



# Harvard Pilgrim Health Care Quality Program Description 2019

Applicable to Harvard Pilgrim Health Care's Commercial, Marketplace Exchange & Medicare products for:

Harvard Pilgrim Health Care, Inc. (HMO, POS and PPO)  
Harvard Pilgrim Health Care of New England (HMO, POS)  
Harvard Pilgrim Health Care Insurance Company (PPO)

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June 2018 - June 2021

**HARVARD PILGRIM HEALTH CARE  
QUALITY PROGRAM DESCRIPTION  
2019**

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# **THE HARVARD PILGRIM HEALTH CARE QUALITY PROGRAM**

## **I. MISSION**

The Harvard Pilgrim Health Care mission statement provides clear direction “To improve the quality and value of health care for the people and the communities we serve.” This translates to focusing on member and community health improvement while improving the value of health care defined as cost divided by quality.

## **II. GOAL AND OBJECTIVES**

The goal of the Quality Program at Harvard Pilgrim Health Care is to ensure the provision of consistently excellent health care, health information and customer service to Harvard Pilgrim members. This goal aligns with Harvard Pilgrim’s mission to enable members to maintain and improve their physical and behavioral health and wellness.

The objectives of the Quality Program are to:

- ensure the provision of high quality, cost-effective, affordable health care to all Harvard Pilgrim members in accordance with the standards of the National Committee for Quality Assurance (NCQA) and the requirements of the federal Centers for Medicare and Medicaid Services (CMS), state regulatory agencies and state and federal laws, including the Patient Protection and Affordable Care Acts (federal health care reform);
- consistently deliver exceptional customer service to members, practitioners, providers and purchasers;
- develop and implement valuable measures that enable Harvard Pilgrim to report organization-wide results of clinical and service quality initiatives, that are also consistent with the external reporting requirements of NCQA’s HEDIS (Healthcare Effectiveness Data and Information Set) and CAHPS (Consumer Assessment of Healthcare Providers and Systems), and other monitoring or regulatory reporting efforts;
- identify and provide a population-based approach to achieving demonstrable health improvement through implementation of effective and innovative clinical programs, services and processes;
- serve a diverse membership in a culturally and linguistically competent manner by assessing the race/ethnicity and primary language of members in an effort to identify and reduce disparities in clinical care;
- ensure that the needs of members with complex health issues, including those with physical and developmental disabilities, multiple chronic conditions, and severe mental illness, are addressed;
- participate in collaborative partnerships with external organizations focused on aligning quality, safety, data-gathering and e-health activities across health care organizations and provider and purchaser networks; and,
- evaluate the overall effectiveness of the Quality Program at least annually to identify strengths, gaps and best practices, and continually evaluate our service model to ensure that it is providing superior service in a manner that is cost-effective and responsive to the changing needs of our constituents.

### III. SCOPE: QUALITY IMPROVEMENT PROGRAM

#### A. Overview

The vision of the Quality and Clinical Compliance Department is to identify, develop, and implement *quality improvement* activities that further the delivery of best in class care and best in class experience to our members. The specific goals of the Quality and Clinical Compliance Department are as follows:

- Improve the health of all members served including identifying disparities and increasing Health Equity;
- Implementing a comprehensive BH Strategy that includes enhancing the Behavioral/Medical Integration and articulating an Opioid Strategy addressing chronic pain and Substance Misuse; and,
- Collaborating on Quality indicators with our provider partners.

These goals are measured using four strategies, including assertive medical management, clinical innovation, communication and collaboration and enhancing core functions.

The Quality Program at Harvard Pilgrim Health Care (HPHC) supports the corporate mission by including the following elements:

- a program of preventive care;
- development of clinical standards and guidelines;
- implementation of customer service standards and processes;
- evaluations and audits of clinical and service processes;
- quality improvement activities that comply with CMS, NCQA and other regulatory requirements;
- risk management activities, including patient safety initiatives;
- credentialing and recredentialing of physicians, other practitioners, and facilities; as well as focused occurrence reporting
- utilization management, focused on providing the appropriate level of service to members;
- population health program addressing the health care needs of members with emerging and complex medical, physical and mental health conditions;
- analysis of and effective response to member complaints and appeals;
- policies supporting and protecting patients' rights and confidentiality as required by the Health Insurance Portability and Accountability Act (HIPAA);
- a focus on serving a culturally and linguistically diverse membership that includes analysis of health care disparities and implementation of initiatives to reduce them;
- reviewing results for CAHPS, establish threshold for performance and identify opportunities for improvement and from this determine next steps;
- assist in handling individual member and provider appeals in a thoughtful, timely, consistent, and professional manner;
- oversight of delegated quality activities related to vended Utilization Management and Care Management programs.

## **B. Scope of the 2019 QI Work Plan**

Each year, in conjunction with the annual business planning and budgeting cycle, Harvard Pilgrim develops its plan of initiatives to improve clinical and service quality. This process is documented in the annual QI Work Plan, along with individual project plans which support the work plan and provide detailed milestones that are tracked and reported on throughout the year.

The 2019 QI Work Plan includes initiatives in these major areas:

- *Population Health Improvement*: includes member and/or practitioner outreach for common chronic conditions like asthma, diabetes, cancer, and heart disease; includes projects related to HEDIS effectiveness-of-care (EOC) measures, coordination of care, providing culturally and linguistically appropriate services to help achieve health equity and eliminate health care disparities, serving members with complex health needs via identification, outreach and complex care management programs and projects related to regulatory requirements, as needed.
- *Wellness & Health Promotion*: addresses numerous and evolving approaches to worksite health and wellness programs, which are becoming increasingly customized for members and employers, and includes initiatives to assist with developing personalized lifestyle management.
- *Patient Safety*: includes programs addressing medication adherence and reduction in medical errors in inpatient and outpatient settings, especially errors related to drug prescribing and monitoring.
- *Behavioral Health*: focuses on improving the coordination between medical and behavioral health care, including collaboration with the behavioral health partner/vendor on programs that address specific behavioral health conditions, like Attention Deficit Hyperactivity Disorder, antidepressant medication management, initiation and engagement in treatment for substance abuse and metabolic monitoring for children and adolescents on anti-psychotics and in our prevention and early detection program for postpartum depression in new moms.
- *Service Quality*: includes projects directed at achieving excellent customer service as assessed by our members. Launched HPHC's Voice of the Customer program (VOC), a systematic approach to gather, aggregate, integrate, interpret and distribute ongoing member feedback to more effectively influence and direct improvement activities, guide tradeoffs and allocate resources. Initiatives address issues identified from member complaints, appeals, experience surveys, and regulatory requirements, and focus on improving Harvard Pilgrim's ability to provide online support via health education information and providing members with information and tools that improve their health insurance literacy. Also includes projects that improve member experience with the Health Plan and Customer Service operations.
- *Quality Infrastructure*: includes initiatives related to programs and incentives to promote clinical quality in the provider network, and ongoing monitoring of activities such as compliance with the clinical quality and service standards of the National Committee for Quality Assurance (NCQA), a key accrediting body.

## **IV. HARVARD PILGRIM HEALTH CARE QUALITY STRUCTURE**

### **A. Senior Leadership for Quality Improvement**

#### Chief Medical Officer

The Chief Medical Officer (CMO) is Harvard Pilgrim's designated physician leader responsible for quality improvement and the quality program. The CMO position reports to the Chief Business Growth Officer and provides him and the Harvard Pilgrim Board of Directors with routine reports on the quality of care received by HPHC members. The CMO has ultimate responsibility for the Harvard Pilgrim Quality Program and for ensuring that superior quality of care, and clinical programs and services, are provided to HPHC members. He is a member of the Patient Care Assessment Committee (PCAC), which is Harvard Pilgrim's corporate quality committee. He chairs the Medical Management and Quality Committee (CQIC), the body accountable for clinical quality improvement. These two committees have ultimate responsibility for organizational review and planning for clinical and service quality. Other responsibilities of the CMO include ensuring that a comprehensive Quality Program and Quality Improvement (QI) Work Plan are developed each year and regularly evaluated to determine effectiveness and continually identify improvement opportunities.

