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QUALITY MANAGEMENT/QUALITY IMPROVEMENT

QUALITY MANAGEMENT/QUALITY IMPROVEMENT OVERVIEW

Phoenix Health Plan (PHP) has a comprehensive quality management/performance improvement (QM/PI) program that encompasses both clinical and service aspects of care under the direction of the Chief Medical Officer (CMO). The QM/PI program strives to promote continuous quality improvement across the continuum to:

- Achieve optimal member health outcomes
- Address issues that adversely affect member care
- Ensure that services are accessible, timely and occur in an appropriate setting
- Manage quality within available resources

The QM/PI program uses information obtained from various sources to monitor, evaluate and improve the quality and appropriateness of care and services delivered to members. Information is identified from various internal and external sources including, but not limited to:

- Claims submission
- Focus studies/analyses
- Health plan and AHCCCS performance Indicators
- Medical record audits
- Member appeals
- Member and provider grievances
- Peer Review findings, credentialing and recredentialing activities
- Prior authorization
- Professional organization findings and reports
- Provider quarterly service reviews
- Satisfaction surveys
- Utilization management findings

PHP recognizes that quality healthcare involves collaboration among internal departments, medical and service providers to ensure the provision of optimal quality care. PHP encourages participation by providers in the development and implementation of all quality management/quality improvement activities.

Quality Management Department

Activities of the quality management (QM) department include:

- Establish and measure standards of care
- Analyze data for trends
- Oversee and educate health plan staff regarding the quality of care referral process
- Develop and oversee performance improvement studies
- Report findings and suggested strategies to the Quality Improvement Committee (QIC)
- Organize multi-departmental reporting to QIC
- Lead implementation of programs and processes

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Staff is also responsible for the evaluation and implementation of quality improvement activities that include general preventive health education and health promotion, as well as interventions to improve care for women, pregnant women and children.

QUALITY IMPROVEMENT COMMITTEE (QIC)

The QM/PI program receives community input through QIC. QIC consists of representation from key health plan departments as well as contracted primary care and specialty care providers. CSQIC is charged with:

- Assessing services and make recommendations to PHP regarding aspects of care and service by reviewing reports, analyzing trends and sentinel events
- Regular review of both quality and utilization data
- Designing specific action steps to correct deficiencies
- Assists in the development of quality activities and projects, including performance improvement projects and interventions to impact performance measure rates

All physicians interested in participating in QIC are encouraged to contact network management or the quality department for additional information.

PEER REVIEW

Peer review and credentialing/recredentialing oversight functions are carried out in Executive session of the credentialing and peer review committee (CPRC). The peer review process complies with all Federal and State Laws governing peer review, including reporting obligations and confidentiality. All physicians interested in participating on the peer review committee are encouraged to contact network management or the quality department for additional information.

Peer Review Process

Potential quality-of-care or risk management issues are referred to the QM department for research and review by the CMO. The CMO determines the severity of the issue and may take one of several actions: close, trend, refer to outside specialty and review, or committee presentation. If the case is sent to committee, the provider may be sent a certified letter from the committee asking for additional information as indicated. If no response is received from the provider, a second letter will clearly delineate that if the provider does not send additional information, the Committee reviews the case assuming the provider agrees that the records already obtained are sufficient to make a decision.

Options of the Committee include the following:

- Close the case if no quality-of-care issues are identified.
- Close the case, and trend for future evaluation.
- Send the case for outside specialty review.
- Send a letter of concern regarding the variation from the standard level of care.

The Committee may make corrective action plan (CAP) recommendations whenever it believes that such action is warranted. The recommendations may include, but are not limited to:

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- Focused chart review for the purpose of trending provider performance.
- Second opinion consultations on specified cases.
- Close case, trend provider and re-evaluate as necessary for quality improvement opportunities
- Request a formal CAP
- Require additional education or continuing medical education (CME)
- Mandate second opinion consultations for future specific cases or procedures
- Proctoring of specified procedures or operations by a peer for a specified number of cases
- Capping the providers enrollment
- Temporary or permanent withdrawal of specific privileges
- Termination with cause with 30 days written notice
- Summary suspension of network participation immediately, when necessary, to guard the safety of members, with assignment of an immediate provider replacement to assume care of hospitalized or seriously ill members.

