5 Quality Management

HEALTH CHOICE ARIZONA QUALITY MANAGEMENT OVERVIEW

Health Choice Arizona's (HCA) Quality Management (QM) Program centers on continuous quality improvement (CQI), through the plan-do-study-act cycle (PDSA), and monitors, evaluates and improves the continuity, quality, accessibility and availability of health care and services provided to Health Choice Arizona's members. HCA conducts P erformance Improvement Projects (PIPs) that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non- clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction. HCA maintains a formal process for peer review to analyze issues involving quality of care (QOC) issues arising from the activities of providers for the purpose of improving the quality of the Health Choice Arizona provider network and the quality of care received by Health Choice Arizona members.

The QM program also provides the foundation by which member issues regarding care or service will be evaluated and improved for the benefit of the member, the practitioner, and Health Choice Arizona in order to meet or exceed both the internal and external customer expectations. The credentialing and recredentialing program ensures the delivery of quality health care services to members through the review of participating network provider files against national credentialing standards. Every Health Choice Arizona employee plays a key role in directing quality improvement and ensuring members and providers receive excellent customer service. The QM program extends across all HCA departments, integrating QM activities with other processes and programs throughout HCA. It is Health Choice Arizona's philosophy that quality does not simply involve the Quality Management Department or the grievance system. Rather, excellent quality necessitates a focus on not just the individual task at hand, but on a larger focus on systems improvement. To that end, our approach is systemic in nature to ensure improved processes and outcomes.

QM Program Structure

The Quality Management/Performance Improvement Committee (QM/PIC) oversees Health Choice Arizona's QM Program. The QMC is responsible for implementation, oversight and evaluation of QM /Performance Improvement (PI) Programs.

Authority and responsibility for the daily operational activities of the quality management program are delegated to the Chief Medical Officer/Medical Director (s), Chair of the QMC and the Quality Management Director, or designee. With approval of the QM/PIC, subcommittees are created to meet specific organizational goals and needs. Examples of subcommittees include but not limited to: The Medical Management Committee, The Technology Assessment Committee, the Credentialing Committee, the Peer Review Committee, Pharmacy and Therapeutics Committee. The Chief Medical Officer/Medical Director (s) facilitates communication of QM activities with participating practitioners and providers and serves as a liaison between the Health Choice Arizona and participating practitioners and providers.

QM Program Functions

- Coordinate the collection, analysis, and reporting of data used in monitoring and evaluating care. The QM Program includes monitoring of the Health Choice Arizona's community focused-programs, practitioner availability and accessibility, coordination and continuity of care, and other programs or standards impacting health outcomes and quality of care.

- Identify and address instances of substandard care including those affecting patient safety, access to care and coordination of care. This includes review, research, and resolution and follows up of grievance (complaints) and quality of care issues.

- Track the implementation and outcomes of quality management interventions and programs. This includes the regulatory required Performance Improvement Projects (i.e. e-Prescribe, Developmental Screening, and CSPMP).

- Oversee organizational compliance with accreditation standards and regulatory requirements governing managed care organizations.

- The credentialing/recredentialing process for individual providers, delegated providers and organizational providers.

Scope/Methodology of the QM Program

The program is designed to monitor, evaluate and continually improve the care and services delivered by the Health Plan, network practitioners and affiliated providers, across the full spectrum of services and sites of care. The particular model used in the quality process consists of: Plan – Do - Check (Study) -Act cycle methodology which is used to systematically test and implement changes and determine if the change is an improvement. The methodology includes the elements of: identification of the improvement opportunity; establishment of baseline measurements, interventions, performance goals and benchmarks; establishing data sources, data collection methods; measuring and analyzing data; and finally trending, making modifications as required

and re-measurement.

Performance Measures

Health Choice Arizona maintains clinical and service improvement projects/activities that relate to key measurements of quality; and utilizes data that is statistically valid, reliable, clearly defined and comparable over time. Performance measures provide a structured framework in which to target and concentrate clinical and service efforts.

