Chapter 5: Quality Management

Health Choice Insurance Co. Quality Management Overview

Health Choice Insurance Co. Quality Management (QM) Program centers on continuous quality improvement (CQI) and monitors, evaluates and improves the continuity, quality, accessibility and availability of health care and services provided to Health Choice Insurance Co. members. Health Choice conducts performance improvement projects 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. Health Choice 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 Health Choice provider network and the quality of care received by Health Choice Insurance Co. members.

The QM program also provides the foundation by which members issues regarding care or service will be evaluated and improved for the benefit of the member, the practitioner, and Health Choice in order to meet or exceed both the internal and external customers' expectations. The credentialing and re-credentialing program ensures the delivery of quality health care services to members through the review of participating network providers' files against national credentialing standards. Every Health Choice employee plays a key role in directing quality improvement and ensuring members and providers receive excellent customer service. The QM program extends across all Health Choice departments, integrating QM activities with other processes and programs throughout Health Choice. It is Health Choice 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 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 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 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 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, resolution, and follow up of complaints and quality of care issues.
- Track the implementation and outcomes of quality management interventions and programs.
- Oversee organizational compliance with accreditation standards and regulatory requirements governing managed care organizations.
- Performs the Credentialing/re-credentialing 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 Choice, 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 modification, as required, and re-measurement.

Performance Measures

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

The following lists some of the performance measures that are collected and analyzed for identification of performance opportunities.

- HEDIS Measures:
  - Follow-up After Hospitalization for Mental Illness
  - Annual Monitoring for Patients on Persistent Medications
  - Chlamydia Screening for women
  - Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
  - Follow-Up Care for Children Prescribed ADHD Medication
  - Breast Cancer Screening
  - Well-Child Visits in the First 15 months of Life (6 or More Visits)

- Comprehensive Diabetes Care: Eye Exam (Retinal) Performed
- Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Controlling High Blood Pressure
- Adult BMI Assessment
- Immunizations for Adolescents (Combination 1)
- Childhood Immunization Status (Combination 3)
- Colorectal Cancer Screening
- Cervical Cancer Screening
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
- PQA Measures:
- Proportion of Days Covered (Diabetes All Class)
- Proportion of Days Covered (RAS Antagonists)
- Proportion of Days Covered (Statins)
- Survey Measures
- Access to Care
- Cultural Competence
- Rating of Personal Doctor

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

Performance Improvement Projects

Health Choice 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; 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 and appeals data, 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 an Improvement Project (IP). An IP, initiated by Health Choice, 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 of Health Choice members, what aspect of care the IP addresses and what data will be used for analysis of the project.

The current IPs that are monitored for Health Choice Insurance Co. are (1) Pharmacy Call Queue Communications: Response Time and Call Abandonment Trending, (2) Inpatient Hospital Readmissions within 30 Days of Discharge, and (3) Member Services Communications: Response Time and Call Abandonment Trending.

Quality of Care (QOC) and Service Complaints*:* QOC and service complaints are researched, resolved and communicated back to the member through the QM Department. 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 through Health Choice formalized peer review process. Resolution may include for example, policy changes, education, process changes or monitoring.

Health Choice 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, the Medical Director(s) or the QM Department. All information is confidential and is peer-protected.

The Health Choice Quality Management/Performance Improvement Committee (QM/PIC), Chaired by the Health Choice 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 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 network representative and/or with the CMO/Medical Director(s).

Credentialing and Recredentialing Program

The principle obligation of the Health Choice Credentialing and Re-credentialing Program is to promote the delivery of quality healthcare services to members through evaluation of the training and experience of the participating healthcare providers. The Health Choice credentialing program does not discriminate against any health care professional solely on the basis of the type of license 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 re-credentialing process oversight is delegated directly to the CMO/Medical Director (s) 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 his/her designee, QM Senior Director or designee, QM Credentialing Manager, and contracted Health Choice physicians with varied specialties. In order to provide a thorough assessment and reassessment of the qualifications of Health Choice providers, the members of the Credentialing Committee have experience in and knowledge of the credentialing process and represent those medical and surgical specialties commonly found in the Health Choice network. If you are interested in participating in the Credentialing Committee, please contact the Senior Director of Quality Management at [480-760-4935]. 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 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 OptumInsight™ /Aperture Credentialing Inc. for primary source verification (PSV) services for the alliance. OptumInsight™/Aperture Credentialing, Inc. 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 re-credentialed, the new alliance credentialing process will apply.

