

Introduction

The Quality Improvement Program (QIP) at WellCare represents a company-wide commitment to continuously monitor and improve clinical care and services provided to its membership. The program utilizes clinical and service indicators to monitor, plan, implement and improve service delivery to its members. Through its advanced information technology system, management structure and support staff, WellCare strives to maintain a QIP that will effectively improve the health status and satisfaction of members across all product lines.

WellCare believes that providers are crucial to the success of the QIP. Therefore, we foster an atmosphere of collaboration and cooperation with our participating providers. WellCare requires participating providers to comply with the requirements of its Quality Improvement Program as outlined in the Agreement and to encourage members to develop better health habits.

**WellCare's
Quality
Improvement
Program**

The Quality Improvement Program serves to improve the health of our members through emphasis on health maintenance, education, diagnostic testing and treatment. The purpose of the quality improvement program is to establish a systematic process of Quality Improvement that will ensure a comprehensive, integrated, plan-wide system to assess and improve the quality of clinical care and services provided to members.

Goals

The goals of the Quality Improvement Program are:

1. To improve the quality of services delivered to members.
2. To ensure the availability of, and access to, qualified and competent providers.
3. To provide members with quality health care within a system that promotes efficient use of resources and supports the physician-patient relationship.
4. To ensure provider input into the Quality Improvement Program activities.

5. To ensure care consistently meets quality standards as required by contract, regulatory agencies, recognized care guidelines, industry and community standards of care.

Objectives

The objectives of the Quality Improvement Program are to:

1. Monitor and evaluate health care and plan services.
2. Monitor and verify clinical competence.
3. Establish and apply clinical indicators/standards.
4. Implement action plans in response to identified opportunities for improvement.
5. Evaluate the effectiveness of action plans and take additional action when needed.
6. Evaluate member satisfaction with health care and other plan services.
7. Evaluate provider satisfaction with the health plan programs and services.
8. Manage the utilization of resources.
9. Maintain record keeping of all Quality Improvement program activities. Report findings, actions taken, and their outcomes to the Board of Directors, Plan administration/staff, providers and members.

Scope

The Quality Improvement Program incorporates continuous quality improvement processes. This strategy is demonstrated by the structure of the Quality Improvement Program's committees and subcommittees, the QI program description, work plan and annual evaluation. The strategy incorporates the continuous tracking and trending of quality indicators to ensure outcomes are being measured and goals are attained.

Strategy**Governance and Structure--Board of Directors**

The Board of Directors has overall accountability and responsibility for the quality of health care and other services rendered to its members. The Board of Directors will support and have the final authority and responsibility for the assurance of a comprehensive and integrated Quality Assessment and Improvement program.

Quality Improvement Committee

The Quality Improvement Committee is responsible for promoting the goals and objectives of the health plan by:

1. Demonstrating corporate commitment to high quality care and to the organization's quality improvement.
2. Requiring that objective measures be used to evaluate the quality of care and service being provided.
3. Ensuring that quality improvement processes are in place and working effectively to improve quality.
4. Reviewing and approving the annual Quality Improvement and Utilization Management Program Descriptions, work plans, and evaluations.
5. Centralizing and coordinating the integration of health plan activities.
6. Monitoring ongoing health plan activity toward health plan goals and objectives.
7. Providing oversight of the following activities and providing recommendations for improvement:
 - a. Quality measurement studies
 - b. Quality Assurance Report Requirements
 - c. (QARR)/HEDIS[®] performance measures
 - d. Disease management programs
 - e. Member and provider surveys
 - f. Medical record review
 - g. Appeals and grievance

- h. Pharmacological reviews
 - i. Utilization Management reviews
 - j. Credentialing and re-credentialing reviews
 - k. Pharmacy and Therapeutics review
- 8. Overseeing credentialing and re-credentialing activities for the health plan providers.
 - 9. The Quality Improvement Committee has final approval of all credentialing and re-credentialing activities.
 - 10. Monitoring activities of contracted and delegated agencies.
 - 11. Providing a forum for the review, revision, and approval of health plan policies and procedures, guidelines, standards.
 - 12. Overseeing application and enforcement of national confidentiality policy.
 - 13. Ensuring compliance with regulatory and accrediting bodies.
 - 14. Monitoring activities of the Quality and Utilization Management subcommittees.