Effective October 1, 2016, significant changes have been made to performance measures regarding services for adults and children, as defined by AHCCCS. AHCCCS now includes measures such as Inpatient and Emergency Room Utilization, Follow up After Hospitalization, Reasons for Admissions including Asthma, COPD, and Congestive Heart Failure. See chart below for all new and recurring performance measures for CYE 2017:

Acute Care Performance Measures	
Measure	**Minimum Performance Standard (MPS)**
ADULT MEASURES	
Inpatient Utilization	33
ED Utilization	55
Hospital Readmissions	11%
Breast Cancer Screening (BCS)	50%
Cervical Cancer Screening	64%
Colorectal Screening	65%
CDC- HbA1c Testing	77%
CHC- HbA1c Poor Control (>9.0%)	41%
CDC- Eye Exam	49%
Timeliness of Prenatal Care: Prenatal Care Visit in the First Trimester or Within 42 Days of Enrollment (PPC)	80%
Timeliness of Prenatal Care: Postpartum Care Rate (PPC)	64%
Mental Health Utilization	Baseline Measurement Year
Ude of Opiods From Multiple Provders at High dosage in Persons Without Cancer	Baseline Measurement Year

CHILDRENS MEASURES	
Children's Access to PCPs, by age: 12-24 mo.	93%
Children's Access to PCPs, by age: 25 mo.- 6 yrs.	84%
Children's Access to PCPs, by age: 7 - 11 yrs.	83%
Children's Access to PCPs, by age: 12 - 19 yrs.	82%
Well-Child Visits: 15 mo.	65%
Well-Child Visits: 3 - 6 yrs.	66%
Adolescent Well-Child Visits: 12–21 yrs.	41%
Children's Dental Visits: 2-21 yrs.	60%
Percentage of Eligibles Who Received Preventive Dental Services (1)	46%
SEAL: Dental Sealant For Children Ages 6-9 at Elevated Caries Risk	Baseline Measurement Year; CMS will be establishing MPS
Human Papillomavirus Vaccine for Female Adolescents	50%
Childhood Immunization Status	
DTaP	85%
IPV 2	91%
MMR 2	91%
Hib 2	90%
HBV 2	90%
VZV 2	88%
PCV 2	82%
Combination 3*- 4:3:1:3:3:1:4	68%
Hepatitis A (HAV)	40%
Rotavirus	60%
Influenza	45%
Adolescents Immunizations	
Adolescent Meningococcal	75%
Adolescent Tdap/Td	75%
Adolescent Combination 1	75%

One of Health Choice's strategies to collaborate and support providers with achieving the ultimate quality performance is through distributing Physician's Toolkits. These toolkits will be distributed to participating providers monthly via their network representative and will be a guide to help identify where their office is in performance and how to improve.

These tools will range from a "Report Card" summary of their office, their paneled membership with their specific gaps in care, and an overview sheet to help bill the codes to get credit for the work that's completed. Additionally, a continued change is the administration of the Consumer Assessment of Healthcare Providers and Systems, CAHPS® for both adults and children. This annual consumer satisfaction survey is administered to a random sample of adult and child members. Results are aggregated and reported to health plans. The CAHPS® survey includes satisfaction on topics including but not limited to: rating of all health care, rating of personal doctor, getting appointments and care quickly, communication with personal doctor, coordination of health care services between primary and specialist care, to name a few.

Performance Improvement Projects

Health Choice Arizona (HCA) identifies quality improvement opportunities through continuous quality monitoring that takes place in every department and through departmental sharing of ideas for performance improvement. Quality Improvement opportunities are the result of input from internal and external sources, mainly from Arizona Medicaid regulatory office; direction from the QM/PIC; and follow-up actions from previous projects, trends identified from clinical and service quality performance indicators and analysis of age or gender specific diagnoses that occur frequently. Additional sources include member and provider satisfaction surveys, utilization management reports, provider profiling data, peer review, on-site reviews of providers, grievances (complaints) and appeals/disputes data, and Arizona Medicaid performance measures and trends. Quality Improvement opportunities may range from those targeted at individual system improvements or to those opportunities which are more on-going and result in the development of a Performance Improvement Project (PIP). A PIP, regulated by AHCCCS and carried out by HCA, will measure performance in one or more focused areas; undertake system interventions to improve quality; and evaluate the effectiveness of those interventions. The project methodology includes: why the project was developed or the purpose of the project, why the project topic was chosen and the impact that it is expected to have on Health Choice Arizona members, what aspect of care the PIP addresses and what data will be used for analysis of the project. Our current PIP is E-Prescribing. However, Health Choice is also monitoring: Developmental Screening and use of the CSPMP prior to

prescribing opioids, benzodiazepines and/or muscle relaxants.

