

QUALITY IMPROVEMENT
SECTION VI

I. INTRODUCTION

Community Health Plan has a strong commitment to quality. In order to achieve and maintain our standards, we rely on the individual commitments to quality from each of our participating providers. We also rely on our providers' clinical experience and judgment. It is the cornerstone of our quality improvement program.

We strive to ensure that Community Health Plan delivers the right procedure, in the right setting at the right time. We enlist quality programs, which educate and support both the patient and provider. We align our performance and quality with the National Committee for Quality Assurance (NCQA) by comparing ourselves with over 300 other health plans nationwide.

NCQA is an independent not-for-profit organization that evaluates managed care plans. It provides a set of performance measures called the Health Care Effectiveness Data and Information Set (HEDIS®), which is used to evaluate managed care plans annually. We demonstrate our commitment to this data collection effort by reporting our HEDIS results to NCQA for public release. Community Health Plan is committed to achieving the highest levels of satisfaction from our members and providers. We use HEDIS results to improve our quality programs and satisfaction levels.

II. THE QUALITY PROGRAM

Community Health Plan's Quality Improvement Program is comprehensive and includes the systematic and objective monitoring, evaluation, and improvement of the quality of care (medical and behavioral health) and services provided to Community Health Plan customers. The selection of clinical issues for monitoring and evaluation reflect our population and may be based upon demographic and epidemiology data, and special needs population.

Our quality program is carried out through several committees. These include:

Provider Relations/Quality Review Committee

The Provider Relations/Quality Review Committee (PR/QRC) was established to oversee and provide overall direction for a comprehensive, planned and systematic Quality Improvement Program, which includes the quality of care and services, and utilization management provided to Community Health Plan members. Various areas of oversight include review of the medical management programs, including Utilization Management and Quality Improvement standards as they relate to the provider network. Other areas include review of provider credentialing/recredentialing, the provider network maintenance and contract review process and routine measurement and monitoring of provider performance, provider profiling, and the provider satisfaction process. The PR/QRC is a multi-disciplinary committee composed of Community Health Plan participating practitioners, Community Health Plan Board of Directors representative(s) and Community Health Plan staff. This committee reports to the Community Health Plan Board of Directors, which has granted them this oversight authority. Sub-committees are formed, as appropriate, to develop specific clinical programs.

Quality Improvement Committee

The Quality Improvement Committee (QIC) is an interdisciplinary committee composed of members from each Community Health Plan department. The QIC was established to provide a multi-disciplinary approach to identify, discuss, analyze, recommend, implement, follow-through, monitor and re-assess the impact of quality improvement processes on the clinical and administrative services and issues for improving the quality of care and service provided to Community Health Plan customers. The committee discusses operational implications and rationale for new program development, analyzes data for service and quality improvement implications and discusses interdepartmental linkages and opportunities on issues and services of health plan operations that impact care and services. The QIC also develops recommendations while considering multidisciplinary needs to provide ideas for quality improvement studies, actions or initiatives. In summary, the QIC evaluates the overall effect of improvement processes on the service and care provided to Plan members. The QIC reports to Community Health Plan Leadership as well as the Provider Relations/Quality Review Committee.

Internal Review Committee

The Internal Review Committee (IRC) was established to provide an appeal process that members or providers with financial recourse against members may utilize if their inquiry has not been resolved to their satisfaction. The IRC is composed of the Plan Administrator, Medical Director and the Departmental Team Leaders of Community Health Plan.

III. QUALITY INDICATORS

Community Health Plan has defined and established specific areas of focus to effectively measure the quality of care provided to our members. These quality indicators will allow us to monitor and measure the quality of care throughout the health care continuum.

The following is a list of Community Health Plan's quality indicators. A 100% review will be conducted on all cases:

- Unplanned re-admission to a hospital within 7 days of discharge
- Unexpected death:
 - within 48 hours of hospital admission
 - peri-op death within 48 hours of receiving anesthesia
 - intra-op death, non-trauma related
 - death following delivery of infant
 - neonatal death
 - suicide
- Suicide attempt while hospitalized
- Medication errors with unfavorable outcome
- Blood transfusion error
- Complications to care
- Member or provider quality of care complaint/issue (to include Community Health Plan purpose codes located under the Quality of Care section)
- Wrong patient/wrong site (surgery/radiology).
- Member admitted to hospital within 24 hours of visit to and discharge from ER
- Other_____

A quality indicator case review will originate within the Quality Improvement Department and be referred to the Medical Director for evaluation and recommendation. If the Medical Director feels there is a potential quality of care issue, the case may be presented to the Provider Relations/Quality Review Committee for peer review.

