TheHealthPlan

Chapter 10

Quality

Provider Manual

Introduction

The Health Plan (THP) is dedicated to ensuring that all federal and state laws, rules, and regulations are compiled in a timely and effective manner, including The Center for Medicare and Medicaid Services (CMS), The Bureau for Medical Services (BMS) and The Department of Insurance.

THP Quality Management Program consists of quality improvement strategies and the collection/analysis of data to identify and track quality of care issues or concerns. Interventions are based on recognized industry standards.

Goals and Objectives

1. Demonstrate compliance with the following external quality management regulators and programs:
    - The National Committee for Quality Assurance (NCQA)
    - Centers for Medicare and Medicaid Services (CMS)
    - Qlarant - External Review Organization for WV Department of Health and Human Resources (DHHR)
    - West Virginia Office of Insurance Commissioner (WV OIC)
    - Ohio Department of Insurance (ODI)
2. Establish standards and processes for measuring and improving the quality of care and services provided to THP members through the following indicators:
    - Clinical Care
        - Medical/Surgical Variance Investigation
        - Behavioral Health Variance Investigation
        - Medicare Advantage, West Virginia Mountain Health Trust (West Virginia Medicaid, and WV Children's Health Insurance Program)and/or CMS Driven Investigations which include:
            - Never Events (NE)
            - Hospital-Acquired Conditions (HAC)
            - Health Care-Associated Conditions (HCAC)
            - Provider Preventable Conditions (PPC)
    - Customer Satisfaction
        - Member Complaint Investigation
        - Physician Change Report Reviews
    - Care and Service
        - Clinical Practice Guidelines
        - Standards for Patient Records and Access to Care and Services
        - Medical Record Audit
    - Quality Management document annual review and revision
        - Quality Management Evaluation
        - Quality Management Program
        - Quality Management Work Plan which is designed to designate each department's annual quality management priorities and track progress towards meeting goals.

The work plan describes the organization's overall priorities and activities undertaken that address the quality and safety of member care and' experience.

- Quality Management Policies and Procedures

3. Utilize a multi-disciplinary approach through the following identified areas:
   - Implement and monitor corrective action plans
   - Collaborate with nursing, medical directors, and pharmacy
   - Demonstrate improvement in the quality of medical care and services provided to members as a result of quality management initiatives

Clinical Care Quality Indicators

The Quality Management Department monitors quality of care concerns centered on evidence-based guidelines through a root cause analysis conducted by a THP nurse quality coordinator. . If the concern requires further action, the Program Integrity Team determines reimbursement.

THP follows these evidence-based guidelines:

- Agency for Healthcare Research and Quality (AHRQ) for PSI 90 Patient Safety Indicators
- National Healthcare Safety Network (NHSN) for healthcare-associated infections
- National Quality Forum (NQF) for serious reportable events

Customer Satisfaction Quality Indicators

THP's Customer Service and/or Quality Management Department investigates and tracks every member complaint, grievance, or dissatisfaction.
Indicators of dissatisfaction include:

- Quality of Care
- Access to care
- Attitude/Service
- Billing/Financial Service by The Health Plan
- Quality of practitioner office site

Clinical and Customer Service Quality Indicators Review Process

Quality Indicators

Anyone within THP can identify a customer satisfaction or quality indicator by reporting the issue to THP's. Quality Management Department. A nurse quality coordinator performs a case analysis on the potential issue and obtains medical records to review, if applicable. A letter of inquiry may be sent to the facility or practitioner, requesting review or clarification of the potential issue. The letter may include a request for a written analysis or opportunities for improvement established by the facility or practitioner. .

If THP determines a practitioner is not keeping with reasonable and prevailing standards of care, a corrective action plan (CAP) may be requested in writing by the Quality Improvement Committee (QIC) Corrective measures include one or more following:

- A written warning to the practitioner
- Discussion with the practitioner
- Placing the practitioner under a focused review per medical record or claim data reviews
- Requiring the practitioner to enter a preceptor relationship with another practitioner
- Requiring the practitioner to complete continuing medical education specific to the treatment, procedure, or service in question
- Setting limitations on the practitioner's privileges or authority to perform specific procedures

Physician and Practitioner Expectations

THP's Quality Improvement Committee (QIC) identified the following expectations and behaviors for all THP participating physicians and practitioners:

1. Medical Records and Confidentiality Statement

The medical records and confidentiality statement ensure that a separate comprehensive medical record is created and maintained in a confidential manner for each member, provides access to all biographical and medical information, and promotes quality care.

All participating physicians and practitioners shall maintain a current member medical record in accordance with THP standards for patient records and shall comply with all federal and state laws and regulations.

All physicians and practitioners shall preserve all records related to members for a period of not less than 10 years and retain records longer if the records are under review or audit.

The medical records shall be made available, as required, to each physician treating the member. Medical records will be made available upon request to an authorized representative of THP for medical audit, utilization review, fiscal audit, and other periodic monitoring.

All medical records and patient information should only be accessed to complete job duties; discussion outside of normal job duties is strictly prohibited and should be kept confidential.