OptumInsight™/ Aperture Credentialing, Inc. 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. 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 OptumInsight™/ Aperture Credentialing, Inc. 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 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 participating providers shall be re-credentialed every 36 months in order to ensure their continued adherence to Health Choice's credentialing and quality standards. OptumInsight™/Aperture Credentialing Inc, will make a maximum of up to three attempts over a 60-day period to obtain re-credentialing information. Failure by the provider to submit the completed re-credentialing 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 re-credentialing 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,; 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 member PCP change trends; review of general cooperation with Health Choice staff, policies and procedures and cooperation with other network participants. Approval of the re-credentials is for a thirty-six (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 re- credentialing of the provider occurs, the provider may, if he/she so chooses, appeal the decision through the QM Appeals Process. Within three (3) days of the Credentialing Committee meeting, the Credentialing Coordinator will notify the Network Services Department Director of the Committee's credentialing decisions. The Credentialing Coordinator will notify the

providers of the committee's decision within sixty (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 through the peer review process.

Any report of a deficiency in the quality of care 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 department and referred to QM for research and review. Internal sources may include all Health Choice department staff members who identify potential specific peer review quality issues while conducting their daily operations, member or provider appeals, Health Choice medical committees, provider profiling reports, on-site provider reviews and utilization management reports. Internal peer review 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 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 Senior Director of Quality Management at 480-760-4935. All committee members must sign confidentiality agreements.

Health Choice also utilizes peer review processes in contracting and credentialing decisions. The QM/PIC Executive peer review session 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 Chief Medical Officer and/or the Medical Director, and at a minimum, the Senior Director of Quality Management, representation from the functional areas within Health Choice, representation of contracted or affiliated providers serving Health Choice 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. 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 develop and implement a corrective action plan addressing the specific issues necessary to improve the quality of care provided to Health Choice members.
- Reduce, restrict, suspend, terminate or not renew the provider's credentials necessary to treat members as a participating provider of Health Choice.
- Recommend assigning, or adjusting a severity rating.
- Other action necessary to evaluate the issue and recommend appropriate adverse or corrective action.

The QM/PIC Executive peer review session is responsible for reporting quality issues and Health Choice actions regarding these issues, as required or allowed by law, to the appropriate authorities including but not limited to, the Board of Medical Examiners, Alopathic Board, Podiatric Board, and National Practitioners Data Bank, 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. However, no issue or action is reported until the appeal process is exhausted.

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 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 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. This process is pursuant to 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 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 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 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 Records 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 for purposes of quality review or other administrative requirements.

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 patient's 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. 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.

The PCP is responsible for ensuring that a medical record is established when information is received about a member. This includes behavioral health information received from the any behavioral health provider. If the PCP has not yet seen the member, such information may be kept temporarily in an appropriately labeled file, in lieu of actually establishing a medical record, but must be associated with the member's medical record as soon as one is established.

In order to strengthen the effectiveness of the QP Program and the member's health care; Health Choice supports the Utilization Review Accreditation Commission (URAC) and National Committee for Quality Assurance (NCQA) standards for medical records. These are the minimum standards acceptable for medical record documentation within Health Choice contracted network.

Each visit must be documented in the medical record to support the diagnosis and to justify treatment.

Medical record documentation must include the following:

- Member name and/or ID number on every page; records are organized and kept confidential
- Personal information including age, gender, date of birth, marital status, home address, work and home telephone numbers, identification number, next of kin, and if applicable, guardian or authorized representative
- All entries must be legibly written in blue or black ink, dated and signed or initialed for each entry to identify the writer. Electronic format records must also include the date and name of provider who made the entry
- 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 are allowed to provide services

