CHAPTER 12 - QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT

12.0 – QUALITY MANAGEMENT REQUIREMENTS
Health Choice Integrated Care works in partnership with providers to continuously monitor and improve the care given to our enrollees.

QUALITY MANAGEMENT DEPARTMENT RESPONSIBILITIES
The Quality Management Department is responsible for development of Clinical Practice Guidelines and policies related to quality management. Whenever possible, Health Choice Integrated Care adopts AHCCCS requirements and practice guidelines from national organizations known for their expertise in the area of concern. Please refer to the Clinical Practice Guidelines located on the Health Choice Integrated Care Provider website.

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT ANNUAL PLAN
Under the leadership of the Chief Medical Officer, Health Choice Integrated Care’s Quality Management department has developed a written Annual QM Plan that addresses Health Choice Integrated Care’s proposed methodology to meet or exceed AHCCCS minimum performance standards for contractual performance measures, as well as statewide performance improvement projects (PIPs). The QM Plan describes the components of the program and how the activities improve the quality of care and service delivery for enrolled members.

Provider Quality Management Plans
Health Home Providers shall develop an annual QM/PI Plan and provide to HCIC for approval. The plan is to include an evaluation of all quality management/performance improvement activities performed the prior year and outlines the QM goals for the coming year. The plan must address at a minimum, efforts to improve quality of care, a discussion of progress improving deficiencies identified internally or by HCIC, state-wide Performance Improvement Projects, performance measures, seclusion and restraint trends and any other efforts to improve quality.

QUALITY OF CARE CONCERNS
Documentation Related to Quality of Care Concerns
Quality of Care (QOC) concerns may be referred by state agencies, AHCCCS sources (e.g., Customer Service, the Office of the Deputy Director, Division of Clinical Quality Management), and external sources (e.g., behavioral health members; providers; other stakeholders; Incident, Accident, and Death reports). Upon receipt of a QOC concern, Health Choice Integrated Care follows the below procedures:

• Document each issue raised, when and from whom it was received and the projected time frame for resolution.
• Determine promptly whether the issue is to be resolved through one or more of the following areas:
  o Quality of Care;
  o Customer Service/Complaint Resolution;
  o Grievance and appeals process; and/or
  o Fraud, waste, and program abuse.
• Acknowledge receipt of the issue and explain to the member or provider the process that will be followed to resolve his or her issue through written correspondence. If the issue is being addressed as other than a QOC investigation, explain to the member or provider the process that will be followed to resolve their issue using written correspondence. QOC related concerns will remain in the quality management arena due to state and federal regulations: 42 U.S.C. 1320c-9, 42 U.S.C. 11101 et seq., A.R.S. §36-2401, A.R.S. §36-2402, A.R.S. §36-2403, A.R.S. §36-2404, A.R.S. §36-2917.
• Assist the member or provider as needed to complete forms or take other necessary actions to obtain resolution of the issue.
• Ensure confidentiality of all member information.
• Inform the member or provider of all applicable mechanisms for resolving the issue.
• Document all processes (include detailed steps used during the investigation and resolution stages) implemented to ensure complete resolution of each issue, including but not limited to:
  o Corrective action plan(s) or action(s) taken to resolve the concern.
  o Documentation that education/training was completed. This may include, but is not limited to, in-service attendance sheets and training objectives.
  o New policies and/or procedures, and
  o Follow-up with the member that includes, but is not limited to:
    ▪ Assistance as needed to ensure that the immediate health care needs are met, and
    ▪ Closure/resolution letter that provides sufficient detail to ensure all covered, medically necessary care needs are met and a contact name/telephone number to call for assistance or to express any unresolved concerns.

Process of Evaluation and Resolution of Quality of Care Concerns
The quality of care concern process at HCIC includes documentation of identification, research, evaluation, intervention, resolution, and trending of member and provider issues. Resolution must include both member and system interventions when appropriate. The quality of care process must be a standalone process and shall not be combined with other agency meetings or processes.

Health Choice Integrated Care, as active participants, complete the following actions in the QOC process:
• Identification of the quality of care issues;
• Initial assessment of the severity of the quality of care issue;
• Prioritization of action(s) needed to resolve immediate care needs when appropriate;
• Review of trend reports to determine possible trends related to the provider(s) involved in the allegation(s) including: type(s) of allegation(s), severity and substantiation, etc.;
• Research, including, but not limited to: a review of the log of events, documentation of conversations, and medical records review, mortality review, etc.; and
• Quantitative and qualitative analysis of the research, which may include root cause analysis.