Medical Advisory Committee

The Medical Advisory Committee is the principal physician committee that oversees all clinical quality improvement, utilization management and behavioral health activities. The Medical Advisory Committee is responsible for promoting the goals and objectives of the health plan by:

- 1. Reviewing and approving the annual Quality Improvement and Utilization Management program descriptions, work plans, and evaluations.
- 2. Monitoring ongoing health plan activity toward health plan goals and objectives.
- 3. Analyzing and evaluating summary data from the

following activities and providing recommendations for improvement:

4. Quality measurement studies; QARR / HEDIS[®] performance measures; Disease management programs; Member and provider surveys; Medical record review; Utilization Management reviews.
5. Providing a forum for the review, revision, and approval of health plan policies and procedures, guidelines, standards, etc.
6. Providing peer review of all professional and technical activities.
7. Publicizes quality improvement findings to the appropriate staff and departments within the Plan.
8. Reports the findings and recommendations to the appropriate executive authorities.

Credentialing Committee

The Credentialing Committee is the principal physician committee that oversees health plan credentialing and re-credentialing activity. The committee also provides peer review for quality of care issues. The Credentialing Committee reports to the Quality Improvement Committee. The functions of the Credentialing Committee are to:

1. Perform the credentialing and re-credentialing of all health plan providers, including facilities, to assure that all providers meet minimum practice parameters established by the Plan and the physician community at large.
2. Conduct peer review on cases forwarded to Committee and develop recommendations for improvement initiatives.
3. Provide a forum for the review, revision, and approval of credentialing policies and procedure, and standards.

4. Provide peer review oversight of delegated credentialing activities.

Delegation Oversight Committee

The Delegation Oversight Committee coordinates and oversees all delegated activities ensuring that delegated entities adhere to contractual, regulatory, and accreditation requirements. The Delegation Oversight Committee ensures compliance with regulatory, contractual, and accreditation standards by:

1. Maintaining appropriate policies and procedures
2. Monitoring potential delegation activities
3. Completing pre-delegation audits
4. Executing delegation implementation
5. Completing annual delegation audits
6. Monitoring agencies on corrective action
7. Monitoring vendor reporting and data submission

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics Committee is an advisory group of physicians and pharmacy providers. The Committee is responsible for recommending the adoption of, or assisting in the formulation of, broad professional policies regarding evaluation, selection, and therapeutic use of drugs by the Plan physicians. The Committee also recommends or assists in the formulation of programs designed to meet physicians' and pharmacy providers' needs with regard to complete current knowledge on matters related to drug use. The Committee also assists in the detection of possible or potential problems for Plan beneficiaries at it relates to the prescription drug program. The Committee accomplishes its goals and objectives by:

1. Serving in an advisory capacity to physicians, the Quality Improvement Committee, and pharmacy providers, in all matters pertaining to the use of drugs (including experimental and investigational drugs).
2. Developing a formulary of drugs accepted for use by physicians and providing for its constant revision.

The selection of items to be included in the formulary will be based on objective evaluation of their therapeutic merits, safety and cost. The Committee should minimize duplication of the same basic drug type, drug entity or drug product.

3. Establishing suitable educational programs for physicians and pharmacists on matters related to drug use.
4. Studying problems related to over-utilization or inappropriate utilization among health plan beneficiaries or providers (physician or pharmacist).
5. Establishing and directing drug use review programs and studies.

Customer Service Quality Improvement Workgroup

The Customer Service Quality Improvement Workgroup functions as a multidisciplinary task force to identify opportunities for improvement in customer service. The committee reviews data relevant to member and provider complaints and appeals to ensure that individual member and provider issues are addressed, resolutions are appropriate and timely, the process is compliant with regulatory standards, and identified issues are referred for system response through the quality improvement process. Dedicated to the continuous quality improvement process, the committee facilitates open and consistent communication among, members, providers, the QIC and the company's departments. The committee's focus is on systemic analysis of access and quality of service provided to the members under the health care contract.