Members have the right to approve or deny the release of identifiable personal health information by the physician or practitioner except when required by law. Member information shall not be released without signed authorization.

- All files should have limited access and not left open where they could be casually read.
- Computer system files require special password capability for access. All computers should be logged off at the close of each day to prevent unauthorized access to system data.

All member medical records requiring disposal should be placed in appropriate receptacles for shredding or burning.

All physicians and practitioner offices should require review of the medical record and confidentiality statement, annually.

Standards for Patient Records

1. Each medical record must comply with THP's current medical record documentation standards. These standards address health record content and organization, including specifications of basic information to be included in each health record that include at least the following:
   - Information needed to conduct utilization review
   - Member/Beneficiary identification information: Name or identification number on each page or electronic file
   - Personal/biological data: Age, sex, address, employer, home and work phone number, and marital status
   - Entry date
   - Provider identification
   - Allergies
   - Past medical history
   - Immunizations (for members aged 12 and under there is a completed immunization record or notation that immunizations are up-to-date, and when subsequent immunizations, if any, are required
   - Diagnostic information
   - Medication information
   - Identifications of current problems: Significant illness, medical conditions, and health maintenance concerns
   - Smoking/ethanol/substance use Notation concerning cigarette and alcohol use and substance use is present for patients 14 years and over and seen three or more times
   - Consultations, referral, and specialist reports: Notes from consultations, lab, and x-ray reports with the ordering physician's initials or other documentation signifying review, explicit notation in the record and follow up plans for significantly abnormal lab and imaging study results
   - Emergency care
   - Hospital discharge summaries: All hospital admissions which occur while the member is enrolled in the plan, and prior admissions as necessary

- Advance directives: Documentation of whether the member has executed an advance directive
- Visit data of individual encounters must provide adequate evidence of, at a minimum:
- History and physical examination, including appropriate subjective and objective information for the presenting complaints
- Plan of treatment
- Diagnostic tests
- Therapies and other prescribed regimens
- Follow up, including encounter forms with notations concerning follow up care, or visits; return times noted in weeks, months or as needed; unresolved problems from previous visits are addressed in subsequent visits
- Referrals and results thereof
- All other aspects of care, including ancillary services
- History and physical examination, including appropriate subjective and objective information for the presenting complaints
- Plan of treatment
- Diagnostic tests
- Therapies and other prescribed regimens
- Follow up, including encounter forms with notations concerning follow up care, or visits; return times noted in weeks, months or as needed; unresolved problems from previous visits are addressed in subsequent visits
- Referrals and results thereof
- All other aspects of care, including ancillary services

2. Medical records must be legible, meaning the record is legible to someone other than the writer. Any record judged as illegible will be evaluated by a second reviewer.
3. Medical records must be available and accessible to THP and to appropriate state and federal authorities, or their delegates, involved in assessing the quality of care or investigating member grievances or complaints
4. THP ensures appropriate and confidential, privacy protected, exchange of information among providers
5. THP ensures that the identification and assessment of member needs are promptly shared with the State, other MCO's and private insurers and makes all efforts to prevent duplication of these activities

Electronic Health Record (EHR)

Copy/Paste or Cut/Paste

The office has a policy/procedure to monitor and audit information "copied and pasted" or "cut and pasted" into the EHR to ensure copied information includes proper validation including name, credentials, date, time, and source of data.

Defaults

Defaults are defined as data that is entered that does not require a positive action or selection, or data is entered by abbreviated words or keystrokes.

The office has a policy/procedure to verify the validity of auto-populated information.

Multiple individuals adding text/addendums to the same process note, entry, flowsheet Documents with multiple authors or contributors retain signatures so that each individual's contribution is clearly identified.

E-prescribing

For offices currently utilizing E-prescribing, they have a policy/procedure for monitoring to prevent fraud, waste, and abuse.

Technical Specifications

The office has a policy/procedure such as a backup system to prevent loss or destruction of EHR.

EHR Health Information Exchange

The office has a policy/procedure to ensure secure, authorized electronic exchange of patient information.

Resources used in standard development:

- The Bureau for Medical Services (BMS)
- Centers for Disease Control
- The Centers for Medicare and Medicaid (CMS) Quality Improvement Standards
- Qlarant (formerly Delmarva) Quality Improvement Standards
- The Health Plan Guidelines
- The Health Plan Quality Improvement Committee
- US Department of Health and Human Services

2. Continuity and Coordination of Care

THP supports and guides the partnership of members and primary care practitioners to ensure continuity and coordination of care. THP's continuity and coordination of care policy specifies the following responsibilities:

- All physicians and practitioners involved in a member's care must share clinical information with each other and the member timely. Most referrals to specialty care should be submitted by the PCP. Treatment plans should specify an adequate number of direct access visits to specialty care to accommodate the treatment plan's implementation. Members are afforded direct access to behavioral health physicians and practitioners. All referral notifications will include a reminder to all parties to share clinical information timely.
- Practitioners/providers must document member input in all treatment plans submitted;
- Clinical Services/Behavioral Health Services nurse navigators will review treatment plans for such documentation before approving requested services.
- When required, nurse navigators will educate members regarding their rights and responsibilities to provide input to physicians and practitioners as to their care preferences and document such education appropriately. Nurse navigators, will, where appropriate, advise members and physicians and practitioners of available training in self-care, health promotion, etc. This advice should include information about non-covered community resources, as well as THP coverage for such services as dietary consults, smoking cessation programs, certified diabetic education, home health nurse educators, wound or ostomy care teaching, home infusion services, etc. and are documented.
- THP does not prohibit a health care professional from advising and advocating on behalf of a member.
- Physicians and practitioners should provide information about the findings, diagnoses, and treatment options regardless of coverage, so the member has the opportunity to decide among all relevant treatment options.
- The member should be given information about the risks, benefits, and consequences of treatment or non-treatment. They should be provided a choice to refuse treatment and discuss their preferences about failure treatment decisions.
- Nurse navigators will periodically review treatment plans with their members to ascertain progress and compliance. These reviews will be shared with the primary care practitioner, and updated plans requested where appropriate. This process and outcomes are documented.

3. Physician and Practitioner Availability Standards

Primary Care Physician (PCP) and Practitioner Expectations:

- Maintain continuity of enrollee's health care by serving as the primary care provider
- Provide access twenty-four (24) hours a day, seven (7) days a week
- Make referrals for specialty care and other medically necessary covered services, both in-network and out-of-network, consistent with THP's utilization management policies
- Maintain a current medical record for the enrollee, including documentation of all services provided by the PCP, as well as specialty or referral services
- Adhere to EPSDT Periodicity Schedule for enrollees under age twenty-one (21)
- Follow THP's established procedures for coordination of in-network and out-of-network services for Medicaid enrollees
- Have one (1) or more THP participating physician(s) as back up coverage to be available by phone or answering service.
- Required to notify THP if they are no longer accepting new patients provide a minimum of 20 hours per week of patient care availability

Screening for Behavioral Health Needs

THP encourages PCPs to assess members for behavioral health needs. Screenings should be provided to people of all ages. If you need assistance with referral to a behavioral health specialist contact THP's Clinical Services Department at 1.800.624.6961, ext. 7644 for assistance.

THP's suggests the following when encountering patients who may be experiencing problems with substance use disorders.

- Ask about substance use and screen for problem use.
- List the patient's diagnosis in the medical record.
- Refer to a qualified behavioral health clinician, when necessary
- Encourage the patient to follow through. Express interest in his/her progress.

Specialty Care Physician and Practitioner Expectations

Except in situations requiring emergency treatment, specialists should only treat members upon referral from a PCP. Except in situations requiring emergency treatment, specialists must submit a report to the appropriate PCP or SCP concerning the proposed plan of specialty treatment, including possible hospitalization or surgery, as soon as possible after examination of a member.

Specialists should contact the PCP to arrange referrals to another physician. Specialist-to- specialist referrals are not generally permitted. In emergencies, a specialist to whom a member has been referred may refer that member to another specialist only when the referral is related to care his or her specialty, i.e., specialized surgery and/or care requiring tertiary services. THP recommends, however, that the specialist communicate with the PCP regarding the need for the referral. This may be done after the fact in instances where the emergency may require immediate action.

Specialists should send a copy of the member's treatment record to the appropriate PCP.

4. Physician Self Care/Treatment and/or Family Care/Treatment

THP follows American Medical Association (AMA) recommendations that physicians and practitioners should not treat themselves, their immediate family members, or their household members. Accordingly, THP does not permit payment to a provider for treating their family members.

The following degrees for relationship are included within the definition of immediate relative:

- Husband and wife
- Natural or adoptive parent, child, and sibling
- Stepparent, stepchild, stepbrother, and stepsister
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law
- Grandparent and grandchild
- Spouse of grandparent and grandchild

EMERGENCIES: In the case of medical emergencies, a THP practitioner can provide care until a qualified practitioner is available.

ORDERS (written or verbal): THP practitioners shall not write orders or dictate verbal orders for themselves or a member of their immediate family.

PRESCRIPTIONS: THP practitioners shall not write prescriptions for themselves or members of their immediate family.

PCP ASSIGNMENT: THP practitioners shall not be permitted to act as primary care physician for themselves or members of their immediate family.

5. Access Standards

Primary Care Providers (PCP)	
Routine Care	Within 21 days
Urgent Care	Within 48 hours
Emergent Care	Same day, refer to ER, or call 911
Behavioral Health	
Initial Routine Care	Within 10 days
Follow Up Routine Care	Within 30 days (prescribers) Within 20 days (non-prescribers)
Non-Life-Threatening Emergency Care	Within 6 hours
Emergent Care	Same day, refer to ER, or call 911
OBGYN	
Initial Prenatal Care	Within 14 days
Initial or Follow Up Routine Care for Non-OB Patients	Within 30 days
Specialty Care	
Initial Routine Care	Within 30 days
Follow Up Routine Care	Within 30 days

After Hours Accessibility

Practices should be available to the THP members through on call practitioner, answering service, or voice mail message directing the member to the Emergency Room if the case is emergent.