The Office of the CMO is responsible for quality-focused areas such as clinical programs and disease management, care management, clinical policy development, utilization management, NCQA compliance, and network medical management. The CMO also provides clinical input into corporate initiatives and assists in managing the quality program and all related documentation.

#### Behavioral Health Medical Director

The Behavioral Health Medical Director is the senior behavioral health clinician at HPHC's designated behavioral health vendor, United Behavioral Health dba Optum (UBH). The Medical Director provides the overall clinical supervision and medical leadership for the day-to-day clinical operations. He/she oversees the implementation of the QI Program, including quality monitoring and improvement activities, ensures the consistent application of policies and procedures, and participates in training of clinical staff. In addition, he/she oversees the certification process and appeals decisions and serves as a Peer Advisor in the peer review/appeals process.

### **B. Quality and Compliance Team Structure**

The structure of the Quality and Clinical Compliance department can be seen in Exhibit A. The department has 5 FTE's dedicated to the quality program a director and the department also includes two Quality Review Specialists, a Senior Quality Review Specialist, and a Senior Clinical Programs Specialist. The department structure forms the committee structure, which is depicted in Exhibit B.

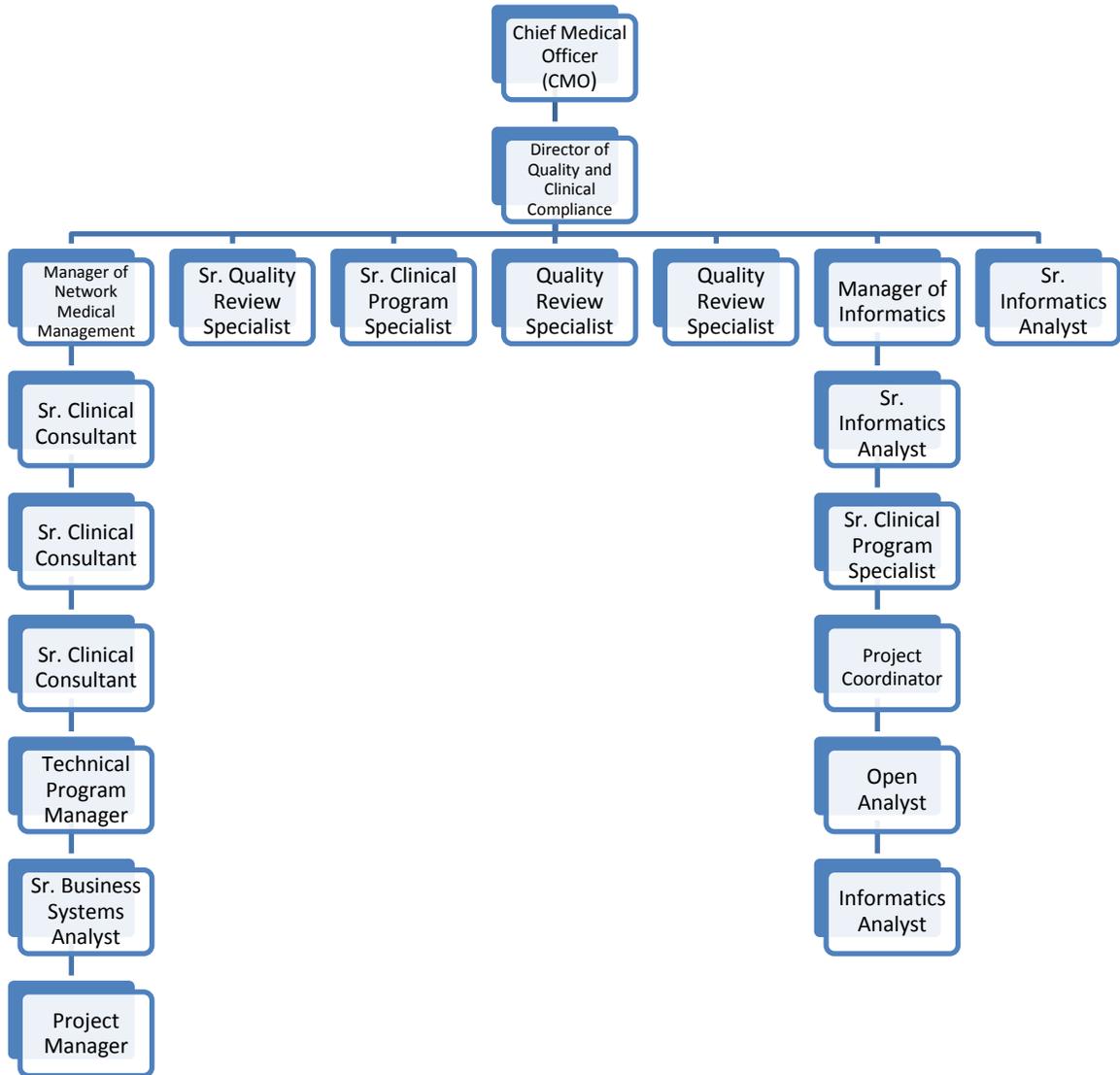
The expertise of the department includes:

- The Quality and Clinical Compliance department is under the direction of the Director of Quality and Clinical Compliance, who holds a Master's in Public Health and is also a Certified Professional in Healthcare Quality with over 20 years of experience in quality.

- The two Quality Review Specialists each have graduate level education. One holds a Master's degree in Health Administration; the other has a Master's degree in Public Health.
- The Senior Quality Review Specialist has over thirty years' experience at Harvard Pilgrim Health Care.
- The Senior Clinical Program Specialist maintains her nursing registration license from the UK and has been working on healthcare quality projects since 2010, with over 25 years of clinical experience in healthcare quality.

Additionally, the Quality and Clinical Compliance department includes Network Medical Management and HEDIS operations. The focus on provider quality and provider health outcomes provides the opportunity for synergy with core quality functions.

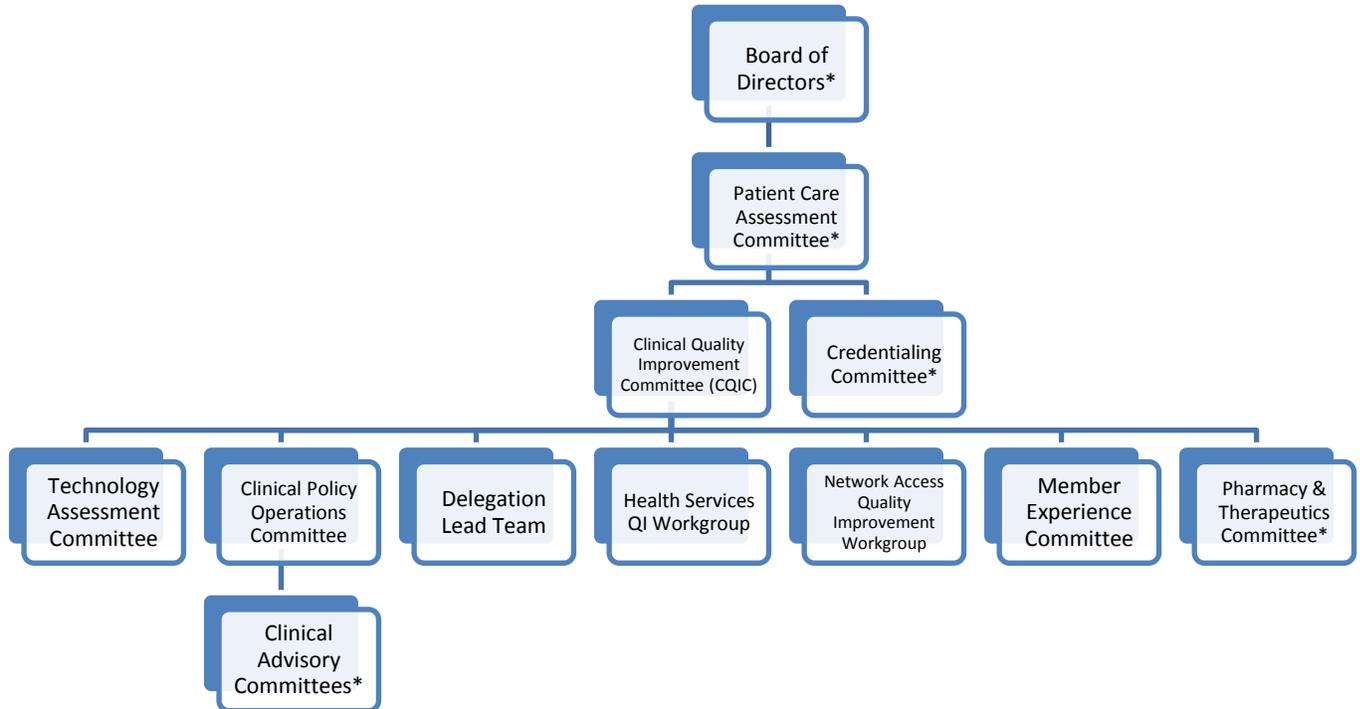
**Exhibit A. HPHC Quality and Clinical Compliance Department Structure 2019**



## V. HARVARD PILGRIM HEALTH CARE QUALITY COMMITTEE STRUCTURE

The Quality and Compliance Department manages HPHC's quality committee structure that includes direct involvement of the Board.