Fair Hearing

The provider is notified if the Committee recommends a reduction of privileges or termination and the health plan's executive management committee accepts that recommendations. The provider may request a fair hearing in writing to PHP within 30 days of receiving written notification of the adverse action. A panel of three peers not in the involved provider's direct service area will be appointed by the CMO to conduct the hearing within 30 days of receiving the request from the provider. Both the health plan and the provider are fully entitled to legal representation. Expert testimony and presentation of supporting documents will be allowed. The panel, after hearing arguments from both parties, will decide by majority vote to uphold or overturn PHP's recommendations. The CMO will be notified of the fair hearing outcome in writing by the panel, and the CMO will in turn notify the provider verbally and in writing of the outcome within 72 hours of receiving notice from the panel.

Immediate Action

If the CMO believes that immediate action is required to protect members' health or welfare, the CMO notifies the provider by certified mail of the immediate actions, which may include any of the following:

- Supervision of or additional prior authorization requirement for the provider's services to member
- A hold on any new member assignments or referrals summary suspension
- Any other actions the CMO deems necessary to protect members' health or welfare.

The actions will remain in effect pending the completion of the committee's investigation of the allegations concerning the provider's conduct, competence or practices. The committee will complete its investigation within 30 days of the impositions of the immediate action, unless the plan and the provider agree to a longer period of time to obtain relevant information.

Based on the findings of the investigations and relevant information including previous quality issues or trends involving the provider, the CPRC renders a final decision consisting of one of the following:

- Continue the immediate action in effect

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- Impose other sanctions structured to prevent harm to members or to correct identified issues
- Remove the immediate action

A provider may appeal an action by the health plan only after the CPRC completes its investigation and renders a final decision. Any action taken by PHP as a consequence of recommendations made by the CPRC shall become a part of the provider's QM file and is considered at the time of recredentialing. PHP shall report any final decision sanction or limitation of services, including reduction and/or termination, to AHCCCS administration, the applicable reviewing authority, and the NPDB as required by PHP's contract with AHCCCS, applicable law and health plan policy.

MEDICAL RECORD AUDIT

Medical records of PCPs are reviewed by established standards by clinical staff at least every three (3) years. The results of the review are forwarded to the credentialing department for use in the credentialing process. In addition, data collected from the review is utilized for quality improvement processes. All providers audited receive a copy of the findings and problems identified along with an explanation of the scores received. Providers scoring less than 80% on the review receive education regarding the standards, and a re-audit may be scheduled within one year to follow up on deficiencies found. If necessary a corrective action plan may be requested in areas of deficiency.

Medical Record Standards

- There is a defined system for medical record keeping.
- Electronic record system is password secured and in lock out mode when not in use.
- Electronic record system software is backed up, to assure maintainability of records.
- Each page in the medical record contains the patient's name or ID number.
- Personal biographical data includes, but is not limited to, the address, ID number, home and work telephone numbers, gender, date of birth, next of kin/guardian/authorized representative, and marital status.
- All entries in the medical record contain the author's identification; author identification may be a handwritten signature, and initials-stamped signature, or a unique electronic identifier. There is evidence of provider compliance with appropriate supervision of other licensed professionals or other staff members.
- All entries are dated.
- The record is legible to someone other than the writer.
- Initial history for the member includes but is not limited to: family medical history, social history, preventive laboratory screening (for members under age 21, include prenatal care and birth history of the members mother while pregnant with member)
- Significant illness and medical conditions are indicated on the current problem list.
- Medical record contains a complete and current medication list.
- Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
- Past Medical history is easily identified and includes disabilities, serious accidents, operations, and illnesses. For children and adolescents (20 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.

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- There is documentation of tobacco and/or alcohol/substance habits for members' 14 years and over and seen 3 or more times.
- The history and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.
- Laboratory and other studies are ordered, as appropriate.
- Working diagnoses are consistent with the findings.
- Treatment plans are consistent with diagnoses.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits. The Specific time of return is noted in weeks, months, or as needed.
- Unresolved problems from previous office visits are addressed in subsequent visits.
- There is evidence of appropriate use of consultants.
- The medical record shall reflect continuity of care for any emergency treatment rendered in a hospital, emergency room or urgent care setting and include provisions for follow-up or continued treatment. Physicians shall document referrals to specialists, treatments rendered or recommendations made and follow-up care to be instituted.
- Consultation, lab and imaging reports filed in the chart are initialed by the PCP to signify review. Review and signature by professionals other than the PCP, such as nurse practitioners, and physician assistants, do not meet this requirement. If the reports are presented electronically, or by some other method, there is also representation of physician review. Consultation, abnormal lab, and imaging study results have an explicit notation in the record for follow-up plans.
- Care appears to be medically appropriate for the diagnosis/conditions. There is no evidence that the member is placed at inappropriate risk by a diagnostic or therapeutic procedure.
- An immunization record for children is up to date, or an appropriate history has been made in the medical record for adults.
- Preventive services are appropriately used.
- There is evidence of provider compliance with notifying or informing audit members about Advance Directives. HEDIS Care for Older Adults requires annual review or discussion of Advance Directives
- There is documentation of discussion of a living will or advanced directive.
- Obstetric providers must also complete a risk assessment tool for obstetric patients (i.e. Mutual Insurance Company of Arizona Obstetric Risk Assessment Tool [MICA] or American College of Obstetric and Gynecology [ACOG]).
- For members under the age of 21 there must be documentation of current and complete appropriate number of EPSDT encounters according to age. The AHCCCS EPSDT form must be used for all EPSDT visits including pregnant members under age 21.