The committee is responsible for:

1. Identifying areas of needed quality improvement through analysis of trends found in member satisfaction surveys, complaint and appeal data, requests for PCP changes and member disenrollments.
2. Targeting interventions, implementing process

improvements and establishing tracking mechanisms to monitor and evaluate progress.

3. Developing performance goals and indicators, reviewing trends, and evaluating progress
4. Facilitating member focus groups for the purpose of improving the delivery of health care by obtaining member input to policies and benefits.
5. Reporting identified barriers to improvement in processes, progress, and implementation to the MAC.

Quality Indicators Outcome Measurement

QARR/HEDIS[®] measures are incorporated into the quality improvement program. The selection of measures is governed by contractual requirements for the Medicaid product. Based on analysis of the results, quality initiatives are developed and implemented to improve performance. Initiatives are reassessed on an annual basis to evaluate their effectiveness and to compare levels of performance with prior periods. Annual member satisfaction surveys are performed by an independent agency contracted by the Plan. QARR are reported annually to the New York State Department of Health for the following lines of business: Healthy Choice (Medicaid), Family Health Plus and Child Health Plus.

Annual QI Work Plan

Annually the Quality Improvement Department develops a Quality Improvement work plan for the upcoming year. The work plan integrates QI reporting and studies from all areas of the organization, and includes requirements for external reporting. The work plan includes the following elements:

- A written measurable objective for each QI activity planned;
- An attachment of all clinical care and service indicators, benchmarks, performance goals and results from the previous year;

- Schedules of reporting to Board of Directors and QIC;
- Schedules for reporting to outside regulatory agencies;
- Staff responsible for implementation and management;
- Initiation date, projected time frames, monthly updates and the targeted completion date; and
- The work plan is approved by the Board of Directors and QIC.

Annual QI Evaluation Program

At least annually the Quality Improvement Department conducts a formal evaluation of the QI Program. The annual evaluation identifies the outcomes and includes the following:

- Evaluates results, barriers and opportunities for improvement;
- Evaluates resources, scope, training and content of the program; and
- Formulates recommendations for the upcoming year's work plan.

Data Sources

On both a routine and ad hoc basis WellCare collects and/or analyzes data from external as well as internal sources to support quality improvement functions. Data from the following sources is routinely analyzed and results are used to identify opportunities for improvement, implementation of corrective action plans (if needed), and/or reporting to regulatory agencies:

- Appeals and Grievances
- Member satisfaction surveys
- Utilization/Disease management

- Claims/Encounter Data
- Medical Record Review
- Provider Access and Availability Surveys
- Member/Provider Complaints
- Site visits

**HEDIS[®]/QARR
WellCare's
Annual Report
Card**

The Healthcare Effectiveness Data and Information Set is the most widely used set of performance measures in the managed care industry. Developed and maintained by the National Committee for Quality Assurance (NCQA), it has become the standard to establish accountability in managed care.

HEDIS[®] contains measures across the following domains of care:

- Effectiveness of care
- Access/Availability of care
- Satisfaction with the Experience of Care
- Health Plan Stability
- Use of Services
- Cost of Care
- Informed Health Choices
- Health Plan Descriptive Information

New York State utilizes measures from the data set to monitor Managed Care Plan Performance in NYS through the Quality Assurance Reporting Requirements (QARR) measures. All managed care operating in New York State are required to report QARR to the NYS Department of Health for their Commercial, Child Health Plus and Medicaid/Family Health Plus populations. The reports are due in June of the year following the reporting year, with collection of data taking place between February and May. The New York State Department of Health or its designee audits the reported data between June and September.

Collection of data from claims/encounter data and medical record review is a vital part of HEDIS[®]/QARR reporting. To achieve accurate rates for the required measures it is essential that providers record and report the services required for the measures appropriately, regardless of

reimbursement methodology. Practices should ensure that claim forms are submitted with correct CPT codes for each service rendered. Proper submission will significantly reduce the need for on-site medical chart review and request for mailing of chart copies.