### Exhibit B. HPHC Quality and Clinical Compliance Committee Structure 2019



\*Includes Network MD's

#### The Board of Directors (Board)

The Board provides direct oversight for the Harvard Pilgrim Quality Program and its activities. The Board has designated the Patient Care Assessment Committee (PCAC), a subcommittee of the Board, as the Quality Committee. The PCAC's responsibilities include, but are not limited to, ensuring the development and implementation of the Quality Program and QI Work Plan.

#### Patient Care Assessment Committee (PCAC)

*Role:* The PCAC, a subcommittee of the Board, has been designated by the Board as the Quality Committee for Harvard Pilgrim Health Care, with responsibility for oversight of both clinical and service quality. The PCAC's responsibilities include, but are not limited to, overseeing the development, implementation, and evaluation of the quality program. The PCAC executes its responsibility by performing an oversight function, with senior managers accountable for discrete activities providing regular reports. Illustrated in Exhibit B.

The PCAC is responsible for ensuring the development and implementation of Harvard Pilgrim's quality program description. The QI work plan ensures organizational programs are established and maintained in the areas of clinical and service quality as well as patient safety, behavioral health, culturally and linguistically appropriate services, complex health needs and delegation oversight. The committee reviews and approves the annual quality program description, including the QI work plan and other supporting documents, before making a recommendation for Board approval. The committee also reviews and approves the annual Evaluation of Harvard Pilgrim's quality program.

The PCAC is also responsible for: ensuring the focus of the quality program is consistent with the corporate mission, values and strategy; carrying out the statutorily-required functions of a Patient Care Assessment Committee; receiving reports about the clinical and service quality activities of HPHC's quality committees and departments; providing input to the development of medical policy and clinical standards through active participation in the review of existing clinical policies; advising on medical management systems; serving as HPHC's medical peer review committee; participation in Harvard Pilgrim's clinician credentialing process through review of appeals of credentialing and recredentialing decisions; developing and implementing a Patient Care Assessment Plan; providing input to the Board on matters related to clinical and service quality; and ensuring that the Quality Program consistently operates in compliance with state and federal regulations and the standards of the National Committee for Quality Assurance (NCQA).

As part of its responsibility for reviewing and evaluating the full range of activities that relate to Harvard Pilgrim's Quality Program, the PCAC focuses on:

- approval and oversight of each year's QI work plan;
- periodic monitoring and an annual evaluation of the effectiveness of the quality program;
- assessment of peer review activities;
- oversight of clinical quality improvement and patient safety initiatives;
- review of process failures in the delivery of care and actions taken to remedy them; and,
- outcomes of peer review activities conducted by subcommittees that it charters.

*Membership:* Committee members, including a Committee Chair, shall be appointed by the Board. Committee members shall include at least one HPHC Board member and the Company's Chief Medical Officer. A majority of the Committee members shall be medical professionals providing, or responsible for overseeing the provision of and access to, care to the Company's members; provided, however, there are no powers that require Board action that are or may be delegated to the PCAC. Responsibilities that are functions of the Committee acting as the Company's designated Patient Care Assessment Coordinator and medical peer review committee, may be delegated to the PCAC.

*Reports to:* The Board

*Meeting frequency:* Five-six times per year

#### Clinical Quality Improvement Committee (CQIC)

*Role:* A key action body, the CQIC leads HPHC's clinical program and oversees the delivery of high-quality and cost-effective care to members. It is designated by the PCAC as the organization's clinical and service quality committee and is responsible for overseeing implementation of the quality program and QI work plan. In addition, there are many ongoing

clinical initiatives to support improvement on the HEDIS Effectiveness of Care measures and CAHPS member experience and their status is reviewed by CQIC at least annually. The CQIC has responsibility for:

- Providing guidance to the organization regarding clinical strategies, quality improvement opportunities as it relates to Health Services, Member Experience and Network access and availability,
- Developing HPHC's clinical care priorities, goals, and related standards, planning annual quality and utilization initiatives, developing the clinical measurement agenda, and evaluating HPHC's clinical performance before review and approval by the PCAC,
- Reviewing and coordinating the quality program description, the utilization management program description, and the annual QI Workplan,
- Overseeing the Health Services QI workgroup and the Delegation Lead Team, subcommittees of the Clinical Quality Improvement Committee,
- Receiving reports from its subcommittees responsible for utilization management and clinical policy, pharmacy, behavioral health, or practitioner input into the quality programs and member experience;
- Design and approval of the annual quality program documents, including the Quality Improvement (QI) Work Plan, before review and approval by the PCAC;
- Monitoring quality of care and patient safety, including members' clinical complaints and adverse events such as clinical occurrences;
- Strategizing on representation externally to HPHC on committees and workgroups related to clinical quality. Updating and collaborating internally on committee work being done externally to HPHC and leveraging where possible this work for Quality Improvement workplan.

*Membership:* Chaired by the CMO, members include: the VP & Sr, Medical Director and the VP Population Health, Directors Population Health Improvement and Director for Quality and Clinical Compliance, Director Care and Disease Management, Director of Market Research, Director of Network Operations. Several times a year, when the agendas focus primarily on service quality, the meetings are expanded to include additional HPHC staff from Member and Customer Service.

*Reports to:* the PCAC

*Meeting frequency:* Monthly

#### **A. Other Committees Supporting the Quality Program**

The following committees support the Harvard Pilgrim structures for oversight and management of clinical and service quality.

##### Credentialing Committee

*Role:* The Credentialing Committee is responsible for assessing the qualifications and performance of individual practitioners seeking initial or continued affiliation with HPHC, in accordance with HPHC standards and policies. The Committee's decisions are based on an examination of the individual qualifications provided by the practitioner and verified by external sources. This process occurs at the time of initial credentialing and at set intervals thereafter. Additional review between scheduled cycles may occur if a quality issue or disciplinary action is

identified during the ongoing monitoring process. The Committee also oversees HPHC's delegated credentialing activities and monitors regulatory compliance of the Credentialing Department through review of routine audits. Membership includes primary care practitioners and specialists from across HPHC's network.

*Membership:* The Committee's chair and its members are licensed primary or specialty care practitioners practicing throughout Harvard Pilgrim's network. HPHC's CMO is represented on the Committee by an HPHC medical director.

*Reports to:* the PCAC

*Meeting frequency:* Monthly

#### Technology Assessment Committee

*Role:* Harvard Pilgrim Health Care (HPHC) utilizes medical and scientific sources to assess whether a specific procedure or technology product (i.e. medical device, healthcare procedure, drug or biologic) improves the net health outcome of its members. The goal of the Technology Assessment Committee is to facilitate the adoption and use of safe, efficacious and cost-effective health technology (medical device, healthcare procedure, drug or biologic) for its members.

