SECTION X: Quality Improvement

The Quality Improvement (QI) Program is designed to objectively, systematically, and expeditiously monitor and evaluate the quality, appropriateness and outcome of care and services, and the structures and processes by which they are delivered to Plan members, and to continuously pursue opportunities for improvement and problem resolution.

Network Practitioners and Providers are contractually required to cooperate with all Quality Improvement (QI) activities to improve the quality of care and services and member experience. This includes the collection and evaluation of performance data and participation in the Care1st's QI programs. Practitioner and Provider contracts, or a contract addendum, also require that Practitioners and Providers allow Care1st the use of their performance data for quality improvement activities.

As part of this program, providers and practitioners are required to cooperate with Quality Improvement (QI) activities and allow the Care1st to use their performance data.

SCOPE

The scope of the QI Program is comprehensive and includes activities that have a direct and indirect influence on the quality and outcome of clinical care and services delivered to all Care1st Plan members. The scope of the QI Program encompasses both quality of care and quality of service. Responsibility for monitoring the scope of care rests with the QI Department.

This QI Program covers all programs and products. All QI standards and procedures are applicable to all Care1st members.

Care1st targets special and vulnerable populations for focused quality studies, which may include childhood immunizations, dental services, behavioral health, utilization, customer satisfaction, EPSDT screening and follow-up.

Quality Improvement activities may include but are not limited to:

- Access to and availability of care
- Quality and coordination between physical and behavioral health services
- Provider satisfaction
- Credentialing/Recredentialing
- Clinical practice guidelines
- Under/over utilization
- Adverse outcomes/sentinel events
- Medical record keeping practices
- Facility/Office site review results
- Member satisfaction, complaints and grievances

- Timeliness of handling claims
- High risk and high volume services
- HEDIS results
- Performance Measures
- Performance Improvement Projects
- Patient Safety Measures

Care1st adopts and maintains clinical guidelines, criteria, quality screens and other standards against which quality of care, access, and service can be measured. Practice guidelines are available on our website (www.care1staz.com) under the Providers drop down menu. For requests for training, obtaining additional information or if you do not have internet access and would like a copy mailed to your office, please contact Network Management.

Compliance with standards is measured using a variety of techniques, including but not limited to:

- Quality of service concerns
- HEDIS
- Quality of care concerns
- Performance Indicators
- Medical record audits
- Facility/Office site review results
- Outcome measures
- Focused review studies
- Member satisfaction surveys
- Peer Review
- Access to care audits
- Disease management outcomes
- EPSDT compliance rates

CONFIDENTIALITY AND CONFLICT OF INTEREST

All information related to the QI process is considered confidential. All QI data and information, inclusive of but not limited to, minutes, reports, letters, correspondence, and reviews, are housed in a designated and secured area within the QI Department. All aspects of quality review are deemed confidential. All persons involved with review activities will adhere to the confidentiality guidelines applicable to the appropriate committee.

All persons attending the Quality Oversight Committee (QOC) or its related committee meetings will sign a Confidentiality Statement. All Care1st personnel are required to sign a Confidentiality Agreement upon employment.

No persons shall be involved in the review process of QI issues in which they were directly involved. If potential for conflict of interest is identified, another qualified reviewer will be designated.

Furthermore, information provided to physicians within the network may be proprietary and/or confidential. When this occurs it is expected that physicians will hold this information in confidence and treat the handling of such information with care.

DISCLOSURE OF MEMBER HEALTH INFORMATION

To ensure the confidential release of member information, the following apply:

- Providers should submit all necessary documentation when submitting a request for a referral.
- Providers may release a member's medical information to other health care providers, Care1st or AHCCCS as long as it is necessary for treatment of the member's condition, or administration of the program.
- Member's records are to be transferred to a new PCP within ten business days when one is selected.
- Release of medical information to out of network providers generally requires authorization from the member or guardian.
- Medical records must be released in accordance with Federal or State laws, court orders, or subpoenas.