Quality of Care (QOC) and Service Complaints

QOC and service complaints are investigated, assigned a substantiation rating and severity level. Resolutions are communicated back to the member through the QM Department. Investigations may include a request to the provider for medical records, inquiry letter regarding allegations, and possibly site visits by the QM staff. Potential quality of care issues and complaints, identified through referrals from both internal as well as external sources, may range from a member's allegation of medical care not meeting expectations to the identification of a potential deviation from the standard of care in the services rendered by a provider.

All complaints regarding quality of care are tracked and trended in the QM database and those that indicate serious quality, utilization or risk management issues are immediately flagged to be addressed by the Health Choice Medical Director (s) and/or through Health Choice Arizona's formalized peer review process. Resolution may include, for example, policy changes, education, process changes or monitoring.

Health Choice Arizona encourages communication between the Health Plan and the Primary Care Provider regarding quality of care issues or concerns. Issues may involve specific patient cases or systems problems, which can impact patient care. Concerns may be communicated to the Chief Medical Officer/Medical Director(s) or the QM Department. All information is confidential and is peer-protected.

The Health Choice Arizona Quality Management/Performance Improvement Committee (QM/PIC), chaired by the Health Choice Arizona Medical Director (s) or his/her designee provides oversight for the QM/PI Program and is responsible for the quality of care and peer review functions. Contracted physicians, representing a variety of medical specialties, serve on the Committee and are appointed by the Medical Director (s). If a provider issue is investigated by the QM/PIC, and that particular specialty is not represented within the Committee, the QM/PIC may consult on an ad hoc basis with a peer from that specialty.

The Health Choice Arizona Quality Management Department strongly encourages a working relationship with providers and welcomes comments, questions, or suggestions. Network providers, contracted or affiliated, are able to participate and become engaged in quality improvement initiatives through involvement with the Health Plan's committees, survey participation and directly on a one-to-one basis with the Health Choice Arizona Provider Services Representative and/or with the CMO/Medical Director(s).

Credentialing and ReCredentialing Program

The principle obligation of the Health Choice Arizona Credentialing and Recredentialing Program is to promote the delivery of quality healthcare services to covered members by evaluating the training and experience of the participating healthcare providers. The Health Choice Arizona credentialing process does not discriminate against any health care professional solely on the basis of licensure or board certification, or on the basis of a health care professional servicing high risk populations or specializing in the treatment of costly conditions. The responsibility of credentialing and recredentialing process oversight is delegated directly to the CMO or designee and to the Credentialing Committee, a subcommittee of the QM/PIC. The members of the Credentialing Committee consist of the CMO/Medical Director(s) or designee, QM Sr. Director or designee, QM Credentialing Manager, and contracted Health Choice Arizona physicians with varied specialties of Primary Care, pediatrics, endocrinology, general surgery, etc.

In order to provide a thorough assessment and reassessment of the qualifications of Health Choice Arizona providers, the members of the Credentialing Committee shall, to the extent practical, have experience in and knowledge of the credentialing process and shall represent those medical and surgical specialties commonly found in the Health Choice Arizona Network. If you are interested in participating in the Credentialing Committee, please contact the Credentialing Manager at (480) 760-4919. The CMO/Medical Director(s) and Credentialing Committee will consult with other provider types, when necessary, to advise on the credentials of providers in specialties not represented on the Committee or when additional peer review information is required.

Health Choice Arizona requires that all practitioners who are not hospital or emergency services based, or who are not employees of a contracted facility or are members of a delegated entity to be credentialed.

To make the credentialing and recredentialing process easier, Health Choice Arizona joined The Arizona Association of Health Plans (AzAHP) credentialing alliance. The credentialing alliance was formed to eliminate duplication of efforts and reduce administrative burden. The new credentialing process was launched on October 1, 2012. The process is the result of a two-year intensive review of existing credentialing processes by (8) eight health plans that have agreed to participate in the AzAHP credentialing alliance.