*Membership:* The Committee will be chaired by Senior Medical Director and Medical Policy Manager. In the absence of a Chairperson, a HPHC State Medical Director or HPHC UM Physician Reviewer will serve as a Chairperson. HPHC State medical directors from the following States: Connecticut, Maine, Massachusetts and New Hampshire, Director of Payment Policy, UM Physician, Medical Policy Manager and Senior Medical Director

*Reports to:* CQIC

*Meeting Frequency:* Three times per year

#### Clinical Policy Operations Committee (CPOC)

*Role:* The Clinical Policy Operations Committee (CPOC) is a composed of multidisciplinary individuals from various areas of HPHC, including but not limited to: Medical Informatics, Benefits/Products Commercial, Benefits/Products Medicare Advantage, Legal, Configurations (iCES, OHI, PDM, eCARE), Payment Policy, Reimbursement, Contracting, Marketing/Internal Communication, Customer Relationship/Member Services, Corporate Communication/External Communication, Broker/Sales, Appeals, Provider Services, Provider Communication. Clinical Policy Operations Committee is a cross-functional group who review, approve and opines on the operational aspects of HPHC's medical policy as it relates to operationalizing clinical aspects of a policy. This includes, but is not limited to, to providing impact of a policy as it relates to their operational area. This process is in keeping with HPHC commitment to improve the quality and value of clinical services that HPHC members receive.

*Membership:* The Committee membership includes following areas:

- Care Disease Management
- Claim Services
- Compliance Quality & Appeals
- Customer Service
- eCare Configuration

- iCes Configuration
- Legal
- Marketing
- Medicare Advantage
- OHI Configuration
- Payment Policy
- PDM Configuration
- Product Management/Benefit Design
- Provider Call Center
- Provider Communication
- Provider Contracting
- Reimbursement
- Revenue/Informatics
- Sales
- Vendor Relations

*Reports to:* CQIC

*Meeting Frequency:* Monthly

#### Clinician Medical Advisory Committees (CACs)

*Role:* The CAC is a subcommittee of the COPC. The HPHC Clinician Advisory Committees (CAC)s are composed of HPHC physicians and clinicians. The committees vary by specialty (Primary Care, Reconstructive Surgery, Surgery, ENT, Ophthalmology, GI, Cardiology, Oncology, Ob-Gyn, Pulmonology) The primary focus of these ad hoc committees is to review and opine on HPHC medical policies, utilization management and quality initiatives that have an impact on their clinical practice and the members they serve. These clinicians are not reimbursed for their comments. They are asked to sign a COI prior to rendering their opinion.

*Membership:* The Committees are comprised of HPHC in network contracted clinicians in MA, ME, NH and CT in the following specialties: Primary care (Internal medicine, family medicine and pediatrics), Reconstructive Surgery, Surgery, ENT, Ophthalmology, GI, Cardiology, Oncology, Ob-Gyn, Pulmonology

*Reports to:* CQIC

*Meeting frequency:* The Clinician Advisory Committees are a virtual committee that meet on an ad hoc basis. The committees feedback is send to and processed by the Clinical Medical Policy Committee.

#### Delegation Lead Team

*Role:* The Delegation Operations and Oversight Committee provides oversight and support to Health Services Vendor Relations and Pharmacy Operations staff on compliance with NCQA standards and state/federal requirements related to UM, CM, QI and PHM delegated entities supporting HPHC's Health Services programs and initiatives. The Delegation Lead Team has responsibility for:

- Reviewing and approving quarterly file audit reports from delegated entity relationship mangers,
- Reviewing and resolving compliance related issues brought to the committee,

- Tracking any issued corrective action plans related to NCQA standards and state/federal requirements,
- Yearly review of delegated entity's Program Descriptions and Evaluations and presenting both to CQIC for approval,
- Pre-delegation assessment review and approval for new delegated entities,
- Approving revisions to HPHC's Delegation templates (including attachment A (NQCA standard grid) and attachment B (reporting)).

*Membership:* Reporting to the Clinical Quality Improvement Committee (CQIC), the Delegation Lead Team is comprised of representatives from HPHC's Health Services Quality and Clinical Compliance department, Pharmacy Operations department, Vendor Relations Department, Appeals and Grievances department and UM/CM department, and Network Medical Management. The committee is chaired by the Director of Quality and Clinical Compliance.

*Reports to:* CQIC

*Meeting frequency:* Monthly

#### Health Services Quality Improvement Workgroup

*Role:* The Health Services Quality Improvement workgroup (HSQI) is a cross-functional team of Harvard Pilgrim Health Care Directors, Managers and Supervisors or their designees who oversee NCQA UM/PHM/QI Standards and related Policies & Procedures. The primary focus of HSQI workgroup is to coordinate the organization's NQCA and related quality workplan and improvement initiatives across the Health Services teams. The HSQI workgroup serves as a working group to fulfill NCQA and regulatory clinical requirements and related programming in Health Services. The Health Services Quality Improvement workgroup ensures that all documented processes, reports and materials required comply with NCQA UM, PHM, MEM and QI standards.

*Membership:* Chaired by the Director of Quality and Clinical Compliance, the committee is comprised of: Director of Clinical Programs, Director of Care and Disease Management, Associate Director of UM/CM, Manager of Utilization Management, Manager of Care Management, Supervisor of Care Management, Manager of Appeals and Grievances, Business Compliance Lead, Sr. Quality Review Specialist and Quality Review Specialist.

*Reports to:* CQIC

*Meeting frequency:* Monthly

#### Network Access Quality Improvement Workgroup (NAQI)

*Role:* The Network Access Quality Improvement Workgroup is a cross-functional team of Harvard Pilgrim Health Care Directors, Managers and staff who oversee NCQA NET/PHM/QI Standards and related Policies & Procedures. The primary focus of the NAQI workgroup is to coordinate the organization's NQCA and related quality workplan and improvement initiatives across the Network and Market services teams. The workgroup oversees the way the organization works with practitioners or providers to achieve population health management goals by sharing information on total medical expenses, primary care and specialist cost and quality, data and members gaps in care.

*Reports to:* CQIC

*Membership:* Chaired by the Director of Quality and Clinical Compliance, the committee is comprised of: Director of Market Research, Director of Network Operations, Manager of Network Medical Management, Manager of Network Services, Senior Market Research Analyst, Quality Review Specialist and Associate Contract Analyst

*Meeting Frequency:* Four times per year as needed

#### Member Experience Committee

*Role:* The Member Experience Committee monitors current customer experience of members by assessing feedback, inputs and performance; identifying initiatives for improving or fixing the experience; accountability for those initiatives; ensuring high quality customer experience and influencing the assignment resources and responsibilities. The duties and responsibilities of the member experience committee include:

- Develop goals and key success measures (internal and external)
- Maintain understanding and support of customer experience work
- Provide support and integration into business planning
- Ensure corporate initiatives are aligned with customer experience initiatives
- Review & monitor customer metrics and feedback (VoC)
- Identify short and long-term customer experience initiatives & projects
- Prioritize initiatives based on impact to consumer and cost of initiative
- Assign ownership (tracking & monitoring)
- Map existing initiatives to customer experience
- Representatives from all affected areas to ID operational impacts to their areas
- Manage budget
- Provide Resources

*Membership:* The Member Experience Committee consists of two teams; the monthly core team and the quarterly steering team. The monthly core team is chaired by the Vice President of Marketing, facilitated by Marketing Manager, and is comprised of: Program Manager Corporate Information Management, Director of Digital Experience, Director of Population Health Improvement, Director of Member Services, Project Implementation Manager, Director of Market Research, Director of Marketing Strategy and Innovation, Vice President of Population Health and Clinical operations, Director of Quality and Clinical Compliance and the Sr. Clinical Programs Specialist.

The quarterly steering team is comprised of the core team, with the addition of: Director of Revenue Management, Director of Pharmacy Operations, Chief Technology Officer, Director of Technology Solutions, Key Account Executive - Massachusetts Operations, Deputy Chief Innovation Strategy Officer, Strategic Business Lead - Provider Strategy, Director of Communications, Strategic Business Lead – Massachusetts Operations, Account Executive – Massachusetts Operations, Director of Care Management and a representative from the HPHC Institute.

*Reports to:* CQIC

*Meeting Frequency:* Monthly

#### Pharmacy and Therapeutics Committee

*Role:* The Pharmacy & Therapeutics (P & T) Committee is an advisory group that serves as the organizational line of communication between HPHC-affiliated physicians and Harvard Pilgrim.