A statewide QARR report, "The New York State Managed Care Plan Performance", is produced each year by the NYSDOH. This report is a compilation of all HMO results in NYS allowing a comparison of all health plans. Copies of the report cards can be obtained from the internet or by contacting your Provider Service Representative.

Access and Availability Surveys and Standards**Access and Availability Surveys and Standards 24-Hour Access Surveys**

All Primary Care Providers are required by contract to provide access to care for members in their panel 24 hours/day, seven days/week. Compliance with this requirement is monitored on an on-going basis using methodology, guidelines and sample size selection formulas provided by the City of New York Office of Medicaid Managed Care (OMMC) and/or NYS DOH. The telephone survey is conducted after-hours (evening or weekends), by trained WellCare employees or a contracted vendor. Providers are expected to return the survey call within thirty (30) minutes to be in compliance with the standard.

Standards for 24 Hour Access

All Primary Care and OB Providers are required to be available 24 hours/day, seven days/week. The PCP, OB or designated on-call provider should be available to coordinate services and return emergency telephone calls within **30** minutes.

Standards for Appointment Availability

Type of Visit	Standard
Emergency Primary or Specialty	Immediate upon presentation

Standards for Appointment Availability (cont'd)

Type of Visit	Standard
Urgent	Within 24 hours
Non Urgent "sick"	Within 48-72 hours
Routine "non-urgent" or Preventive	Within 4 weeks of request
Specialist Referrals Not Urgent	Within 4-6 weeks of request
Adult Baseline and routine physicals	Within 12 weeks
Adult New Member physical	Within 90 days
Initial newborn Care	Within 2 weeks of hospital discharge
Prenatal 1st Trimester	Within 3 weeks of request
Prenatal 2nd Trimester	Within 2 weeks of request
Prenatal 3rd Trimester	Within 1 week of request
Initial Family Planning	Within 2 weeks of request
Provider visits to make health, mental health and substance abuse assessments for the purpose of making recommendations regarding recipient's ability to perform work when requested by a LDSS	Within 10 days of request

Medical Record Review and Documentation Standards

WellCare is required to conduct medical record reviews for various quality improvement initiatives and for an annual medical record documentation study. Records are reviewed against the following list of standards:

- Every page in the medical record contains patient identifiers (Name or Member ID & DOB).
- All entries in the medical record are signed. All entries must include the handwritten signature, unique electronic identifier or initials and profession of the practitioner rendering services, for example: RN, MD, DO.
- All entries in the medical record must be dated.
- All entries are legible to persons other than the practitioner.
- There is evidence of assessment of the patient's language and/or communication needs.
- Medication allergies or "no known allergies" are prominently noted in the record. This may include a sticker on the front of chart or prominent notation in a conspicuous place in the record.
- Past medical history is noted in the record.
- An up-to-date immunization record is included in the chart for children under 18. Included in the **Forms** section is a Vaccine Administration Record for Children and Teens.
- The record contains a problem list that includes significant illnesses or medical conditions. A copy of WellCare's Problem List is included in the **Forms** section.
- There is a listing of all medications the member is taking. A Medication Profile sheet is included in the **Forms** section.

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- There is documentation of screening for substance abuse of tobacco, alcohol and drugs with appropriate counseling/referrals if needed.
 - There is evidence the member was asked about Advance Directives and documentation of acceptance or refusal. Note: The record must contain evidence that the member was provided written information concerning the member's rights regarding Advance Directives and whether or not the member has executed an Advance Directive. A stamp may be utilized. The provider shall not, as a condition of treatment, require the member to execute or waive an advance directive.
 - There is documentation of screening for domestic violence in same sex as well as heterosexual relationships, with appropriate counseling and/or referrals if needed.
 - There is documentation of screening for behavioral health issues.
 - Appropriate laboratory and other studies are ordered and results included in the chart.
 - There are reports of diagnostic testing and reports of consultations in the medical record and evidence of review by the PCP.
 - There is documentation and records for emergency room care when applicable.
 - There is documentation of follow-up after hospitalizations in the medical record of members who were hospitalized.