As part of the new, streamlined process, health plans participating in the Alliance agreed to utilize the Council for Affordable Quality Healthcare (CAQH) Universal Provider Datasource for all practitioner credentialing applications and a common paper application for all facility credentialing applications. The plans also developed a common practitioner data form and organizational data form to collect information necessary for their contract review process and system loading requirements.

On behalf of the participating plans, AzAHP has contracted with Aperture™ Credentials Verification Organization (CVO) for primary source verification (PSV) services for the alliance. Aperture™ will perform the PSV once and share the results with each participating plan that you have authorized to receive it.

Providers existing credentials will remain valid, but as new providers are added to the system or existing providers are recredentialed, the new alliance credentialing process will apply.

Aperture™ began performing primary source verification (PSV) services for the initial credentialing of new providers on October 1, 2012. In February, 2013, under the new alliance credentialing process they began recredentialing providers that are due for recredentialing.

Following are additional details related to the AzAHP credentialing alliance and some of the benefits that you can expect to see from it.

Practitioners and Facilities *currently* contracted with more than one of the participating plans

1. A single date will be established that allows one recredentialing process to satisfy the recredentialing requirement for each of the participating plans with which a provider is contracted. That date will be the earliest date that the provider is scheduled to be recredentialed by any of the participating plans. The next recredentialing date will be set three (3) years following the initial alliance recredentialing event.

2. For practitioner groups that are adding a new practitioner, complete the common Practitioner Data Form (found on the website of any participating plan) once and send to each of the participating plans which the group is contracted.

   Practitioners must also make sure CAQH is updated and each contracted, participating plan is approved to access the CAQH application.

Practitioners and Facilities *requesting* contracts with one or more of the participating plans

1. Complete the appropriate common data form (Practitioner or Organizational, found on the website of any participating plan) once and send to the participating plan(s) you wish to contract with.

2. Practitioners who are registered with CAQH are encouraged to make sure CAQH is updated and each of the participating plans that you wish to contract with is approved to access your CAQH application. Practitioners who are not currently registered with CAQH and Facilities will be contacted by the plan or Aperture™ regarding the need for a credentialing application.

3. If you are a practitioner that requires a site visit as part of the initial credentialing event (Primary Care Provider or Obstetrician) or a facility that requires a site visit as part of the initial credentialing event (facilities that are not accredited or surveyed), the participating plan(s) that you are requesting to contract with will have access to any site visit already performed under the alliance. If a site visit has already been performed by another participating plan in the AzAHP credentialing alliance, another site visit will not be necessary. If no site visit has been performed by a participating plan in the AzAHP credentialing alliance, a single site visit will be performed as part of the initial credentialing event and made available to all participating plans.

For practitioner groups that are adding a new practitioner, complete the common Practitioner Data Form (found on the website of any participating plan) once and send to each of the participating plans you are contracted with. **Practitioners must also make sure CAQH is updated and each of the participating plans that you are contracted with is approved to access your CAQH application**.

The CAHQ application requires that the provider document the following information: Reasons for inability to perform the essential functions of the position, with or without accommodation; history of substance abuse, including illegal drug use; history of loss of license and/or felony convictions; history of loss or limitations of privileges or disciplinary activities; attestation by the applicant of the correctness and completeness of the application; a copy of the current license to practice; a copy of a valid DEA certificate (if applicable); a copy of a current malpractice insurance liability certificate, with a minimum of $1million/$3 million coverage; a current curriculum vitae (CV); a copy of the ECFMG, if applicable; written explanations regarding any sanction activity, malpractice

Judgments/settlements, restriction of privileges, etc.; board certification, if applicable professional education, if not board certified; and documentation of after-hours, on-call

support providers. NOTE: new Insurance requirements beginning October 1, 2013 include Commercial General Liability, Business Automobile Liability, Worker's Compensation and Employer's Liability and Professional Liability. Contact your Provider Services Representative for further information.

All Health Choice Arizona participating providers shall be re-credentialed every 36 months in order to ensure their continued adherence to Health Choice Arizona credentialing and quality standards. Aperture™ (CVO) will make a maximum of up to three attempts over a 60-day period to obtain recredentialing information. Failure by the provider to submit the completed recredentialing application following the third attempt will be considered a voluntary withdrawal of the application and may result in the provider not being retained in the Health Choice network.