CREDENTIALING AND RECREDENTIALING

Care1st credentials all providers within its network to ensure they are adequately trained, appropriately licensed and able to provide quality health care to Care1st enrollees. Care1st re-credentials all providers within its network at least every three years in order to ensure their continued adherence to Care1st quality standards.

Care1st partners with the Arizona Association of Health Plans (AzAHP) in a delegated agreement with a Credentialing Verification Organization (CVO) to ensure all primary source verification of the credentialing process is completed. All providers are required to utilize the Council for Affordable Quality Healthcare (CAQH) application.

The Care1st credentialing program does not discriminate against a health care professional, solely on the basis of the license or certification or a health care

professional who serves high risk populations or who specializes in the treatment of costly conditions.

The Credentialing/Peer Review Committee (CPRC) is delegated the responsibility of monitoring credentialing and re-credentialing activities for providers and practitioners. The Credentialing Committee meets at least ten times annually, but may meet more frequently as needed.

Scope of responsibilities include but are not limited to:

1. Review, recommend, approve or deny initial credentialing and re-credentialing of contracted network.
2. Ensure appropriate reporting to regulatory/national data banks.
3. Ensure the provision of a fair hearing process.
4. Oversight of delegated credentialing.
5. Peer review for adverse outcomes.
6. When a practitioner's contracting/recredentialing status is denied or restricted based upon a quality concern, the practitioner is provided appeal rights and procedures upon notice of the denial or restriction.

PEER REVIEW

Peer Review is conducted in any situation where, based on the findings of a Quality of Care review, peers are needed to assess the appropriateness or necessity of a particular course of treatment, to review or monitor a pattern of care provided by a specific provider or to review aspects of care, behavior or practice, as may be deemed inappropriate. The Peer Review Committee scope includes cases where there is evidence of deficient quality or the omission of the care or service provided by a participating, or non-participating, physical, or behavioral health care professional whether delivered in or out of state. The Chief Medical Officer or designee is responsible for authorizing the referral of cases for peer review based on the findings of a quality of care investigation.

All peer review consultants (including members of the Credentialing/Peer Review or ad-hoc Peer Review Committees) are duly licensed professionals in active practice. At least one consultant will be a provider with the same or similar specialty training as the provider whose care is being reviewed, except in those cases where there is no applicable board certification for the specialty. At a minimum he Peer Review committee shall consist of the local CMO or designee as Chair, contracted medical providers and a contracted BH provider from the community that serves AHCCCS members.

If the Peer Review Committee makes a recommendation to the Board of Directors to deny, limit, suspend or terminate privileges based on a medical disciplinary cause or reason, the affected provider shall be entitled to a formal hearing pursuant to the Fair Hearing Procedure.

FAIR HEARING

A provider is entitled to an appeal and/or hearing if the Peer Review Committee makes a recommendation to:

- Suspend
- Terminate or
- Non-renew a physician's contract.

The provider will be notified of the committee's recommendation and has 30 days following the date of notice, to request a hearing. The request must be submitted in writing to the Chief Medical Officer or designee.

The Chief. Medical Officer or designee will schedule a hearing as soon as practicable. The Chief Medical Officer or designee will appoint at least 3 providers and an alternate who have the requisite expertise to ensure a fair hearing. At least 1 provider will be of the same specialty as the practitioner requesting the hearing. No provider will be in direct economic competition with the affected provider and will not stand to gain direct financial benefit from the outcome.

Both parties are entitled to legal representation. Expert testimony and presentation of supporting documents are allowed.

The committee will complete its investigation within 30 days unless both parties agree to a longer period of time to obtain information.

The committee will issue a final decision which may consist of one of the following:

- Continue the immediate action effect
- Impose other sanctions structured to prevent harm to member or to correct identified issues
- Remove the immediate action.

A provider may appeal an action only after the committee renders a final decision. Any action taken as a result of the recommendation of the committee becomes a part of the provider's Credentialing file. Care1st reports to the appropriate authorities such as licensing or disciplinary bodies, AHCCCS or to other appropriate authorities, any provider who are terminated for quality of care issues.