On each visit there is documentation of the following:

- History and physical examination as related to the visit, chief complaint or purpose of the visit,

objective findings of the practitioner and diagnosis or medical opinion.

- Plan of treatment, referrals, disposition, diagnostic testing, therapies and prescribed regimens.
- There is documentation of follow up plans for abnormal testing/consultation reports or missed/cancelled appointments. There is documentation that the abnormal results or consultations were reviewed by the provider and documentation of the follow up to be done.
- There is documentation of patient education and instruction whether verbal, written or via telephone. The member is provided with verbal and/or written education/instruction as indicated and appropriate.

Significant medical advice given via telephone is entered in the member's record and appropriately signed and initialed. (This includes medical advice provided by after-hours telephone patient information or triage telephone services.) This applies to Medicaid and Family Health Plus members.

Pediatric/ Adolescent Health Screening

Ages 0 to 20 years. The purpose of the Child/Teen Health Check-up is to provide comprehensive, preventive, well child care on a regularly scheduled basis for identification and correction of medical conditions before the conditions become serious and disabling, and as an entry into the health care system and, for access to a medical home. Age appropriate Child Health Check-Up Tracking Forms are included in the **Forms** section of this manual.

Periodicity Schedule

A well-child visit should be conducted at Birth (neo natal examination), and at minimum at one month, two months, four months, six months, nine months, 12 months, 15 months, 18 months and once a year for

ages 2-20 years.

- An initial health screening should be performed within 90 days of enrollment in the plan. *If the member is seeing a new PCP there must be a screening within 90 days.*

Documentation for a well-child visit

- There is documentation of a comprehensive unclothed physical examination.
- There is documentation that a comprehensive health and developmental history was done.
- There is documentation that a developmental assessment was done.
- Vision screening is documented—vision status is assessed and the findings are documented in the medical record at each well-child visit. This includes age appropriate testing to determine if the child's vision is within the normal range.
- Dental screening is documented—dental status is assessed and the findings and/or recommendations are documented in the medical record.

The provider must recommend children who are three years and older (or a younger child if medically necessary) for an assessment by a dentist and document this referral in the child's medical record. Documentation of recommendation to see a dentist is sufficient.

- Nutritional assessment is documented—nutritional status is assessed and the findings are documented in the medical record at each well child visit.

This includes height and weight (measured and plotted on standard chart), head circumference if

24 months or younger, dietary intake, eating habits, use of alcohol, drugs or tobacco. Evaluation is suggested for the following groups: children who demonstrate weight loss or no gain over a period of time, children who are overweight in proportion to their height (greater than 95th percentile, weight for height variation from expected growth parameters, height below 5th percentile), presence of diseases in which nutrition plays a key role (such as cardiovascular disease, hyperlipidemia, GI disorders, hypertension, metabolic disorders, physical and mental handicaps affecting feeding, allergies, surgery and burns).

- **Lead Poisoning Prevention/Screening**

New York State Lead Screening and Follow-up Regulations, require Pediatric health care providers to:

- Test one and two year olds for blood lead levels as part of well-child care
- Assess other children six months to six years of age for risk of high dose exposure
- Test every child found, through risk assessment, to be at risk for lead exposure and any Medicaid enrollee from 36 to 72 months who has not been previously tested.
- Provide parents with written documentation of blood lead testing
- Report all blood lead levels = 10µg/dL to the NYC Department of Health and Mental Hygiene within 24 hours. (Providers using portable blood lead analyzers must report all test results).
- Provide appropriate medical management including follow-up blood lead testing,

developmental surveillance and risk reduction education for children found to have blood lead levels = 10µg/dL. See the **Member and Provider Education Section** or medical management guidelines.

- Guidelines from the New York City Department of Health Lead Poisoning Prevention Program are available in the **Member and Provider Education Section**.
- Anemia screening was done with a report of the Hemoglobin and Hematocrit (H&H) in the record.

