
PPO		X	FEP only
POS		X	

Quality Improvement Program Documents

QI Program Description

The BCBSIL QI Program Description is reviewed annually and is updated as needed. On an annual basis, the document is presented to the Emerging Issues Committee for review and approval.

QI Work Plan

The BCBSIL QI Program Work Plan is initiated annually based upon the planned activities for the year and includes improvement plans for issues identified through the evaluation of the previous year's program. The scope of the BCBSIL Work Plan must include all aspects of the QI Program and the activities must be appropriately linked to the established goals and objectives. The Work Plan will include a delineation of responsibility and time frames for accomplishing each planned activity. The BCBSIL QI Work Plan is presented to the BCBSIL Managed Care Quality Improvement Committee for feedback. The document is updated throughout the year to reflect the progress on QI activities and new initiatives as they are identified. On an annual basis, the document is presented to the Emerging Issues Committee for review and approval.

QI Program Evaluation

On an annual basis, there is a written evaluation of the BSBSIL Quality Improvement Program. The evaluation includes an assessment of progress made in meeting identified QI initiatives and goals and an evaluation of the overall effectiveness of the Quality Improvement program. The BCBSIL evaluation process includes:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service.
- Analysis of the results of QI initiatives, including barrier analysis.
- Evaluation of the overall effectiveness of the QI program, including progress toward influencing network-wide safe clinical practices

The QI program is then updated accordingly. On an annual basis, the document is presented to the Emerging Issues Committee for review and approval.

Disclosure of the QI Program Information

Information regarding the QI Program is made available to BCBSIL participating physicians and other providers and to enrollees, upon request.

Quality Improvement Program Approval

The 2008 *BCBSIL* Quality Improvement Program Description has been reviewed and approved by:

Chair, *BCBSIL* Quality Improvement Committee

Date

Chair, Emerging Issues Committee

Date