SECTION X: Quality Improvement

DUTY TO WARN

All providers, regardless of their specialty or area of practice, have a duty to protect others against a member's potential danger to self and/or dangers to others. When a provider determines, or under applicable professional standards, reasonably should have determined, that a member poses a serious danger to self or others, the provider has a duty to exercise care to protect others against imminent danger of a member harming him/herself or others. The foreseeable victim need not be specifically identified by the member, but may be someone who would be the most likely victim of the member's dangerous conduct.

The provider's responsibility to take reasonable precautions to prevent harm threatened by a member may include any of the following:

a) Communicating, when possible, the threat to all identifiable victims.

b) Notifying law enforcement in the area where the member or any potential victim resides.

c) Taking reasonable steps to initiate proceedings for voluntary or involuntary hospitalization in accordance with AHCCCS AMPM 320-U.

d) Taking any other precautions that a reasonable and prudent provider would take under the circumstances.

No cause of action or legal liability may be imposed against a behavioral health provider for breaching a duty to prevent harm to a person caused by a member unless both of the following occur:

a) The member has communicated to the behavioral health provider an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s), and the member has the apparent intent and ability to carry out such threat

b) The behavioral health provider fails to take reasonable precautions.

INCIDENTS, ACCIDENT, AND DEATH REPORTING

An Incident, Accident, and Death (IAD) report must be submitted to Care1st in writing or via the AHCCCS QM Portal by the individual or organizational provider within two business days of the event. If the incident is a Sentinel IAD then it must be submitted within one business day of the occurrence or awareness of the occurrence.

An IAD is reportable if it includes: allegations of abuse/neglect/exploitation of a member, death of a member, delays in access care, healthcare acquired or provider preventable conditions, serious injury, injury from seclusion/restraint, medication error at a licensed facility, missing person from licensed BH facility, member suicide attempt, suspected or alleged criminal activity and any other incident that casus harm or has potential to cause harm to a member.

Sentinel IAD's include death associated with a missing person, suicide or attempted suicide or self-harm resulting in serious injury while in a healthcare setting, death or serious injury associated with medication error or fall in a healthcare setting, stage 3, 4 or unstageable pressure ulcers acquired after admit to healthcare setting, death or serious injury associated with use of seclusion and/or restraints, sexual abuse/assault during provision of services, death or serious injury resulting from assault during the provision of services and homicide committed or allegedly committed by member.

Care1st Quality Improvement Department will review the IAD report within 24 hours of receipt to make a determination of whether the incident includes a quality of care concern (QOC). Care1st must assure that the report is fully and accurately completed. If the report is returned to the provider for corrections, the provider must return the corrected version of the report to the Quality Improvement Department within 24 hours of receipt.

MEDICAL RECORD GUIDELINES

PCPs must maintain a legible medical record for each enrolled member who has been seen for medical appointments or procedures, and/or for whom a provider receives medical/behavioral health records from other providers who have seen the enrolled member. If the PCP has not yet seen the member such information may be kept temporarily in an appropriately labeled file, in lieu of establishing a medical record, but must be associated with the member's medical record as soon as one is established. The record must be kept up-to-date, be well organized and comprehensive with sufficient detail to promote effective patient care and quality review. The PCP must maintain a comprehensive record whether a hard copy chart or electronic medical record (EMR) is used, that incorporates at least the following components:

Physical health medical record requirements

1. Member identification information on each page of the medical record. (i.e., name or AHCCCS identification number)

2. Identifying demographics including the member's name, current and previous address, telephone number, email address, AHCCCS identification number, gender, birth sex, age, date of birth, marital status, race, ethnicity, preferred

language, next of kin, and if applicable, guardian or health care decision maker

3. 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

4. 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 (to include discharge summaries), surgeries and emergent/urgent care received

5. Immunization records (required for children; recommended for adult members if available)

6. Dental history if available, and current dental needs and/or services

7. Current problem list

8. Current medications

9. Documentation, initialed by the member's PCP to signify review of:

    a. Diagnostic information including:
        i. Lab tests and screenings
        ii. Radiology reports
        iii. Physical examination notes, and/or other pertinent data

    b. Documentation of coordination of care activities including but not limited to:
        i. Reports form referrals, consultations and specialists
        ii. Emergency//urgent care reports
        iii. Hospital discharge summaries
        iv. Transfer of care to other providers, and
        v. Behavioral health referrals and services provided, if applicable