It serves in an advisory capacity to HPHC on matters pertaining to the clinical management of drug use, including recommendations regarding drug selection, clinical practice guidelines, prior authorization guidelines, or coverage of specific drug therapies as they relate to medical necessity or appropriateness of use.

In furtherance of these responsibilities, the Committee shall:

- Recommend therapeutic designations and appropriate prescribing guidelines to assist with the placement of products on the Drug Formulary, intended for use in the ambulatory care setting;
- Provide ongoing review and monitoring of the safety, effectiveness and quality of care of drugs covered by HPHC;
- Annually approve prior authorization guidelines (including Step Therapy);
- Make recommendations for the implementation of effective drug utilization control procedures.

Additional responsibilities may be established and delegated to the Committee as determined by the Chairperson.

*Membership:* Chaired by the Chief Medical Officer, the membership includes HPHC staff, physician and pharmacy specialists, and primary care physicians. A majority of the members are physicians and/or pharmacists.

*Reports to:* CQIC

*Meeting frequency:* Four times per year

## **VI. QUALITY MANAGEMENT AT HARVARD PILGRIM HEALTH CARE: SCOPE OF ACTIVITIES**

### **A. Problem Identification through Quality Monitoring, Analysis and Reporting**

The PCAC, as the corporate quality committee, is the senior committee in the HPHC quality committee structure through which potential quality issues are identified and reviewed, and decisions are made regarding improvement initiatives. The quality committee structure, including the PCAC and the CQIC, receive input from the following information sources:

<b>Source</b>	<b>Information Provided</b>
<i>Quality Measurement</i>	Results of formal clinical quality and outcomes measurement initiatives; results of focused program evaluations; results of member, patient and provider surveys
<i>Clinical Programs</i>	Assessments and recommendations on opportunities to improve health through preventive health outreach, disease management, and health promotion and education

<i>Clinical Complaints</i>	Assessment of data from clinical occurrence reports, clinical complaints, and other risk management activities
<i>Utilization Management</i>	Assessment of utilization data and trends to evaluate appropriateness of patient care
<i>Credentialing</i>	Quality and safety issues identified through the credentialing and recredentialing processes
<i>Clinician Advisory Committees</i>	Clinician assessments of the utility of new programs, standards or guidelines, and feedback on results of quality improvement and utilization management projects
<i>Other population-specific clinical lead teams and steering committees</i>	Quality issues identified through formal evaluations targeting specific high-priority clinical conditions (e.g., asthma), or populations with health care disparities and/or barriers to good quality care (e.g., language access, health literacy), or those with complex medical, physical and mental health conditions, as well as more qualitative assessments
<i>External Reviews</i>	Results of external accreditation or purchaser reviews (e.g., NCQA, CMS)
<i>Market Research Department</i>	Results of practitioner and member experience surveys
<i>Member Services</i>	Analyses of members' administrative/service complaints, CAHPS results, Member Services Feedback Survey of members who have filed complaints, as well as service metrics like call abandonment rates and average speed-to-answer
<i>Provider satisfaction</i>	Measures provider satisfaction across a variety of aspects and HPHC overall, identifies key drivers of satisfaction/recommendation and high-level improvement opportunities to inform action planning and tracks performance over time

***i. Improving Health Literacy***

Health literacy and the unique cultural perspectives of our members are important considerations in our preventive care and chronic disease health and wellness communications.

Harvard Pilgrim's Clinical Programs/Health Engagement team reviews and revises monthly and annual health and wellness mailing materials to meet health literacy guidelines via a health literacy checklist and software. We also evaluate multi-lingual content needs. For example, Living with Diabetes, a booklet for newly identified members with diabetes is available in Spanish. Also, taking a Beta-Blocker after a Heart Attack, a flyer for members post-acute myocardial infarction is available in Spanish. Upon request asthma action plans are available for children and adults in Spanish, Portuguese, Haitian Creole, Russian, Chinese, Vietnamese or Khmer. Healthwise Care Support pages provide several different health and wellness topics and are available in English and Spanish. These pages are available to all nurse care managers.

HPHC also has a member panel called Harvard Pilgrim Listens. Harvard Pilgrim Listens is an interactive forum for our members to share their thoughts, opinions and ideas through online surveys and discussions. Members receive an email from Harvard Pilgrim Listens—usually no

more than once or twice a month—asking them to take part in online surveys and discussions and give feedback on educational materials before they are sent out to members.

*ii. Monitoring Disparities and Improving Health Equity*

A key aspect of eliminating health inequity relies on supporting effective and comprehensive clinical practices targeted to assist disparate populations. Aligned with our enterprise-wide Inclusion Initiative, we seek to identify and positively impact types of health and health care disparities that impact individuals in the following population segments:

- Race
- Ethnicity
- Language (i.e. verbal and written for those with Limited-English Proficiency)
- Age (i.e. children, adolescents, seniors)
- Gender (male, female, other)
- People with Disabilities
- Veterans
- Rural Location (i.e. based on a patient’s geographical location for home or work and distance to primary care or behavioral health provider/facility)
- Low Socioeconomic Status (SES) (i.e. based on the federal poverty levels)
- Low Education Level
- Gender Identity
  - Harvard Pilgrim is proud that we were the first insurance company in the New England Region to cover gender affirming surgery and medical care as a standard benefit

As a member of the Diversity Workforce Coalition, Harvard Pilgrim will continue to serve as a visible and active resource in the area of diversity and inclusion leadership and business strategy in New Hampshire.

The Health Services Division and Medical Informatics departments of Harvard Pilgrim pull data from a variety of sources to develop a comprehensive population assessment. These range from internal claims data to widely validated algorithms, based on surname analysis and geocoded census data, for the indirect estimation of members’ race and ethnicity, in the absence of self-reported data. Members’ income and educational levels are indirectly estimated by attributing characteristics of the population in the census block group, or neighborhood, where a member resides.

Prevalence and overall cost of clinical conditions are calculated from the Optum Impact Intelligence DataMart, which is sourced from a variety of Harvard Pilgrim data sources: claims (medical, behavioral), pharmacy and enrollment spans. High Cost Claimant information is sourced from the Optum Impact Pro DataMart.

The following is a list of the demographic variables analyzed and notation of the data sources used:

- Ethnicity, Race, Age, Gender
  - Internal Harvard Pilgrim Member Demographic Data

- Language
  - Internal Harvard Pilgrim Member–reported Language Data
- Income and Education
  - Indirectly estimated Harvard Pilgrim Member Data
- Top Clinical Conditions
  - Claims, Pharmacy data in the Optum Impact Intelligence DataMart
- High Cost Claimant Report
  - Current member data in the Optum Impact Pro DataMart

*iii. Population Health Management and Improving Strategies*

**Medication Safety and Adherence Program**

Harvard Pilgrim has a comprehensive and innovative Medication Safety & Adherence Program. The goals are to reduce the likelihood of medication errors in the outpatient setting, increase medication adherence and increase the awareness of members and providers about patient safety, adherence and the major sources of outpatient medication errors. The program has different components, including both member and provider registries and adherence reports.

The **Anticoagulation Management program** is a weekly member mailing designed to reduce the risk associated with the use of warfarin to prevent the potential of serious and adverse drug events. Using real-time pharmacy data, members newly started on warfarin treatment receive the educational brochure, *Warfarin (Coumadin®): Taking your Medication Safely*.

The practitioner adherence reports include a Cardiac Medication Adherence Report, a Multiple Prescriber Report and an Asthma Controller Medication Adherence Report.

The **Cardiac Medication Adherence Report** is generated biannually when a member aged 18 and older is hospitalized within the last 2 years and discharged with a diagnosis of an acute myocardial infarction (AMI). Primary care practitioners (PCPs) receive an adherence report to identify non-adherence with prescribed beta blocker therapy. As a two-pronged approach, on a weekly basis member receive the educational brochure, *Taking a Beta-Blocker after a heart attack*, which stresses the importance of staying on a beta-blocker to prevent a secondary AMI. The Multiple Prescriber Report is sent to PCPs biannually listing their patients with diabetes that are identified as having five or more prescribers to encourage coordination of care and a thorough review of a patient’s drug therapy to reduce adverse drug events and improve adherence.

