
Quality Improvement Program

The Plan's Quality Improvement Program serves to improve the health of its members through emphasis on health maintenance, education, diagnostic testing and treatment.

The Quality Improvement Program incorporates activities to assess the accessibility, availability, efficiency, safety, efficacy, appropriateness, effectiveness and continuity of patient care and services delivered by health care providers and the Plan itself.

The Quality Improvement department will assess for practitioner compliance to the minimum guidelines of care and documentation, as required by regulatory agencies and accreditation organizations. Assessment information will include, but not be limited to medical record documentation, health screening rates and disease management care.

Quality Improvement Organization (QIO)

Under a Memorandum of Agreement between the Plan and the Quality Improvement Organization (QIO), the Plan is required to participate in specific reviews and tasks applicable to the Medicare QIO Programs geared toward improving care for beneficiaries enrolled in managed care.

Providers contracted with the Plan are required to participate in all quality improvement functions and tasks required by the QIO.

These activities may include but are not limited to:

- Compliance with request for medical records for quality improvement studies and audits;
- Cooperation with quality improvement initiatives related to QIO collaborative projects;
- Cooperation with QIO efforts to improve care for chronic disease and/or preventive care measures;
- Compliance with requests for information and recommendations formulated by the QIO in the

process of reviewing/resolving beneficiary and/or provider complaints.

The QIO for Medicare (CMS) will also perform annual audits. Providers will need to copy office records for these audits. It is very important that any time a copy of a record is requested the entire record is sent.

In addition to monitoring the guidelines in this manual, continuity of all patient care will be monitored (see the **Medical Records** section). The results of all reviews are maintained in a physician profile and utilized at the time of re-credentialing.

Provider Participation with QI Activities

In accordance with regulatory contracts and accreditation guidelines, the Plan and its providers contractually agree to participate in quality improvement projects and medical record review activities to:

- Promote the appropriate medical record documentation and management of patients with designated diagnoses;
- Identify areas of medical record documentation and management that may be improved;
- Oversee the quality of the medical record;
- Provide periodic feedback to the physicians;
- Identify areas of practice that require peer review; and
- Create a performance profile to be utilized during the credentialing process.

Access to Records

- Access to the Plan's member's medical record in the office or facility for review is required (Results of all reviews will be housed in a provider profile to utilize during re-credentialing and re-contracting.)

Other Requirements

- Copying and providing office records as needed for quality-review activities;
- Requests for internal QI data from delegated credentialing entities; and
- Copying and providing office records for state, federal and QIO review.

Quality Improvement Activities

The following are Quality Improvement activities performed by the plan on an ongoing basis:

- Preventive Health Maintenance;
- Development and review of Clinical Practice Guidelines;
- Disease Management Initiatives;
- HEDIS[®] Studies;
- Referrals for quality issues;
- Provider specific issues identified through tracking and trending of complaints or referrals;
- Medical Record Content Reviews – see **Medical Records** section for specific documentation standards and requirements;
- Medicare National QI Projects;
- State QI Projects; and
- Chronic Care Improvement Programs.

Focus on Patient Safety

The Plan is committed to offering a network of providers that ensures the safe delivery of clinical care to member enrollees. The Plan's Patient Safety Plan (Plan) exists to establish the framework for demonstrating this

commitment. Through execution of standardized internal processes and collaborative participation of providers, the Plan seeks to promote improvement in network patient safety practices.

The objectives of the Plan are to:

- Inform members and providers regarding the Plan's expectations for patient safety;
- Engage the provider community in adopting processes to improve safe clinical practices;
- Assist members to be participants in the delivery of safe health care;
- Formally recognize and support patient safety best practices.

The Plan addresses key elements of patient safety, such as the extent of coordination of care between providers, medical record review findings, clinical practice guideline compliance, adverse event and quality of care complaint tracking/trending, pharmaceutical management practices and member interactions. Through tracking and trending of relevant Plan metrics, the Plan can identify opportunities for improvement and facilitate education of a specific practitioner and/or the provider community at large in order to reduce the potential for patient safety incidents.

Annually, the Plan will define the specific areas of patient safety to be monitored during the year. The Plan will utilize the provider newsletter to periodically communicate the results of patient safety activities and any provider best practices identified in the promotion of patient safety.

Quality-of-Care Issues

Quality-of-Care referrals are defined as complaints and adverse outcomes related the quality-related issues. They may be generated by the Appeals, Grievance, Risk Management, or Utilization Management departments or may be identified through routine record review.

Issue types include items such as unplanned re-admission for a same or similar diagnosis in less than 30 days, patient fall, serious complication of anesthesia, transfusion error or serious transfusion reaction, medication error or adverse drug reaction with serious potential for harm, care or lack of care which could have resulted in a potentially serious complication, etc.

Record review identifying possible quality-of-care issues will be referred to peer review. In the event the peer reviewer/panel feels there is a possible quality-of-care issue, the physician will be asked, in writing, to provide additional information to address the issue. The response is reviewed and a final determination is rendered.

Peer review is categorized in the following manner:

1. Substantiated – there is evidence of a deviation in the standard of care
2. Unsubstantiated – there is no evidence of a deviation from the standard of care

Once that determination is made, the outcome is classified as either “adverse event” or “no adverse event”.

Results of peer review activity will be reported to state and regulatory agencies as appropriate.

**HEDIS[®]
Studies**

The following HEDIS[®] indicators may be reviewed and reported on an annual basis. Throughout the year, initiatives involving physician and members will be undertaken as necessary to achieve an improvement in outcomes.