For substantiated QOC allegations it is expected that some form of action is taken, for example:
• Developing an action plan to reduce/eliminate the likelihood of the issue reoccurring;
• Determining, implementing, and documenting appropriate interventions;
• Monitoring and documenting the success of the interventions;
• Incorporating interventions into the organization’s Quality Management (QM) program if appropriate, or
• Implementing new interventions/approaches, when necessary.

Each issue/allegation must be resolved; member and system resolutions may occur independently from one another. The following determinations should be used for each allegation in a QOC concern:

• **Substantiated** – the alleged complaint (allegation) or reported incident was verified or proven to have happened based on evidence and had a direct effect on the quality of the recipient’s behavioral health care. Substantiated allegations require a level of intervention such as a corrective action plan of steps to be taken to improve the quality of care or service delivery and/or to ensure the situation will not likely happen again.

• **Unable to Substantiate** – there was not enough evidence at the time of the investigation to show whether a QOC allegation did occur or did not occur. The evidence was not sufficient to prove or disprove the allegation. No intervention or corrective action is needed or implemented.

• **Unsubstantiated** – there was enough credible evidence (preponderance of evidence) at the time of the investigation to show that a QOC allegation did occur. The allegation is based on evidence, verified or proven, to have not occurred. No intervention or corrective action is needed or implemented.

Health Choice Integrated Care uses the following process to determine the level of severity of the quality of care issue:

• **Level 0 (Track and Trend Only)** – An issue no longer has an immediate impact and has little possibility of causing, and did not cause, harm to the recipient and/or other recipients, an allegation that is unsubstantiated or unable to be substantiated when the QOC is closed.

• **Level 1** – Concern that MAY potentially impact the recipient and/or other recipients if not resolved.

• **Level 2** – Concern that WILL LIKELY impact the recipient and/or other recipients if not resolved promptly.

• **Level 3** – Concern that IMMEDIATELY impacts the recipient and/or other recipients and is considered potentially life threatening or dangerous.

• **Level 4** – Concern that NO LONGER impacts the recipient. Death or an issue no longer has an immediate impact on the recipient, an allegation that is substantiated when the QOC is closed.

Health Choice Integrated Care report issues to the appropriate regulatory agency including Adult Protective Services, AHCCCS, Department of Child Safety, the Attorney General’s Office, law enforcement for further research/review or action. Initial reporting may be made verbally, but must be followed by a written report within one business day.

• Cases are referred to the HCIC Peer Review Committee when appropriate. Referral to the Peer Review Committee shall not be a substitute for implementing interventions (see Chapter 12.2, *Peer Review*).

• Health Choice Integrated Care must notify AHCCCS of any adverse action taken against a provider.

Upon receiving notification that a health care professional’s organizational provider or other provider’s affiliation with their network is suspended or terminated as a result of a quality of care issue, Health Choice Integrated Care will implement any necessary interventions/approaches, if appropriate, or will develop new interventions/approaches, when necessary.

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• **Level 1** – Concern that MAY potentially impact the recipient and/or other recipients if not resolved.

• **Level 2** – Concern that WILL LIKELY impact the recipient and/or other recipients if not resolved promptly.

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• Health Choice Integrated Care must notify AHCCCS of any adverse action taken against a provider.
Choice Integrated Care will provide written notification to the appropriate regulatory/licensing board or and AHCCCS. Health Choice Integrated Care, as active participants in the process, are required to notify AHCCCS of the same.

When the review of a quality of care concern is complete, Health Choice Integrated Care will submit a closing letter to AHCCCS. These letters will include the following:

- A description of the issues/allegations, including new issues/allegations identified during the investigation/review process,
- A substantiation determination and severity level for each allegation
- An overall substantiation determination and level of severity for the case.
- Written response from or summary of the documents received from referrals made to outside agencies such as accrediting bodies, or medical examiner.

**Tracking/Trending of Quality of Care Issues**

Health Choice Integrated Care uses trended QOC data to monitor the effectiveness of QOC-related activities to include complaints and allegations received from members and providers, as well as from outside referral sources. Health Choice Integrated Care-track and trend QOC data and report trends and potential systemic problems to AHCCCS.

Trended data will be analyzed and evaluated to determine any trends related to the quality of care or service in the provider network. When problematic trends are identified through this process, HCIC incorporates the findings in determining systemic interventions for quality improvement.