If the case is presented for peer review, the Committee will make a determination regarding which level of severity should be applied, and the appropriate actions to be taken. The quality of care levels of severity are:

Level 0: No quality of care concerns were substantiated

Level 1: Minor quality of care concern

Level 2: Potential Harm

Level 3: Harm

Providers are notified when one of their cases is subject to peer review and given the opportunity to present additional information regarding the case. Once a determination is made, the involved provider will be notified in writing of the peer review outcome.

All information regarding the peer review process is kept strictly confidential.

IV. CONFIDENTIALITY

All documentation and information relevant to the administration of the Quality Improvement Program are considered confidential and shall be treated as such in compliance with HIPAA standards. All information specific to the identities of members and/or providers involved in referral cases shall be maintained in trust, as will be the identity of those acting as advisors and/or committee members. Information includes, but is not limited to committee meetings, presentations, discussions, member complaints, appeals, and grievances, meeting minutes, agenda items, and any data presented or requested. Access to information is restricted to committee members and appropriate health plan employees. Statements of Confidentiality are signed in those circumstances where privileged information is discussed and/or handled.

V. STANDARDS OF CARE

The medical community traditionally uses national standards and guidelines as one of the tools in the medical decision-making process. At Community Health Plan, we draw from the clinical knowledge and experience embodied in the most respected guidelines for care:

- American Diabetes Association
- American Heart Association
- American College of Obstetrics and Gynecology.
- Center for Disease Control
- Healthy People 2010
- KCQIC Guidelines
- Milliman Care Guidelines®
- National Heart, Lung, and Blood Institute
- Oak Group MCAP Clinical Review Criteria™
- US Preventive Services Task Force

VI. PREVENTIVE HEALTH GUIDELINES

The Provider Relations/Quality Review Committee has adopted Preventive Health Guidelines to assist Community Health Plan in promoting wellness and healthy lifestyles for its members and to enhance the delivery of preventive care in practice. The guidelines are designed to supply providers with a practical reference on clinical preventive services they are expected to perform routinely for Community Health Plan members in their practice. Population based studies are conducted to assess performance against the guidelines and the established performance goal. The performance is measured annually.

Basic components of our preventive guidelines include:

- Mammography (women over age 40) every year
- Cervical cancer screening – pap test (women age 18 and older) every 1-3 years
- Cholesterol screening (men over age 35 and women over age 45)
- Childhood/adolescent immunizations (DPT, IPV, Hep B, Hib, MMR, VZV, & pneumococcal conjugate)
- Adult immunizations (DPT every 10 years, influenza annually over age 50)
- Colorectal cancer screening for adults over age 50
- Chlamydia screening for sexually active women age 16 to 25
- Prostate exam (men) > age 50 Consider PSA and digital rectal exam

VII. GUIDELINE ADOPTION

The development, implementation, measurement, monitoring and analysis of practice and preventive health guidelines apply principles of continuous quality improvement to the whole spectrum of care for a particular condition or to reduce the incidence of illness, disease and accidents. By educating and encouraging our providers to follow guidelines based on accepted medical and scientific evidence, measuring the results, and feeding those results back to the providers, Community Health Plan hopes to reduce variations in care and produce better outcomes.

VIII. MEDICAL RECORD REVIEW

Community Health Plan routinely reviews provider office-site medical records to evaluate the quality of medical care for Community Health Plan members. Reviews conducted will evaluate several components including: documentation practices, quality and continuity of care, and determine that record documentation is current, detailed, organized, and permits effective patient care and quality review.

The results of the review are provided in writing to the practitioner. This report will include the performance standard established and the practice office site performance. Practice office-sites that do not meet established goals will be monitored by the PR/QRC to assure that performance improves. Corrective action plans and/or educational sessions will be developed when opportunities for improvement are identified.

Medical Record Documentation Standards

1. There is an individual record for the member.
 - A single chart per member is required.
 - A bound chart is strongly recommended but not required.
2. Biographical/personal data are documented.
 - The following information is required: name, address, sex, date of birth, phone number, emergency phone number, and insurance information.
3. All pages contain patient identification.
 - Each page of the medical record is labeled with the patient's full name or one other identifier such as social security number, or medical record number.
4. The medical record is organized.
 - Documentation and pages within the medical record are arranged in an organized fashion (i.e. lab, x-ray filed together in chronological order). Dividers labeling the separate sections by category are recommended.
- *5. There is a current problem list/history.
(only necessary for patients with chronic/on-going medical conditions.)
 - Must be a separate form from the progress notes.
- *6. There is a current medication list/history.
(only necessary for patients with chronic/on-going medical conditions that necessitate medications, i.e.: diabetes, hypertension, asthma.)
 - This list includes every medication the patient is taking.
 - Medication documentation includes name, dosage, frequency and duration.
 - All medications are listed with start and stop dates, and indication of refill limits.
 - Must be a separate form from the progress notes.
- *7. Allergies/adverse reactions are displayed prominently.