The **Asthma Controller Medication Adherence Report** identifies adult and pediatric patients with persistent asthma who were prescribed at least one controller medication and have a controller medication adherence rate of less than 75% in the defined treatment period. The report is sent to PCPs on an annual basis and can help PCPs identify controller/reliever ratio by displaying the number of controller medications and reliever medications, number of asthma related emergency department visits in the calendar year, medications prescribed by other practitioners and coordinate care with a specialist, if needed.

A **Vivitrol Registry** is sent weekly to prescribers whose patients have been newly prescribed Vivitrol therapy in an effort to encourage behavioral health treatment.

The Metabolic Monitoring for Children and Adolescents biannual report is sent to the child's PCP and specialist and alerts practitioners to gaps in cholesterol and blood glucose testing to avoid adverse drug events (high cholesterol and high blood glucose). It also coordinates care amongst multiple practitioners.

### **Serving Members with Complex Health Needs**

Harvard Pilgrim (HPHC) has a population health model for identifying and managing members with complex and emerging health needs. A focus on high-risk members with complex needs remains a core component of the model as these members represent only a small percent of our membership but account for a majority of medical costs. Typically, complex members have multiple diagnoses and psychosocial needs that can significantly diminish their quality of life. HPHC focuses on identifying and reaching out to at-risk members *before* they require more intensive medical services.

To identify this population, HPHC relies on a) bi-monthly algorithms based on claims and authorization data, b) proprietary predictive analytics to segment population for outreach c) referrals made by nurse care managers, UM staff and providers, and d) member self-referral through Customer Service or Harvard Pilgrim's web site to outreach members, care managers use a telephonic guideline to initiate their calls, ensuring consistency in conveying basic elements of the program. Additionally, care managers utilize modern channels for communicating with members including smart phone technology. The care manager describes the voluntary nature of the care management program, as well as the right to disenroll at any time and the right to not be contacted if they are not interested in the program. Members are also reminded that they may initiate services in the future if they wish to do so.

HPHC's complex care management program was implemented in 2001 and has continued to evolve with advances in identification and engagement techniques. The core tenant of the program is the use of a skilled nurse care manager to assess and address member health needs, goals, and barriers to self-reliance. Together, the care manager and member establish an individualized plan that identifies specific health related goals and ways to address barriers to success. Interaction with a member's primary care physician (PCP) and relevant specialists is also an important component of the care manager's role.

Once a member has been identified and agrees to participate in complex care management program, the nurse care manager completes interventions such as the following:

- Completion of a telephonic assessment that includes core domains for medication review, pain assessment, and depression screening.
- Members that have had a hospitalization are assessed for their understanding of their discharge instructions and follow-up care.
- Provider outreach for members in needs of additional coordination or medical intervention
- Collaboration with multi-disciplinary team members such as social workers for community or behavioral health needs.
- Member education including mailed materials or shared resources for information or support.

- Digital enablement of communications and education.

Member education focuses on different ways to improve one's quality of life in the face of a complex health condition. Education includes self-care strategies to help avoid complications associated with one's condition and promotion of self-awareness about changes in health and symptoms requiring early intervention. Nurse care managers inform program participants about educational materials and tools that are available (i.e., web-based programs, links and booklets) and suggest lifestyle modifications.

To evaluate the program's effectiveness, HPHC monitors process metrics such as engagement rates and clinical leading indicators such as admission and readmission rate on a quarterly basis. For members with complex care needs who opt to not participate in HPHC's complex care program, various outreach activities occur to inform both members and practitioners about what is available. Articles are published regularly in the member newsletter *Your Health* describing health and disease management programs and contact information. Likewise, information is made available to practitioners via *Network Matters*, including contact information.

#### *iv. Clinical Programs and Patient Safety for Specific Populations*

As part of HPHC's effort to improve quality and health outcomes, the Clinical Programs department mails educational materials to our members. Member outreaches take place per diem, monthly and annually.

Primary prevention outreaches such as breast cancer prevention, cervical cancer screening and pediatric/adolescent immunization reminders go out to both members and providers. The members receive a letter reminding them if they are overdue to receive their screenings and/or immunization, and the providers receive a report on the members who are due for these.

Secondary prevention includes outreaches for diagnoses such as asthma, cardiac disease, chronic obstructive pulmonary disease (COPD), diabetes, hypertension, medication safety, pneumonia and flu prevention and women's health. Communications are sent to both the members and providers.

The **Asthma Program** sends monthly letters to the guardians of children ages 3-17 and adults (ages 18-85 including Medicare Stride) newly identified with asthma informing them that they are eligible for the Asthma Management Program; this includes asthma educational materials and self-monitoring tools. An annual letter is also sent to all guardians of members with asthma (ages 3-17) and adults with asthma (18-85) with educational materials such as quiz to assess asthma control. On the provider level, an annual letter and medication adherence report for pediatric and adult patients with persistent asthma who have a controller medication adherence rate of less than 75%.

**Diabetes Program** outreaches may differ depending on the time of diagnosis. An annual letter is sent to all members (including Medicare Stride members) with diabetes informing them of the dates of their last diabetes tests during the past year and instructing them to contact their primary care provider if they are overdue for a test. Letters are also sent to members *newly identified with diabetes* informing them that they are eligible for Diabetes Management Program; this includes

educational material and these members are identified on a monthly basis. Outreach calls and a mailing are also done for Medicare Stride members with diabetes and who, according to our claims, have not had a diabetic eye exam within the last year. For providers, an annual letter and case list of patients with diabetes is sent that includes the most recent diabetes-related exams and test results if available.

For **Medication Safety**, educational brochures are sent to members with a new prescription for warfarin. These members are identified on a weekly basis. For members again identified on a weekly basis, a letter and brochure are sent to those who have been discharged after an acute myocardial infarction (AMI), stressing the importance of beta blocker medication adherence after an AMI. A Semi-annual Cardiac Medication Adherence Report (CMAR) is sent to primary care providers listing 6-month cardiac prescription refill history for patients discharged after an acute myocardial infarction (AMI).

Behavioral Health communications include attention deficit hyperactivity disorder (ADHD), Initiation & Engagement of Alcohol and Other Drug Dependence Treatment, Vivitrol outreach to providers and Metabolic Monitoring for Children and Adolescents on Antipsychotics.

For **ADHD** members, monthly letters and patient education materials are sent to parents of children ages 6-12 years who receive a new prescription for ADHD medication; this encourages follow-up visits to doctor. A real time notification is sent to providers with patients ages 6-12 years with new prescription for ADHD medication.

For **Initiation & Engagement of Alcohol and Other Drug Dependence Treatment** outreaches, UBH sends a Road to Recovery brochure to members who have outpatient or inpatient claim for alcohol or SA.

v. *Wellness and Health Promotions*

**Employer Group Health Services**

The Employer Group Health Services (EGHS) supports sales, employers, brokers and consultants by providing health education programs for employees and assists in the development of their culture of wellness. EGHS also provides multiple channels for members to access clinical and health education programs and supports priority clinical initiatives with employer-focused programming.

**Wellness Platform**

Harvard Pilgrim provides an innovative wellbeing, engagement and social recognition platform. Through the platform, we offer custom employer-based programs including capabilities for administering challenges, incentive-based programming, health risk assessments, personalized content, event scheduling, and population wide programming.

For our broader membership, our platform provides a wellbeing program designed to foster online community through challenges, community blogs/forums, custom content and quarterly raffles. This also provides an affordable and scalable wellbeing program option for employers that covers all major elements of wellbeing.

## **Mindfulness**

Mind the Moment is Harvard Pilgrim's innovative training program adapting the principles and practices of mindfulness to the workplace environment.

Leveraging time-honored, scientifically validated techniques, mindfulness training enables individuals to tap into the brain's built-in capacity for focus and clarity. By strengthening neural pathways associated with creativity, health, and performance, mindfulness training furthermore supports the following: improved mood and sleep quality; reduced chance of burn-out; increased job satisfaction; enhanced listening and collaboration skills; concentration, even when multi-tasking; emotional intelligence.