- As evaluated trended data is available, HCIC will prepare and present analysis of the QOC tracking and trending information for review and consideration of action by the HCIC Quality Management Committee and Chief Medical Officer, as Chairperson of the Quality Management Committee.
- Quality tracking and trending information from all closed quality of care issues within the reporting quarter will be submitted to AHCCCS/Division of Health Care Management/Clinical Quality Management (AHCCCS/ DHCM/CQM) utilizing the Quarterly Quality Management Report. The report will be submitted within 45 days after the end of each quarter and will include the following reporting elements:
  - Types and numbers/percentages of substantiated quality of care issues
  - Interventions implemented to resolve and prevent similar incidences, and
  - Resolution status of “substantiated”, “unsubstantiated” and “unable to substantiate” QOC issues.

If a significant negative trend is found, Health Choice Integrated Care may choose to consider it for a performance improvement activity to improve the issue resolution process itself, and/or to make improvements that address other system issues raised during the resolution process.

Health Choice Integrated Care will submit to AHCCCS all pertinent information regarding an incident of abuse, neglect, exploitation and unexpected death as soon as aware of the incident. Pertinent information must not be limited to autopsy results only, but must include a broad review of all issues and possible areas of concern. Delays in the receipt of autopsy results shall not result in a delay in the investigation of a quality of care concern by Health Choice Integrated Care. As Health Choice Integrated Care receives delayed autopsy results, they will use them to confirm the resolution of the QOC concern.
If the cause and manner of death gives reason to change the findings of the QOC concern, Health Choice Integrated Care is expected to notify AHCCCS and resubmit a revised resolution report. Health Choice Integrated Care must ensure that member health records are available and accessible to authorized staff of their organization and to appropriate State and Federal authorities, or their delegates, involved in assessing quality of care or investigating member or provider quality of care concerns, complaints, allegations of abuse, neglect, exploitation grievances and Healthcare Acquired Conditions (HCAC). Member record availability and accessibility must be in compliance with Federal and State confidentiality laws, including, but not limited to, Health Insurance Portability and Accountability Act (HIPAA) and 42 C.F.R. 431.300 et seq.

**Provider-Preventable Conditions**

In accordance with the AHCCCS AMPM, Chapter 1000, HCIC acknowledges the guidelines for Provider-Preventable conditions in coordination with 42 CFR Section 447.26 which prohibits payment for services related to Provider-Preventable Conditions. A Provider-Preventable Condition means a condition that meets the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC).

**Health Care-Acquired Condition (HCAC)** - means a Hospital Acquired Condition (HAC) under the Medicare program, with the exception of Deep Vein Thrombosis/Pulmonary Embolism following total knee or hip replacement for pediatric and obstetric patients, which occurs in any inpatient hospital setting and which is not present on admission. The list of Healthcare Acquired Conditions as published by CMS is as follows:

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and Trauma
  - Fractures
  - Dislocations
  - Intracranial injuries
  - Crushing injuries
  - Burns
  - Other Injuries
- Manifestations of Poor Glycemic Control
  - Diabetic Ketoacidosis
  - Non-ketotic Hyperosmolar Coma
  - Hypoglycemic Coma
  - Secondary Diabetes with Ketoacidosis
  - Secondary Diabetes with Hyperosmolarity
- Catheter-Associated Urinary Tract Infection
- Vascular Catheter-Associated Infection
- Surgical Site Infection following:
  - Coronary Artery Bypass Graft (CABG)-- Mediastinitis
  - Bariatric Surgery-- Laparoscopic Gastric Bypass—Gastroenterostomy and Laparoscopic Gastric Restrictive Surgery
  - Orthopedic Procedures—Spine, Neck, Shoulder, Elbow
Surgical Site Infection Following Cardiac Implantable Electronic Devices (CIED)--Post-operative infection

- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE)
  - Total Knee Replacement
  - Hip Replacement
- Iatrogenic Pneumothorax with Venous Catheterization

Other Provider-Preventable Condition (OPPC) - means a condition occurring in the inpatient and outpatient health care setting which AHCCCS has limited to the following:
  - Surgery on the wrong member
  - Wrong surgery on a member and
  - Wrong site surgery

A member’s health status may be compromised by hospital conditions and/or medical personnel in ways that are sometimes diagnosed as a “complication”. If it is determined that the complication resulted from an HCAC or OPPC, any additional hospital days or other additional charges resulting from the HCAC or OPPC will not be reimbursed. If it is determined that the HCAC or OPPC was a result of a mistake or error by a hospital or medical professional, HCIC will conduct a quality of care investigation and report the occurrence and results of the investigation to the regulatory oversight body.