- Notations are made on front cover or on the first page on either side when the medical record is opened.
 - All medical records in the practice have notations in the same place.
 - Notations indicate all allergies; adverse reactions to medications and other substances are also indicated.
 - The specific allergy or adverse reaction and the specific substance are noted.
 - If no allergies are known, "No Known Allergy" or "NKA" is noted.
- *8. Appropriate past medical history is in the record (for patients seen 3 or more times) A complete history includes the following medical history found in a single, easily accessible location in the medical record:
- Family history (i.e.: hypertension, diabetes, cancer, longevity, respiratory disease, neurological disorders, allergic conditions, heart disease)
 - Surgical procedures
 - Known allergies/adverse reactions to medications and other substances
 - Hospitalizations
 - Chronic illnesses
 - Pregnancies and deliveries - prenatal history, as appropriate
 - Past and current diagnosis and problems
 - Childhood illnesses
- *9. A pertinent history and physical exam is taken.
(Recommend "SOAP" format) and includes:
- Date of service
 - Pertinent information to complaint
 - History of present illness
 - Admitting diagnosis
 - Statement on the course of action planned for this episode of care and its periodic review
 - Physical examination
- *10. PCP has reviewed summaries, lab, and other test results.
- The PCP reviews and signs summaries and test results he/she orders, and those performed/ordered by consultants/specialists.
 - A full signature, or initials, or electronic identifier is present.
 - Consultation and abnormal lab and imaging study results should have an explicit notation in the record of follow-up plans.
11. Each entry is signed or initialed by the provider.
- All entries should identify the author.
 - The physician signs or initials each of his/her entries (unless solo practice and no one else documents in the medical record) or other entries as required.
 - Other staff initials or signs each of their entries.
 - There is a system to match names with initials.
 - Stamped Physician signatures are not accepted
 - Unique electronic identifiers are accepted on Physician entries with electronic medical records.
12. Each entry is dated.

- All entries must be dated.
 - If entries carry over to multiple pages, each page contains a date.
13. The record is legible.
- The entry can be read aloud by 2 out of 3 readers.
 - Corrections are made appropriately: a single line is made through mistakes, initialed and dated.
 - Correction fluid or other methods that obliterate the original entry are not allowed.
14. A completed immunization history is in a single location in the chart for children and adults. A note in the record indicating immunizations are “up to date” is not accepted.
- There is a completed immunization record for patients age 10 and under.
 - A record of immunizations is not counted if documented throughout the progress notes only.
 - The dates (month, day, and year) of the immunization are noted.
 - There is documentation of adult immunizations as appropriate. (i.e. - Tetanus boosters, Pneumonia & Flu Vaccines, Hepatitis B). There is documentation of the adult member’s immunization history, or that the member has been asked if their immunizations are current, or a record notation that immunizations are not indicated for this member.
15. Vital signs are taken.
- For adults age 18 years and older:*
- Blood pressure measured annually, more frequently if medically indicated.
 - Pulse and temperature as appropriate for complaint.
 - Weight yearly or more frequently as needed. Height once.
 - Include pain assessment when this is identified as the chief complaint.
- For Children age 17 years and younger:*
- Height and weight at each visit
 - Height/weight plotted on growth chart for all well-child visits from birth to 6 years, and at least every 2 years for ages 6-18.
 - Blood pressure measured annually beginning at age 3, more frequently if medically indicated.
 - Pulse and temperature as appropriate for complaint.
 - Include pain assessment when this is identified as the chief complaint.
16. There is a follow-up plan or date for a return visit.
(recommend "SOAP" format).
- A date or time frame for a follow-up visit to address a specific problem is documented.
 - If no follow-up visit is needed, a date or time frame for the next routine visit is documented.
17. Unresolved problems from previous visits are addressed.

- Chronic and acute problems identified previously are addressed during subsequent visits.
 - Continuity of care is apparent.
18. There is documentation of member referral to consultants and diagnostic and therapeutic services including , home health services, physical, occupational or speech therapy when applicable.
- Referral letters or telephone record from PCP to specialist; or,
 - Letters, reports, or record of telephone calls from the specialist back to PCP.
19. Signed HIPAA Confidentiality form is present in the chart.
20. Appropriate notation concerning use of: (for patients 11 years and older)
- a.) alcohol
 - b.) cigarettes
 - c.) substance abuse (3 or more visits)
- * Criteria identified as having a high potential for quality issues (90% compliance).

IX. RISK MANAGEMENT/PATIENT SAFETY

Community Health Plan is committed to conducting activities to improve patient safety and reduce risk for the Plan. The Plan will work in collaboration with network providers to provide a “climate” for safety. These activities include, but may not be limited to:

- Quality of care issues
- Member appeals
- Continuity and coordination of care
- Provider site visits