- All revisions/errors must be clearly identified. White out is not allowed. The stricken information must be lined out and initialed by the person altering the record and dated. 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. A system must be in place to track when, and by whom, revisions to information are made. A backup system including initial and revised information must be maintained
- Significant illnesses and medical conditions are noted on the problem list
- A health maintenance flow sheet must be included if there is no known medical illness or condition
- If medications are prescribed, they are recorded on a medication sheet which is easily found and current in the record
- Allergies and adverse reactions to medication or NKA (no known allergies must be noted prominently and in a uniform location); the reactions/symptoms to the medication must be documented in the medical record
- Initial history for 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, hospitalizations, surgeries, and emergent/urgent care received.
- Notes on use of cigarettes, alcohol, or substance abuse are present (for Member's age 12 and over)
- Immunization records (required for children; immunization status recommended for adult members)
- Complete physical exam must document appropriate subjective and objective information for presenting complaints and a complete review of systems, including assessment of member's behavioral health needs
- Lab and/or other studies ordered as appropriate
- Documentation/ records/reports must be, initialed by the provider to signify review of: diagnostic information including laboratory tests and screenings, radiology reports, physical exam notes, and /or other pertinent data, reports from referrals, other consultations and specialists, emergency/urgent care reports, Hospital/LTC facility discharge summaries, behavioral health history, and 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
- Working diagnoses that are consistent with findings noted in each progress note
- Plans of actions and treatments that are consistent with diagnoses
- Prevention and wellness education, family planning counseling, if appropriate
- Preventive services through age 20 years are initiated as appropriate
- Recommendations and instructions to members including return office visits
- Follow up care, calls, or visits noted on encounter forms

- Documentation of nutritional assessment when member has a debilitating disease affected by nutritional needs
- Documentation that problems unresolved from previous office visits are addressed in subsequent visits
- Documentation that shows consultants are appropriately utilized. Notes from consultant must also be included; abnormal lab and imaging study results and consultations have explicit notation in the record of follow up plans
- Records of prescriptions for medications or medical supplies
- Records of any information/chart transfer, including member's authorization to release records and evidence of such transfer
- Dental history, if available, and current dental needs and/or services
- Documentation that reflects diagnostic, treatment, and disposition information related to a specific member was transmitted to the PCP and other providers as appropriate to promote continuity of care and quality management of the member's health care
- Obstetric providers must complete a risk assessment tool for obstetric patients (i.e. Mutual Insurance Company of Arizona Risk Assessment Tool (MICA) or American College of Obstetrics and Gynecology (AGOG). Lab screenings for members requiring obstetric care must also conform to ACOG guidelines)
- Providers should ensure appropriate supervision of service provided by persons other than the contracted provider as required by Arizona State law. Documentation of continuity of care between primary, specialty physicians, and behavioral health. Documentation related to the transmittal of diagnostic treatment and disposition information to the PCP and other Providers as appropriate. Referral is ordered, follow-up for referrals is documented. Specialty providers have documentation of follow-up information provided to PCP and/or referring provider. Update behavioral health providers when changes to medication or diagnosis occur. Response to requests for information about members receiving behavioral health services from behavioral health providers is sent by the PCP within 10 days of receiving the request
- There is documentation that advanced directives have been discussed with the patient and whether or not they have been executed

Health Education and Preventative Screenings

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

Preventative Health Screening Guidelines

Health Choice is committed to promoting wellness and encouraging the provision of care to members utilizing nationally accepted standards of care. Health Choice regularly reviews and incorporates national standards for multiple disease processes and for preventative care. See practice guidelines:
http://www.healthchoiceessential.com/generalproviders/index.asp?st=Provider%20Resources

- 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 Provider Newsletter/website or special mailings, as indicated.

Disease Management Programs

In an effort to improve the health status of those members assigned to Health Choice Insurance Co 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 Case Management Referral Form for help in managing members who require additional assistance, i.e. HIV and/or Hepatitis C, or phone Health Choice case managers at 480-968-6866 or 1-855-452-4242 to refer a member for

assistance. Please go to www.healthchoiceessential.com for a copy of the Case Management Referral Form.

Sentinel Events

A **Sentinel Event** is any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness. Sentinel events specifically include loss of a limb or gross motor function, and any event for which a recurrence would carry a risk of a serious adverse outcome. Such events are called "sentinel" as they signal the need for immediate investigation and response. These events must be reported immediately to Health Choice Provider Services Representative, the Health Choice Quality Management department or Administration.