For members receiving behavioral health services through the RBHA there is a notification of care/assessment form completed by the RHBA filed in the member's medical record/chart. Additionally, the PCP maintains the medical record, even if the assigned member has never been seen, and the following should be included:

- All referral forms
- Individual service plans
- Release of medical and behavioral health information
- Any other medical documents (i.e. progress notes, pharmacy, and emergency room treatment sheets related to behavioral health treatments and/or services)

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Medication management and step therapy for members treated for depression, anxiety and/or ADHD is also audited. Providers are educated about behavioral health referrals and medication management during the audit. They are given copies of the AHCCCS tool kits for child and adult depression, anxiety and ADHD.

A medical record is established by the PCP upon receipt of information about an enrolled member. There is documentation related to requests for release of information and subsequent release in the medical record. Medical records may be documented on paper or electronic format. Records documented on paper must be written in blue or black ink, each entry signed and dated. If the records are altered, the stricken information must be identified as an error and initialed by the person altering the record; whiteout is not allowed. If an electronic record is used, the provider must have an established method of indicating who initiated the information and a means to ensure that the information is not altered inadvertently. There also must be a system in place to track, when and by whom; revisions to information are made

CONFIDENTIAL EXCHANGE OF MEMBER INFORMATION

To ensure appropriate and confidential exchange of information among providers:

- Providers should transmit all necessary information as appropriate when initiating or receiving a referral.
- A provider should request information from other treating providers as necessary in order to provide appropriate and timely care.
- A provider should report appropriate information to a referring provider.
- When a member chooses a new PCP, the member's records are transferred to the new provider within 10 business days of receipt of request.
- Information from, or copies of, medical records may only be released to authorized individuals.
- Original medical records must be released only in accordance with Federal or State laws, court orders, or subpoenas.
- Member information that is considered confidential includes, but it not limited to:
 - Name, address and Social Security number
 - Social and economic conditions or circumstances
 - Dates of medical service provision
 - Medical data including diagnosis and past history of disease or disability.
- Release of member medical record information to out-of-network provider authorized by the member is allowed only after written consent from the member or guardian.
- Written approval from the member is not required when:
 - Transmitting records to a provider who is rendering services to the member through referral or sharing treatment or diagnostic information with the member's regional behavioral health authority (RBHA), if the member is receiving behavioral health services through the RBHA system.

<p>Note: Providers should be in compliance with the Health Insurance Portability and Assurance Act (HIPAA) requirements at all times.</p>
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CLINICAL PRACTICE GUIDELINES

PHP has compiled a set of practice guidelines for your reference. These guidelines are developed through research and nationally accepted practices. The guidelines are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field. These guidelines are reviewed and updated periodically as appropriate, at a minimum of once annually by CSQIC. Additionally, Preventative Care Guidelines/Schedules have been made available for your reference.

The practice guidelines and preventative care guidelines/schedules are available on our website at www.phoenixhealthplan.com under the 'Providers' section. For requests for training, obtaining additional information or if you are unable to retrieve the guideline(s) from the website and would like a copy mailed to your office, please contact network management department.

The practice guidelines currently available are:

- Diabetes
- Asthma
- HIV
- Management of adult depression
- Management of adult anxiety
- Management of adult ADHD
- Postnatal depression management
- Child & Adolescent depression management
- Child & Adolescent Anxiety management
- Child & Adolescent ADHD
- Depression
- Anxiety disorder

The preventative care guidelines/schedules currently available are:

- Childhood Immunization
- Children's Preventative Health Screening
- Adult Health Screening
- Adult Immunizations
- Lead Poisoning Prevention