Since 2009, Mind the Moment has offered practical, integrative, and relatable mindfulness trainings to organizations involved in financial management, health care, higher education, marketing, government, customer experience, and many other industries.

Because we know that organizations of all types and sizes can benefit from mindfulness training, we deliver our programming with customization in mind. Our aim is to plug into an organization's culture as seamlessly as possible, recognizing and honoring the diverse needs of that organization's employees.

Accordingly, we offer a wide range of options, including introductory seminars; targeted workshops; remote learning options; leadership intensives; guided meditation series; app-based learning; and on-going engagement plans directed towards sustainability.

The quality of what we offer is ensured by our highly skilled staff of instructors, all of whom have a minimum of ten years professional mindfulness experience, expertise in group facilitation, and familiarity with teaching in corporate environments.

## **Limeade**

Limeade is an employee engagement company focused on improving well-being and strengthening workplace culture. Limeade integrates well-being, engagement, inclusion and social recognition software to provide web and mobile-app based programs centered around activities and challenges that help members improve their well-being.

Limeade is NCQA WHP Certified for Health Appraisals. Their current certification is effective through 1/24/19.

### *vi. Member Experience*

## **CAHPS**

Harvard Pilgrim participates in the HEDIS measures about member experience, which utilize the annual Consumer Assessment of Health Care Providers and Systems (CAHPS) 5.0 Member Survey initiated through the National Committee for Quality Assurance (NCQA). Participating in this measure provides standardized information for all participating health plans and allows for regional and national benchmarking and comparisons between health plans. The overall objective of the CAHPS survey is to capture accurate and complete information about consumer-reported experiences with health care. Specifically, the survey aims to measure how well health plans are meeting their members' expectations and goals; determine which areas of service have

the greatest effect on members' overall satisfaction; and identify areas of opportunity for improvement, which aid plans in increasing the quality of provided care.

The CAHPS survey is fielded annually between February and May with commercial (non-marketplace) members in each of HPHC's accredited entities. Sample eligible members must be 18 years or older and continuously enrolled in the health plan for at least one year. The survey methodology includes two survey mailings and three attempts by telephone to complete the survey.

Results of the CAHPS survey become available each September and are used to develop quality improvement efforts and initiatives. Results and quality improvement initiatives are discussed with several committees (i.e, CQIC, NAQI workgroup, and PCAC) and socialized throughout the broader organization.

### **NPS – Net promoter score**

The Net Promoter Score (NPS) is a metric is widely used as an indication of loyalty customers have with the company. NPS has become a common practice across industries since 2003 and has been shown to be tied to positive business outcomes, such as retention, share of wallet and forgiveness when things go wrong. Harvard Pilgrim started using NPS in Q2 2017. It is based a question – *How likely are you to recommend Harvard Pilgrim to a friend or family member, where 0 is not at all likely and 10 is extremely likely*, taking the percent who selected 9-10 (Promoters) and subtracting the percent who selected 0-6 (Detractors). Members who select 7-8 are considered passive and while useful in analysis, are not included in the calculation. The result can vary between +100 to -100. The goal is to increase the by 9-10% while decreasing the 0-6%, thus increasing NPS closer to +100. In order to account for any sample bias, the NPS calculation is a rolling 12-month score. While NPS can be used in transactional as well as relationship studies, Harvard Pilgrim primarily focuses on the metric captured in the monthly relationship study. This study is fielded every month to members 3 months out from their renewal. In addition to capturing NPS, other aspects of the members' relationship are also assessed allowing for analysis to identify and prioritize the aspects of the relationship that have the biggest impact on NPS. There is currently no competitive benchmark, however there are plans in Q4'18/Q1'19 to remedy this.

### **Call Monitoring System**

#### *Purpose*

Member calls are monitored and recorded for the purposes of training and coaching representatives and evaluating their job performance.

The purpose of call monitoring is to improve:

- Service quality
- Service efficiency
- First call resolution

A core objective in Member Services is to increase the level of our members' satisfaction. Call monitoring, recording and evaluation helps ensure that a high level of service is being delivered by all representatives. Monitoring, recording and evaluation will also help the department reach

its goal of obtaining excellent ratings on member feedback surveys. These evaluate the representatives on:

- Courteousness
- Ability to listen carefully to what the member had to say, and
- Ability to provide clear and understandable answers to the member's questions

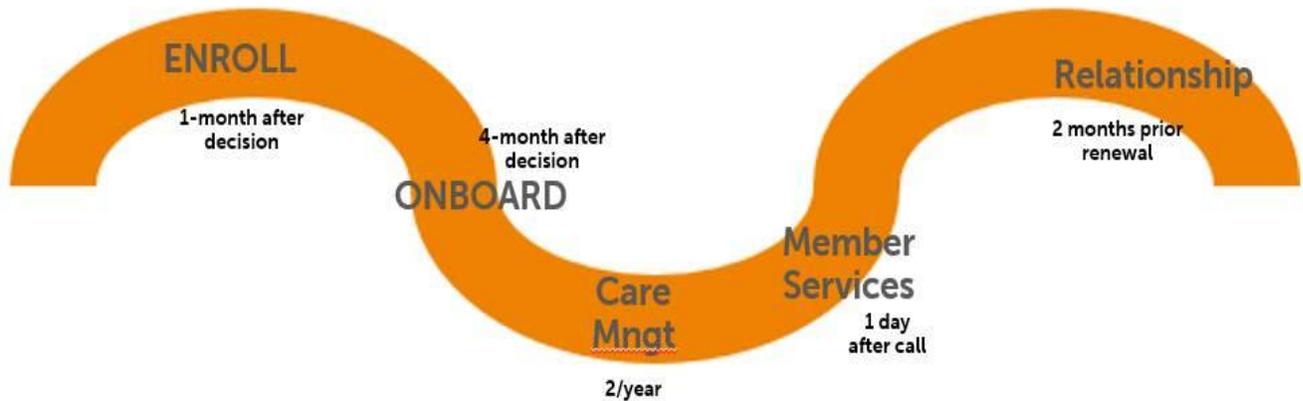
#### *Method of Monitoring/Evaluation*

The Avaya WFO system does the following:

- Records representative phone calls and screen
- Saves and plays back recorded calls
- Records all incoming calls while representatives are logged into the ACD system
- Provides a call monitoring form for evaluating the quality of a representative's performance while taking calls

#### **Member Voice of the Customer Program**

As a critical component of Harvard Pilgrim Customer Experience work, we have started to build a comprehensive Voice of the Customer program. The goal of this program is to provide an enterprise-wide, integrated, single view of our members experiences to support decision making, action planning, implementation, and in market life monitoring. It serves to listen to our members, aggregate and interpret what we are hearing, get that information into the hand of decision makers to act, and then monitor those actions to determine the impact on our members' experiences. It includes structured, unstructured data as well as behavioral and operational data that is collected and used in an ongoing manner. To start we have implemented a series of studies to collect feedback on the important aspects of our members' relationship with us:



- The first is the Enrollment Study that goes out each month to members 30 days after enrolls. This can be new and existing members. This study is focused on the members' enrollment experience and the information and resources available to make an informed and confident plan selection.
- The second study a monthly Onboarding Study, which assesses new members' understanding of and use of their plan at the 4-month mark in their relationship with us. Its purpose is to assess, now they've had a chance to use their plan benefits, how well do

they understand the specifics of their plan. It includes their evaluation of the information in our materials as well as on our website.

- Another key component is our daily member services study, which assesses members' recent phone or email interaction with member services to determine how well their issue was handled and resolved, and their perception of the rep who helped them. There are plans to supplement this feedback with a robust analysis of the call recordings.
- Starting in 2019, we will be assessing the experience among members in our care and disease management program, another key aspect of their relationship with us. The purpose of gathering this feedback is to assess their experience with their care manager, satisfaction with the program in general, and identify ways to improve.
- The final component is the monthly Relationship study, which includes our NPS question. This study goes out to members 3 months before their renewal to assess their experience with us the past year, particularly with these important aspects, and their level of understanding with their benefits.

This data is collected and compiled in a single database to allow us to better view our members' full experience with us. It is then shared with appropriate people with the purpose of providing another input into their decision making.