Antidepressant Medication Management – Optimal Practitioner Contacts for Medication Management

The percentage of members 18 years of age and older who were diagnosed with a new episode of depression and treated with antidepressant medication, and who had at least three follow-up contacts with a practitioner

coded with a mental health diagnosis during the 84-day (12-week) Acute Treatment Phase. At least one of the visits must be with a prescribing practitioner.

Effective Acute Phase Treatment

Percentage of members 18 and older as of April 30 of the measurement year who were diagnosed with a new episode of depression, were treated with antidepressant medication and remained on an antidepressant drug during the entire 84-day (12-week) Acute Treatment Phase.

Effective Continuation Phase Treatment

The percentage of members 18 and older as of April 30 of the measurement year who were diagnosed with a new episode of depression, were treated with antidepressant medication and remained on an antidepressant drug for at least 180 days.

Persistence of Beta-Blocker Treatment After a Heart Attack

Members ages 35 and older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.

Cholesterol Management for Patients with Cardiovascular Conditions

Members ages 18-75 who were hospitalized for AMI, coronary artery bypass grafting (CABG) or Percutaneous Transluminal Coronary Angioplasty (PTCA) or had a diagnosis of ischemic vascular disease and had LCL-C screening performed during the measurement year and a level of < 100 mg/dL.

Colorectal Cancer Screening

Members ages 50-80 who have had appropriate screening for colorectal cancer.

Comprehensive Diabetes Care - Hba1c Screening

The percentage of members ages 18-75 who have diabetes and had an HbA1c test during the measurement year.

Comprehensive Diabetes Care - Hba1c Poorly Controlled

Members ages 18-75 who have diabetes and whose HbA1c level is greater than 9.0 percent during the measurement year.

Comprehensive Diabetes Care - HbA1c Good Control

Members ages 18-75 who have diabetes and whose HbA1c level is less than 7.0 percent during the measurement year.

Comprehensive Diabetes Care - LDL-C Screening

Members ages 18-75 who have diabetes and had a LDL - C test once in the measurement year or the year prior.

Comprehensive Diabetes Care LDL-C Controlled

Members ages 18-75 who have diabetes and had a LDL – C < 100 mg/dL during the measurement year or the year prior.

Comprehensive Diabetes Care - Dilated Retinal Eye Examination

Members ages 18-75 who have diabetes and had a dilated eye examination, in the measurement year, or a negative retinal exam by an eye care professional in the year prior to the measurement year.

Comprehensive Diabetes Care - Monitoring for Nephropathy

Members ages 18-75 who have diabetes and had a nephropathy screening test or evidence of nephropathy. As a minimum, documentation in the medical record must include a note indicating the date on which a urine

microalbumin test was performed, and the results. The following can be used as proof of testing: 24-hour urine for microalbumin, timed urine for microalbumin, spot urine for microalbumin, urine for microalbumin/creatinine ratio, 24-hour urine for total protein, Random urine for protein/creatinine ratio. Evidence of Nephropathy can be demonstrated by: Documentation of a visit to a nephrologists; documentation of medical attention for any of the following: diabetic nephropathy, end-stage renal disease, chronic renal failure, renal insufficiency, proteinuria, albuminuria, renal dysfunction, acute renal failure, dialysis; a positive urine macroalbumin test (*note, "trace" urine macroalbumin test results do not count*); evidence of ACE Inhibitor/ARB therapy.

Comprehensive Diabetes Care - Monitoring Blood Pressure

Members ages 18-75 who have diabetes and blood pressure level <130/80 mm Hg and <140/90 mm Hg.

Controlling High Blood Pressure

Members ages 18-85 years old with the diagnosis of hypertension whose blood pressure was controlled < 140/90mm/Hg during the measurement year.

Flu Vaccination

Members ages 65 and older that received an influenza vaccination.

Breast Cancer Screening

Women ages 40-69 that had a mammogram in the measurement year or year prior.

Osteoporosis Management in Women Who Have Had a Fracture

Women 65 and older who were diagnosed with a fracture and who received either a bone mineral density test or prescription treatment for osteoporosis within six months of the date of the fracture.

Pneumonia Vaccination

Members ages 65 and older that received a pneumonia vaccination.

Management of Urinary Incontinence in Older Adults

Medicare Advantage members ages 65 and older who reported an incontinence problem in the past six months and who discussed the problem with their provider and received treatment.

How Many Visits With The Doctor Was The Patient Advised To Quit Smoking

The number of visits in which enrolled members were advised to quit smoking by their provider.

Adult Health Screening

An adult health screening should be performed by a physician to assess the health status of all Medicare Advantage members within 90 days of the member joining the plan. The adult member should receive an appropriate preventive health assessment and intervention as indicated or upon request. Please refer to the Adult Preventive Health Guidelines in the **Member and Provider Education Materials** section.

Clinical Practice Guidelines

Clinical Practice Guidelines that are based on the health needs and opportunities for improvement are identified as part of the quality improvement program.

The clinical guidelines are reviewed, revised and adopted on a yearly basis, utilizing nationally-recognized evidenced based sources. The guidelines are developed with input from community physicians and reviewed and approved annually by the WellCare Medical Advisory Committee, the Quality Improvement Committee and the Board of Directors.

Member educational materials, benefit plans and coverage parameters are reviewed against the guidelines annually to ensure consistency. Please refer to the **Member and Provider Education Materials** section for copies of current guidelines.

**Disease
Management
Initiatives**

The Chronic Care Improvement program offers members with chronic medical conditions, including but not limited to congestive heart failure (CHF) and diabetes awareness of their condition, direction and education.

The Chronic Care Improvement program has been designed to assist the physician in the educational process for the member and to promote a healthy lifestyle. Please refer to the **Case Management** section of this manual for more information.

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