H&H recommended at the following ages with results documented in the child's medical record.

- 9 months
- 15 months (recommended for children at risk)
- 13 years
- All menstruating adolescents should be screened annually
- When medically indicated
- Annual Tuberculosis (TB) skin testing is done if the member is in a high-risk category.

A Urinalysis is done if indicated. Urinalysis is recommended for children at age 5 and 16 and as indicated. Performing urine dipstick urinalysis for leukocytes is recommended annually for sexually active male and female adolescents.

- Serum cholesterol screening is done if indicated. Serum-cholesterol determination testing is

recommended in children with a family history of familial hyperlipidemia.

- Immunizations are administered at required intervals with dates documented. Providers must assess and document in the child's medical record the immunization status as appropriate for age and health history. If the immunizations are not up to date according to age and health history the provider should document why immunizations were not given at the time of the well child visit.
- Age-appropriate anticipatory guidance, or health education and counseling, is provided to the parent, guardian, and/or child, at each well-child visit.
- Family planning services or counseling will be offered to appropriate members.

The plan shall make available and encourage all pregnant women and mothers to receive, and provide documentation in the medical records to reflect counseling and services for family planning to all women and their partners.

- A WIC referral is completed.

A referral for all pregnant, breastfeeding, and postpartum women, infants and children up to age 5 will be made to the WIC program.

Adult Health Screening

The following applies to Medicaid and Family Health Plus members.

An adult health screening is performed to assess the health status of a member age 21 or older. It is used to detect and prevent disease, disability and other health conditions or monitor their progressions. The adult member will receive an appropriate assessment and intervention as indicated or upon request.

Please refer to the Adult Preventive Health Guidelines in the **Member and Provider Education Materials** section.

WellCare allows one screening every 365 days.

- An initial adult health screening should be performed within 90 days of entering the plan or if the member is seeing a new PCP.
- There is a health history documented.
Required content: present history, past history, family history, list of all known risk factors, and a nutritional assessment.
- There is documentation of a physical examination.
- Required content: measurements of height, weight, blood pressure and pulse; and physical inspection to include: Assessment of general appearance, skin, eyes, ears, nose throat, teeth, thyroid, heart, lungs, abdomen, breasts, extremities, and performance of pelvic, testicular, rectal, and prostate exam as appropriate per member's gender.
- There is documentation of a visual acuity testing.
At a minimum, visual acuity testing must document a recipient's ability to see at 20 feet.
- There is documentation of a hearing screening.
At a minimum, a hearing screen must document a member's ability to hear by the air conduction method.
- Tuberculosis (TB) skin testing is done if the member is in a high-risk category. The provider should consider assessing the member's risk for underlying tuberculosis infection and document the results in the member's medical record.
- There is documentation of an annual influenza

vaccination for members 50 years of age or greater or persons with medical indications.

Medical indications: chronic disorders of the cardiovascular or pulmonary systems including asthma; chronic metabolic diseases including hemoglobinopathies, diabetes mellitus, renal dysfunction, immunosuppression (also includes diseases caused by medications or by HIV (human immunodeficiency virus)), requiring regular medical follow-up or hospitalization during the preceding year; women who will be in the 2nd or 3rd trimester of pregnancy during the influenza season.

- Pneumococcal vaccination is documented for members 65 years of age or greater or for younger members with medical or other indications. A one-time revaccination should be given five years after the primary vaccination.

Medical indications: chronic disorder of the pulmonary system (excluding asthma), cardiovascular diseases, diabetes mellitus, chronic liver diseases including liver disease as a result of alcohol abuse (e.g., cirrhosis), chronic renal failure or nephrotic syndrome, functional or anatomic asplenia (e.g., sickle cell disease or splenectomy), immunosuppressive conditions (e.g., congenital immunodeficiency, HIV infection, leukemia, lymphoma, multiple myeloma, Hodgkins disease, generalized malignancy, organ or bone marrow transplantation), chemotherapy with alkylating agents, anti-metabolites, or long-term systemic corticosteroids.