### **B. Planning and Development Processes for the Quality Program**

Under the direction of the CMO and with the review and approval of the PCAC and CQIC, Quality Program staff develop the annual Quality Program Description and monitor implementation of the annual QI work plan. The QI work plan is a roadmap for the improvement of clinical and service quality. It includes population- or condition-specific strategies (e.g., asthma, diabetes), quality initiatives to improve health and service to members (health promotion, patient safety, culturally and linguistically appropriate services, member outreach and education, member complaints and appeals processes), and improvements to infrastructure to support the delivery of care. Harvard Pilgrim's Quality Program and QI Work Plan are derived from the Harvard Pilgrim mission. Evaluation of the Quality Program and QI Work Plan is ongoing, with periodic monitoring and reporting. An assessment of overall results and effectiveness is provided to the CQIC and PCAC at least annually.

### **C. Harvard Pilgrim Health Care Network Structure and Quality Program Monitoring**

#### *i. HPHC Provider Network Structure*

Harvard Pilgrim Health Care's provider network is organized into Local Care Units (LCUs) and other practitioner-based quality partnerships that provide health services directly to members.

Local Care Units are organized around practitioner and hospital relationships, and the natural groupings of provider groups within a geographic area. HPHC's service area includes Massachusetts, New Hampshire, Rhode Island, Connecticut and Maine. Practitioner-based quality partnerships can include entities such as ambulatory surgical care centers, specialty provider groups, Patient Centered Medical Homes, and other organizations that support quality improvement in physician practice.

HPHC's structure is organized to support effective clinical and service quality for members. This structure ensures there are locally integrated delivery systems that retain the strengths of HPHC's multiple models of care. It also brings management accountability closer to the affiliated practitioners, hospitals and other providers that make up HPHC's delivery system.

HPHC's clinical and business leaders work together with the provider groups to develop, implement and evaluate plans to ensure that patient and customer needs are met in all areas. The leaders responsible for the corporate departments and the network provider groups are ultimately accountable to the Chief Executive Officer (CEO) of Harvard Pilgrim Health Care.

Each of the programmatic initiatives contained on the QI work plan has an identified project leader and a project plan containing specified actions to be taken to meet key milestones and timeframes. Each project leader reports progress on meeting objectives to the Quality Program staff several times throughout the year. Projects encountering significant delays or barriers may report more frequently so issues can be addressed expeditiously. The CQIC and PCAC receive periodic reports on the progress of all work plan activities, and more frequent reports as needed.

The Quality Program staff also prepares a detailed evaluation of the results of the QI work plan initiatives for the previous year. The evaluation of the prior year's quality program is presented to the CQIC in January and to the PCAC in February of each calendar year.

***ii. Utilization Management Collaboration with Network Medical Management and Network Contracting***

Harvard Pilgrim utilizes a team approach to servicing the needs of its provider network and its members. HPHC Network Medical Management staff collaborates with staff within the network contracting area to achieve the goal of seamless provision of quality, cost effective medical services. Examples of this collaboration include the following:

- Identifying high quality providers for selective partnerships, contracting, and relationship building;
- Systematic monitoring (through prospective, concurrent, and retrospective review) of the quality, effectiveness, timeliness and cost of services provided;
- Identifying and reporting potential quality issues and interruptions in service delivery as appropriate.

Development and implementation of "pay for performance" incentives in the areas of quality, patient safety, member satisfaction, clinical information technology and efficiency as driven by national initiatives (Leapfrog, NCQA, HEDIS, and CAHPS, etc.).

***iii. Quality Contracts – Network Medical Management Department***

Network Medical Management (NMM) provides consultation, strategy and practice supports to affiliated local care units, integrated delivery systems, hospitals and provider groups in the areas of quality, satisfaction, utilization and patient safety to improve care outcomes and to mitigate medical cost trends.

Recognizing that physician leaders are key agents of change in the medical system, Network Medical Management fosters and facilitates two-way communication between Harvard Pilgrim

and individual physician thought leaders around key topics of mutual interest, their patients and Harvard Pilgrim members.

The Network Medical Management Team is an essential part of Health Services and is comprised of nurses, health insurance industry professionals and a provider data specialist who work in partnership with Local Care Units (LCU) and physician leadership on programs designed to improve cost efficiency, clinical quality, patient experience and health equity for our members. The Network Medical Management team works collaboratively with Network team in developing and negotiating the quality contracts for our contracted providers and hospitals.

The NMM Clinical Team exists to support internal and external clinical initiatives that impact health care efficiency and effectiveness. By aiming to improve quality and cost, the NMM team supports Harvard Pilgrim's corporate business strategy to manage medical expenses.

Responsibilities include:

- Supporting physician groups with their quality and efficiency metrics
- Developing data sharing on key
- Working with provider partnerships to support innovations to improve patient care quality and satisfaction
- Developing quality contracts for providers and hospitals

The NMM team develops and manages the following programs with collaboration from the CPQM and contracting team:

- Physician Commercial pay for performance
- Medicare (STRIDE) pay for performance
- Hospital P4P
- Physician Honor Roll
- Hospital and physician group tiering for ChoiceNet and other HPHC tiering products
- Quality Grants Program
- Care delivery development, which includes bundles, chronic disease management and innovative care models

Successful engagement with our providers is built through consistent collaboration throughout the year and is reflected in qualifiable indicators. From NMM Team experience, the following are measures of success based on the comprehensive provider engagement:

- Participants openness to collaboration during agenda preparation for the quarterly clinical meeting
- Visible engagement and verbal participation in the quarterly meeting, and responsiveness following it.
- Team participation in meetings from different disciplines on the provider team (i.e. pharmacy or quality leaders) throughout the year to discuss challenges, make requests of HPHC, provide feedback and ask questions
- Willingness to share best practices on WebEx meetings and at Medical Director meetings.
- Expressed satisfaction with innovations we develop for their team.
- Trust in NMM Team consultant as expressed by frequent contact for questions and concerns on email, etc.
- Proposal submissions for the Quality Grants Program

All programs are revised annually to reflect HPHC business needs for HEDIS reporting and new trends and are reviewed with the Health Services CMO and contracting leadership for approval before implementation.

The NMM team works in partnership with Network (contracting) in negotiating the elements of the providers quality program.

#### **D. Oversight of Delegated Behavioral Health Activities**

Effective January 1, 2008, Harvard Pilgrim began delegating the provision of member behavioral health services, including quality monitoring and improvement activities, to United Behavioral Health dba Optum (UBH). UBH is an NCQA-accredited, national behavioral health services vendor. Harvard Pilgrim oversees this delegation in compliance with NCQA and federal and state regulatory requirements.

Prior to the initiation of the contract, Harvard Pilgrim conducted a thorough assessment of the vendor's quality program, including review of its quality program description and a site visit to review quality-related documentation and operations. Harvard Pilgrim collaborates with UBH on the delivery of behavioral health services, including coordination and continuity of care between behavioral health and primary care providers. Senior medical leaders from both organizations meet regularly to discuss clinical care and operational issues. HPHC's behavioral health quality agenda is developed jointly by Harvard Pilgrim and UBH. The committees that provide quality oversight for the delegation include the CQIC, the PCAC and the HPHC/UBH JOC.

The details of the vendor's quality program are contained in its Quality Program Description and QI Work Plan and are appended to this document (see Appendix A). Behavioral health quality projects not fully delegated are also reflected on HPHC's QI Work Plan, with progress monitored throughout the year. Meeting twice a year, the HPHC/UBH JOC focuses its agenda on review and oversight of behavioral health quality indicators, programs and projects.

### **VII. ANNUAL QUALITY PROGRAM EVALUATION**

On at least an annual basis, the PCAC and CQIC review the Quality Program Evaluation, which details the results of QI Work Plan activities. The Quality Program Evaluation provides a year-end summary of the progress and results of clinical and service quality improvement initiatives. It also evaluates the overall effectiveness of the quality program and identifies quality measurement and improvement opportunities for the coming year. Discussion of the program evaluation provides an opportunity to identify gaps, strengths and best practices within the program, with a focus on future activities.