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 monitor for systemic issues, quality of care issues, identify opportunities for improvement through root cause analyses, and develop corrective action plans and initiatives. Once corrective action plans or initiatives are implemented, results are measured and remeasured to determine the effectiveness of actions. Modifications and adjustments are made based on data driven outcomes.

Goals and Objectives

1. Demonstrate compliance with the following:
    - 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. Monitor and improve continuity of care between practitioners and across practitioner settings
3. Establish standards and processes for measuring and improving the quality of care and services provided to members through:
    - Peer Review Processes
    - Medical Record Audits
    - Member and Provider Satisfaction Surveys
    - Clinical Care
        - Medical/Surgical Potential Deviations in Care
        - Behavioral Health Potential Deviations in Care
        - Medicare Advantage, West Virginia Mountain Health Trust (West Virginia Medicaid, and WV Children's Health Insurance Program)and/or CMS driven clinical reviews which include:
            - Never Events (NE)
            - Hospital-Acquired Conditions (HAC)
            - Health Care-Associated Conditions (HCAC)
            - Provider Preventable Conditions (PPC)and other Provider Preventable Conditions (OPPC)

4. Provide a platform for members and practitioners to express concerns regarding care and service experience
    - Quality of care
    - Access to care
    - Customer Service
    - Billing/Financial Service by The Health Plan
    - Quality of practitioner office site
5. Implement initiatives to improve health care outcomes and clinical safety through the use of evidence based guidelines and resources

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.

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

Practitioner Expectations

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

This cooperation includes collection and evaluation of performance measurement data and participation in Quality Improvement programs. THP may use performance data for quality improvement activities.

Additional requirements include cooperation with potential quality of care root cause analyses, member complaints/grievances, or any other review or reporting requirement including state or federal agency with authority, the National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data Information Set (HEDIS), or any other data collection requirement.

Practitioners are expected to cooperate in a timely manner in any of the Quality Improvement activities requested by THP.

THP is responsible for implementing procedures for reducing, suspending, or terminating a practitioner's participation for reasons relating to quality of care, competence, or professional conduct. Remedial action plans will be developed within thirty days of identification of the systemic problem. Corrective Action Plans may be instituted for any treatments, procedures, or services which indicate a practitioner is not practicing medicine in a manner that is keeping with reasonable and prevailing standards of care or medical ethics. This may be identified through complaints, QI activities, failure to maintain adequate medical records, failure to provide adequate care or after hours care, or any other occurrence leading to quality of care issues.

Corrective actions may vary according to the situation and may include but are not limited to, one or more of the following as they relate to treatment, procedure, and service:

- Written warning to the practitioner
- Discussion with the practitioner
- Placing the practitioner under a focused review via medical review or reviews generated by claims data at scheduled intervals; results reported to the Quality Improvement Committee (QIC) who will direct further action of the corrective action plan
- Requiring the practitioner to enter into a preceptor relationship with another practitioner, whereby the practitioner acting as the preceptor would monitor and observe the practitioner subject to corrective action, including examining medical records and interaction with members
- Requiring the practitioner to complete continuing medical education regarding treatment, procedure, or service in question
- Limiting the practitioner's privileges (i.e., limiting the authority to perform certain procedures)
- Recommendation for recredentialing on a shorter cycle
- Recommendation for contract termination

Any final determination resulting in corrective action will be communicated to the practitioner in writing, setting forth the type and nature of the corrective action to be taken. Any corrective action will be monitored for compliance at intervals determined by the Quality Improvement Committee. The practitioner will be notified of the results of such monitoring and will be made aware of the termination or continuation of any corrective action as recommended by the Quality Improvement Committee.

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 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 practitioners shall preserve all records related to members for a period of not less than ten (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 practitioner 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 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 practitioner offices should require review of the medical record and confidentiality statement, annually.

Standards for Patient Records

1. THP requires consistent and legible method of record keeping for all patient encounters. Each patient's medical record entry must comply with the following medical record documentation standards:

    - Must be easily readable
    - 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
    - Practitioner 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 practitioner'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 complaint
        - 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 practitioners
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
6. THP has a process to assess and improve the content, legibility, organization, and completeness of member health records through an annual medical record audit and comprehensive analysis. Practitioners whose medical records do not meet the thresholds will be notified of the audit findings and will be provided with additional educational resources and/or remediation plan if warranted. This process is followed for other QAPI activities that may require a medical record to be reviewed.

Those with medical record audit finding may be placed on a focus review as determined by the Quality Management Director, Medical Director, or Quality Improvement Committee. Focus reviews related to medical record audit finding will be directed by the Quality Improvement Committee, the Executive Management Team or The Health Plan Board of Directors will be conducted as instructed.

Electronic Health Record (EHR)

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.

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.

Auto-populations Information or Defaults

The office has a policy/procedure to verify the validity of auto-populated information. Auto-populated information or defaults refers to data that does not require a positive action or selection, or data that is entered by abbreviated words or keystrokes.

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.

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 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 practitioners. All referral notifications will include a reminder to all parties to share clinical information timely.
- Practitioners must document member input in all treatment plans submitted;
- THP does not prohibit a health care professional from advising and advocating on behalf of a member.
- Practitioner 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.

Practitioner Availability Standards

Primary Care Provider (PCP) and Practitioner Expectations:

- Maintain continuity of enrollee's health care by serving as the PCP
- Provide access twenty-four (24) hours a day, seven (7) days a week
- Emergency cases must be seen immediately or referred to an emergency facility
- Urgent cases must be seen within forty-eight (48) hours
- Routine cases other than clinical preventive services, must be seen within twenty-one (21) calendar days (exceptions are permitted as specific times when PCP capacity is temporarily limited)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services must be scheduled in accordance with EPSDT guidelines and the EPSDT Periodicity Schedule
- 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
- Follow THP's established procedures for coordination of in-network and out-of-network services for Mountain Health Trust enrollees
- Have one (1) or more THP participating practitioner(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 a referral to a behavioral health specialist contact THP's Behavioral Health Department at 1.877.221.9295 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 their progress.

Practitioner Self Care/Treatment and/or Family Care/Treatment

THP follows American Medical Association (AMA) recommendations that practitioners should not treat themselves, their immediate family members, or their household members.

Practitioner should not treat themselves or members of their families.

However, it may be acceptable to do so in limited circumstances such as:

- In emergency settings or isolated settings where there is no other qualified practitioner available
- For short term, minor problems
- Except in emergencies, it is not appropriate for practitioners to write prescriptions for controlled substances for themselves or their immediate family members

When treating self or family members, practitioners have a further responsibility to document treatment or care provided and covey relevant information to the patient's PCP.

Access Standards

Primary Care Providers (PCP)	
Routine Care	Within 21 calendar days
Urgent Care	Within 48 hours
Emergent Care	Immediately or referred to an emergency facility
Behavioral Health	
Initial Routine Care	Within 10 business days
Follow Up Routine Care	Within 30 business days (prescribers) Within 20 business days (non-prescribers)
Non-Life-Threatening Emergency Care	Within 6 hours
Emergent Care	Immediately or referred to an emergency facility
OBGYN	
Initial Prenatal Care	Within 14 calendar days of the date the patient is found to be pregnant
Initial or Follow Up Routine Care for Non-OB Patients	Within 30 calendar days
Specialty Care	
Initial Routine Care	Within 30 calendar days
Follow Up Routine Care	Within 30 calendar 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.