In addition to the elements listed in the initial credentialing procedure and process, the Health Choice Arizona recredentialing process shall also include review of the following data: Review of any quality or risk management issues in addition to an assessment of possible negative trends in the provider's activities; PCP"s and primary care obstetrician, physician panel size; comparison of the provider regarding performance measures to their specialty averages, and the plan average; review of any member complaints or grievances; results of any member satisfaction survey or statements; review of appointment availability surveys; review of member PCP change trends; review of general cooperation with Health Choice Arizona staff, policies and procedures and cooperation with other network participants; review of any information forwarded from AHCCCS or CMS regarding large member panels, i.e., more than the AHCCCS or CMS advised maximum. In such cases the QM file on the applicant will be carefully reviewed to ensure that large member panels are not compromising quality of care in any way. Reports from AHCCCS or CMS will be reviewed at the time they are available even if the provider is not due for recredentialing. Approval of the re-credentials is for a 36 month period, or in the presence of any unusual history, approval for a shorter term or with appropriate limitations, restrictions or supervision may be given. In the event that denial of the recredentialing of the provider occurs, the provider may, if he/she so chooses, appeal the decision through the QM Appeals Process. Within one (1) business day of the Credentialing Committee meeting, the Credentialing Department will notify the Provider Network Department of the Committee's credentialing decision(s). HCMC may designate approval authority to the Chief Medical Officer/Medical Director or/designee to review and approve "clean files" in accordance to the credentialing policies and procedures, and does not need to proceed through the Credentialing Committee. There must be evidence which includes handwritten signature, handwritten initials or electronic identifier of the review and approval on a list of all providers who meet the established criteria.

For “clean files”, the Chief Medical Officer/Medical Director or/designee review date will be used as the “credentialing decision date”. The Credentialing Coordinator (or designee) will notify Provider Relations staff of the Chief Medical Officer/Medical Director or/designee decision of “clean files” no later than one (1) week of the review date. The Provider Network Department will notify the providers of the committee’s decision within 60 days of notification from the Credentialing Coordinator.

PEER REVIEW

The Peer Review Program is designed to develop, implement and evaluate required peer review activities regarding health care delivery issues that affect the Health Plan’s members and participating practitioners and providers. Member safety and quality medical care are the central goals underlying all peer review activities. Peer review is conducted using evidence-based guidelines, when available, or practice parameters that are nationally accepted. Specific provider concerns as well as more global provider network issues are addressed by Health Choice Arizona through the peer review process.

Any report of a deficiency in the quality of care (QOC) or the omission of care or service by a provider is subject to peer review. Referrals of potential peer review issues may be initiated by external or by any internal Health Choice Arizona department and referred to QM for research and review. Internal sources may include all Health Choice Arizona department staff members who identify potential specific peer review quality issues while conducting their daily operations, member or provider appeals, Health Choice Arizona medical committees, provider profiling reports, on-site provider reviews and utilization management reports. Internal potential QOC referrals are sent to the QM department documented on a *grievance/complaint form* with an attachment of any supporting documentation such as utilization reports, excerpts of medical progress notes, or other pertinent documents available. External sources include state and/or federal agencies, media reports, other providers, members, member representatives, advocates and caregivers. Information from external sources may be received by Health Choice Arizona via a letter, phone calls directly to the Chief Medical Officer/Medical Director, or email. If you are interested in participating in the Quality/Peer Review Committee, please call the Director of Quality Management at (602) 829-3355. All committee members must sign confidentiality agreements.

Health Choice Arizona also utilizes peer review processes in contracting and credentialing decisions. The QM/PIC Executive peer review session, which meets as needed throughout the year, is responsible for performing peer review. The Committee investigates upper severity level cases involving Providers that may have an effect on the quality of care provided to members. The Committee consists of the Health Choice Arizona Chief Medical

Officer and /or the Medical Director and, at a minimum, the Director of Quality Management, representation from the functional areas within Health Choice, representation of contracted or affiliated providers serving AHCCCS members, and appropriate clinical representatives. A dentist, who works as a consultant for Health Choice Arizona serves on the committee when dental information is required. If additional expertise is required for a specific peer review case, other specialists are brought in on an ad hoc basis. Health Choice has contracted with an external peer review company to provide expertise that may not be available locally. The QM/PIC Executive peer review session, based upon its investigation, may recommend one or more of the following actions:

- Make a recommendation for corrective action which may include (without limitation) education.
- Request an outside consultation with provider in same specialty (if one is not on the committee) prior to making a recommendation.
- Request additional information.
- Request the provider develops and implements a corrective action plan addressing the specific issues necessary to improve the quality of care provided to Health Choice Arizona members.
- Reduce, restrict, suspend, terminate or not renew the provider's credentials necessary to treat members as a participating provider of Health Choice Arizona.
- Recommend assigning, or adjusting a severity rating.
- Other action necessary to evaluate the issue and recommend appropriate adverse or corrective action, such as a Focused Provider Review (FPR).

The QM/PIC Executive peer review session is responsible for reporting quality issues and Health Choice Arizona actions regarding these issues, as required or allowed by law, to the appropriate authorities including but not limited to, the Board of Medical Examiners, Osteopathic Board, Podiatric Board, National Practitioners Data Bank, and the Arizona Medicaid Administration. Under the Chief Medical Officer/Medical Director's direction, agencies will be notified of the QM/PIC Executive peer review session's decision regarding adverse actions.

Results of peer review activities and of the QM/PIC Executive peer review session's recommendations and actions are documented in the providers file. The actions of the QM/PIC are communicated to all appropriate Health Choice Arizona staff to ensure that contracting and credentialing decisions are made timely and with accurate information to ensure the highest quality medical care for members.

The formal peer review process at Health Choice Arizona is accomplished by evaluating the clinical activities and qualifications of practitioners and providers through the efforts of the QM Department and other review committees of Health Choice Arizona. This process is pursuant to the QM/PI (Performance Improvement) Plan and A.R.S. 36-2401 et seq. and 36-2917 ("Arizona Peer Review Laws"). If an adverse action is taken against a provider as a result of the peer review process, the provider has certain rights pursuant to Health Choice Arizona Policy C.9.023 *Peer_Review_Process_Appeals*, which addresses "Peer Review Process and Appeals". This policy is available upon request from your Provider Services Representative, and will be sent to any provider when an adverse action is taken. The provider has the right to appeal the following:

- Any adverse action that is disputed by the provider in question may be appealed. This option shall be communicated to the provider via a certified letter from the Chief Medical Officer/Medical Director (s). The letter shall state the adverse action and the basis for the finding. The provider may appeal such actions by sending a letter to the Health Choice Arizona Chief Medical Officer/Medical Director (s) requesting invocation of the appeal process.

- If the provider chooses to appeal the adverse action, an ad hoc appeals committee consisting of three (3) providers who are certified to practice in the same specialty. (Policy C.9.023) shall be appointed to serve, in addition to the QM/PIC, to hear the provider's appeal and all evidence presented.

  This committee will review all information and make a formal recommendation regarding the appeal. The details of this process are available and shall be communicated to the provider at the onset of notification of the adverse action.

MEDICAL RECORD GUIDELINES

Providers are required to maintain medical records in a detailed and comprehensive manner, which conforms to good professional medical practice, permits effective professional medical review and medical audit processes and which facilitates an adequate system for follow-up treatment. The provider must ensure that records are accessible to authorized persons only. Medical records must be available to Health Choice Arizona and AHCCCS for purposes of quality review or other administrative requirements, free of charge to Health Choice and any vendor Health Choice delegates to for the purposes of Medical Record Reviews.

A.R.S. 32-1401(2) defines adequate medical records as "legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warning provided to the patient and to provide for another practitioner to assume continuity of the patients care at any point in the course of treatment."

All information in the medical record and information received from other providers must be kept confidential. Per AHCCCS requirements, when a member changes PCPs, his or her medical records or copies of the medical records must be forwarded to the new PCP within 10 working days of receipt of a properly executed request for the medical records.

Health Choice Arizona supports the AHCCCS, URAC, and NCQA medical record standards. These are the minimum standards acceptable for medical record documentation within Health Choice Arizona's contracted network of primary care physicians, primary care obstetricians and high volume specialists.