- Colorectal cancer screening is documented beginning at age 50, both men and women should follow one of these five testing schedules:
 1. Yearly fecal occult blood test (FOBT). The take-home multiple sample method may be used.

2. Flexible sigmoidoscopy every five years.
 3. Yearly fecal occult blood test plus flexible sigmoidoscopy every five years. The combination of FOBT and flexible sigmoidoscopy is preferred over either of these two tests alone.
 4. Double-contrast barium enema every five years
 5. Colonoscopy every 10 years -
All positive tests should be followed up with colonoscopy.
- Urinalysis dipstick for blood, sugar and acetone. Manual or automated dipstick urine.
 - Hemoglobin and Hematocrit (H&H) testing is done.
 - Mammogram is done as indicated.
 - Pap test as appropriate.
 - Baseline screening for osteoporosis.

The U.S. Preventive Services Task Force (USPSTF) recommends that women aged 65 and older be screened routinely for osteoporosis. The USPSTF recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures.

The following are risk factors for osteoporotic fracture:

- Body habitus (weight less than 127 pounds; or body mass index [BMI] <20)
- Caucasian or Asian race
- Family history of osteoporosis

- Hypogonadism (estrogen deficiency)
- Sedentary lifestyle
- Smoking (greater than or equal to one pack per day)
- Excessive alcohol intake (greater than two drinks per day)
- Diet deficient in calcium or vitamin D without adequate supplementation
- Increased likelihood of falling

**Provider
Participation in
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:

1. To promote the appropriate medical record documentation and management of patients with specific diagnoses
2. To identify areas of medical record documentation and management which may be improved
3. To oversee the quality of the medical record
4. To identify areas of practice that requires peer review
5. To provide a performance profile to be utilized during the re-credentialing process.
6. Reviews will be performed on a representative sample of PCP records with member panels of 50 members or more

Access to records

Access to the Plan's member's medical record in the office or facility for review is required.

Types of Review

Medical record content
Continuity of care
Adult Health Screening
Pediatric Health Screening
Diagnosis specific screening
Maternity Care
HEDIS® review
Quality of care review to investigate a complaint or grievance

Review Criteria

The criteria utilized for medical record standards and standards of care are not authored by the plan. The criterion is based on regulatory requirements outlined in the Medicaid handbook, regulatory contracts, accreditation guidelines and accepted national organizations.

Plan of Correction (POC)

If a deficiency is identified during any of the review processes, a plan of correction will be requested from the PCP. Time frame for returning the plan of correction will be specified in the notification of deficiency. In the event a POC is not received in the stated time frame, a second request will be sent to the physician. In the event a POC is not received after the second request, a final request will be sent to the physician informing him/her that new member assignments will be deferred until which time the signed POC is received. Re-credentialing will not occur with any outstanding POCs until they are signed and returned.

Quality of Care Issues

Quality of care referrals may be generated by Appeals, Complaints & Grievance,, Risk Management and Utilization Management Departments or may be identified through routine record review. Quality of care

issues are investigated through an established review process.

Peer Review

A record review identifying possible quality of care issues is referred to peer review. In the event the peer reviewer/panel feels there is a possible quality of care issue, the physician is 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:

Substantiated – there is evidence of a deviation in the standard of care

Unsubstantiated – there is no evidence of a deviation from the standard of care

The outcome is then classified as either “adverse event” or “no adverse event”. Results of Peer Review activity are reported to State or other Regulatory agencies as appropriate.

Actions

Results of Peer Review that are deemed reportable may carry actions ranging from restriction on privileges to termination for cause. Results that are deemed Not Reportable may carry actions that range from tracking and trending, focus review, deferment of members, requiring the practitioner to take CMEs, to counseling.

All results of Peer Review Activity will be housed in a provider profile to be utilized during re-credentialing and contract renewal.

Other requirements

- Copying and providing office records as needed for quality review activities

- Copying and providing office records for state, federal and PRO review

Other Quality Improvement Activities

- Disease Management Initiatives
- State Focused QI Projects
- QIO Collaborative Projects