Primary Care Providers (PCPs) must maintain a legible medical record (including electronic health record/medical record) for each enrolled member who has been seen for medical appointments or procedures. The medical record must also contain clinical/behavioral health records from other providers who also provide care/services to the enrolled member.

PCPs are further required to ensure the medical record documents provider referrals to other providers, coordination of care with other providers, and transfer of care to behavioral health providers, as appropriate, make certain the medical record is legible, kept up-to-date, is well-organized and comprehensive with sufficient detail to promote effective patient care and quality review. A member may have numerous medical records kept by various health care providers that have rendered services to the member.

In order to strengthen the effectiveness of the QM Program and the member's health, PCP's must maintain a comprehensive record that incorporates at least the following components:

- Behavioral health information when received from the behavioral health provider about an assigned member even if the provider has not yet seen the assigned member. In lieu of actually establishing a medical record, such information may be kept in an appropriately labeled file but must be associated with the member's medical record as soon as one is established.
- Member identification information on each page of the medical record (i.e.name or AHCCCS identification number).
- Documentation of identifying demographics including the member's name, address, telephone number, AHCCCS identification number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative.
- Initial history for the member that includes family medical history, social history and preventive laboratory screenings (the initial history for members under age 21 should also include prenatal care and birth history of the member's mother while pregnant with the member).
- Past medical history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received.

- Immunization records (required for children; recommended for adult members if available.
- Dental history, if available, and current dental needs and/or services.
- Current problem list
- Current medications
- Current and complete EPSDT forms (required for all members age 0 through 20 years).
- Documentation, initialed by the member's provider , to signify review of:
    - Diagnostic information including:
    - Laboratory tests and screenings,
    - Radiology reports,
    - Physical examinations notes, and
    - Other pertinent data
    - Reports from referrals, consultations and specialists,
    - Emergency/urgent care reports.
    - Hospital discharge summaries,
    - Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when a member's health status changes or new medications are prescribed.
- Behavioral health history and behavioral health information received from a Regional Behavioral Health Authority (RBHA) behavioral health provider who is also treating the member.
- Documentation as to whether or not an adult member has completed advance directives and location of the document.
- Documentation that the provider responds to behavioral health provider information request within ten business days of receiving the request. The response should include all pertinent information, including, but not limited to, current diagnoses, medications, laboratory results, last provider visit, and recent hospitalizations. Documentation must also include the provider's initials signifying review of member behavioral health information received from a behavioral health provider who is also treating the member.
- Documentation related to requests for release of information and subsequent releases.
- Documentation that reflects that diagnostic, treatment and disposition information related to a specific member was transmitted to the provider including behavioral health providers, as appropriate to promote continuity of care and quality management of the member's health care.
- Obstetric providers must complete a standardized, evidence –based risk assessment tool for obstetric members (i.e. Mutual Insurance Company of Arizona (MICA) Obstetric Risk Assessment Tool or American College of Obstetricians and Gynecologist (ACOG). Also, ensure that lab screenings for members requiring obstetric care conform to ACOG guidelines.

- Ensure that PCPs utilize AHCCCS approved developmental screening tools.
- Organization provider services (e.g. hospitals, nursing facilities, rehabilitation clinics, transportation etc,) maintain a record of services provided to the member including:
    - Physician or provider orders for the service,
    - Applicable diagnostic or evaluation documentation,
    - A plan of treatment,
    - Periodic summary of the member's progress toward treatment goals,
    - The date and description of service modalities provided, and
    - Signature/initials of the provider for each service

- Take into consideration professional and community standards and accepted and recognized evidence-based practice guidelines.
- Must have an implemented process to assess and improve the content, legibility, organization, and completeness of member health records when concerns are identified.
- Require documentation in the member's record showing supervision by a licensed professional, who is authorized by the licensing authority to provide the supervision, whenever health care assistants or professionals provide services.

Medical records may be documented on paper or in an electronic format.

- If records are documented on paper, they must be written legibly in blue or black ink, signed and dated for each entry. Electronic format records must also include the name of the provider who made the entry and the date of each entry.
- If records are physically altered, the stricken information must be identified as an error and initialed by the person altering the record along with the date when the change was made; correction fluid or tape is not allowed.
- If kept in an electronic file, the provider must establish a method of indicating the initiator of information and a means to assure that information is not altered inadvertently.
- If revisions to information are made, a system must be in place to track when, and by whom they are made. In addition, a back-up system including initial and revised information must be maintained. Medical record requirements are applicable to both hard copy and electronic medical records. Contractors may go on site to review the records electronically or utilize a secure process to review electronic files received from the provider when concerns are identified.
- Documentation must be recorded that each member of reproductive age was notified verbally or in writing of the availability of family planning.

HEALTH EDUCATION AND PREVENTATIVE SERVICES

Health education, preventative services recommendations and wellness counseling should be clearly noted and incorporated in the progress notes or in a designated section of the medical records.

These services should be documented as applicable:

- Annual Well Visit
- Date of last cervical cancer screening
- Date of mammogram screening
- Prostate screening
- Alcohol, smoking, or substance abuse
- Exercise
- Nutritional status body mass index (BMI) and weight deviations from normal
- Immunizations
- Family planning counseling
- Children Dental Visit
- Colorectal Cancer Screening
- Diabetic Eye Exam
- Diabetic Blood Sugar Control
- Diabetic Monitoring Nephropathy
- Medication Adherence
- ED Utilization
- Medication Review (Reconciliation)
- Osteoporosis Management in Women with Fractures

PREVENTIVE HEALTH SCREENING GUIDELINES

Health Choice Arizona is committed to promoting wellness and encouraging the provision of care to members utilizing nationally accepted standards of care. Health Choice Arizona regularly reviews and incorporates national standards for multiple disease processes and for preventative care. See practice guidelines: http://www.healthchoiceaz.com/providers/clinical-guidelines

- Periodic screening tests at appropriate intervals, such as cervical cancer screening, mammograms, laboratory PSA testing, etc. Ongoing updates are communicated to Providers via the Health Choice Arizona Provider website or special mailings, as indicated.

Case and Disease Management Programs

In an effort to improve the health status of those members assigned to Health Choice Arizona, the following ongoing disease management programs are available:

- Diabetes
- Asthma
- Hepatitis C
- Chronic Disease
- Pain Management
- Catastrophic Medical Conditions
- Hemophilia,
- Guillain Barre Syndrome
- Complex Medical needs
- Transplant Coordination
- Behavioral Health
- High Risk Maternity

Providers are encouraged to utilize the Health Choice Arizona Case Management Referral Form (Exhibit 5.1) for help in managing members who require additional assistance, i.e. HIV and/or Hepatitis C, or phone Health Choice Arizona case managers at (480) 968-6866 or (800) 322-8670 to refer a member for assistance.

Health Care-Acquired Conditions and Provider-Preventable Conditions (Effective 7/1/2012)

42 CFR Section 447.26 prohibits payment for services related to Provider-Preventable conditions. Provider-Preventable Condition means a condition that meets the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC). If an HCAC or OPPC is identified, Health Choice Quality Management will conduct a quality of care investigation and report the occurrence and results of the investigation to the AHCCCS Clinical Quality Management Unit.

Health Care-Acquired Conditions (HCAC) means a Hospital Acquired Condition (HAC) under the Medicare program which occurs in any inpatient hospital setting and is not present on admission and include:

- 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
    - Electric Shock
    - Other Injuries
- Manifestations of Poor Glycemic Control
    - Diabetic Ketoacidosis
    - Nonketotic Hyperosmolar Coma
    - Hypoglycemic Coma
    - Secondary Diabetes with Ketoacidosis
    - Secondary Diabetes with Hyperosmolarity
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Surgical Site Infection Following Coronary Artery Bypass Graft (CABG) - Mediastinitis
- Surgical Site Infection Following Bariatric Surgery for Obesity
    - Laparoscopic Gastric Bypass
    - Gastroenterostomy
    - Laparoscopic Gastric Restrictive Surgery
- Surgical Site Infection Following Certain Orthopedic Procedures
    - Spine
    - Neck
    - Shoulder
    - Elbow
- Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures:
    - Total Knee Replacement
    - Hip Replacement
- Iatrogenic Pneumothorax with Venous Catheterization

Other Provider-Preventable Conditions (OPPC) – means a condition occurring in the inpatient and outpatient health care setting which AHCCCS has limited to the following:

- Surgical or other invasive procedure performed on the wrong patient
- Wrong Surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part or site