10. Documentation as to whether or not an adult member has been provided information regarding advance directives, and whether an advance directive has been executed

11. Documentation related to requests for release of information and subsequent release

12. Documentation of a Health Care Power of Attorney or documentation of an authorized Health Care Decision Maker, if applicable

13. 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

14. Documentation to reflect review of the Controlled Substances Prescription Monitoring Program (CSPMP) database prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances.

15. Documentation of appropriate completed consents (general and/or informed) and treatment plans which are signed and dated by both the provider and the member, or the member's parent or legal guardian, if the member is under 18 years of age or is 18 years of age or older and considered an incapacitated adult (as defined in A.R.S. § 14-5101).

    a. General consent refers to documentation of an agreement from the member or the member's representative to receive physical health services to address the member's medical condition or behavioral health services to address the member's behavioral health issues

    b. Informed consent refers to documentation that the member was advised of a proposed treatment, surgical procedure, psychotropic drug, or diagnostic procedure; alternatives to the treatment, surgical procedure, psychotropic drug, or diagnostic procedure; and associated risks and possible complications; and documented authorization for the proposed treatment, surgical procedure, psychotropic drug, or diagnostic procedure from the member or the member's representative

16. Obstetric providers must also complete a risk assessment tool for obstetric patients (i.e. Mutual Insurance Company of Arizona Obstetric Risk Assessment Tool [MICA] or American College of Obstetrics and Gynecology [ACOG]). Lab screenings for members requiring obstetric care must also conform to ACOG guidelines.

17. Documentation that each member of reproductive age is notified verbally or in writing of the availability of family planning.

18. Evidence that PCPs are utilizing and retaining AHCCCS approved developmental screening tools.

19. Documentation on the current age appropriate EPSDT tracking form or the equivalent elements noted in the EMR.

20. For medical records relating to provision of behavioral health services, documentation shall include, but is not limited to: Behavioral Health history; applicable assessments; service plans and/or treatment plans; crisis and/or safety plan; medication information if related to behavioral health diagnosis; medication informed consents, if applicable; progress notes; general and/or informed consent.

21. Unique device identifier(s) for implantable devices are documented, if applicable.

22. When a member changes PCPs, his or her medical records or copies of medical records must be forwarded to the new PCP within 10 business days from receipt of the request for transfer of the medical records.

Behavioral Health Medical Record Requirements

The following elements shall be included in all behavioral health medical records:

1. Initial behavioral health assessment that includes:

    a. An initial comprehensive assessment and annual update or follow-up for significant life events.

    b. Assessment must be signed by the BHT and cosigned by the BHP within 72 hours of completion.

    c. The assessment must include presenting concerns, current physical and BH conditions, mental status exam, clinical observations, diagnostic impression, summary and recommendations.

    d. The assessment must include diagnostic information, family history, trauma history, assessment for sexualized behaviors, substance use/or exposure, ASAM if needed, needs related to living environment, needs related to healthcare, needs related to socialization, needs related to education and/or vocational training, needs related to employment, needs related to well-being, developmental history, needs related to public and private resources, presence or absence of health care decision maker, presence of a court order, history of a criminal justice involvement and assessment of a court order, history of criminal justice involvement and assessment of need for assistance with communication.

2. Service plan documentation that includes:

    a. A service plan that was completed and dated/signed by a BHP and reviewed with the member and/or health care decision maker.

    b. The Services plan should address the needs identified within the assessment related to living environment, health care, socialization, education/vocation, employment and well-being.

    c. The service plan goals are based on member/family/healthcare decision maker vision, goals that are positive and utilize the member's identified strengths.

3. The following general clinical chart requirements include:

    a. Evidence that peer support or family support has been offered, services were implemented form the treatment plan within 45 days, person-centered language is used and member/family are linked to additional services as needed.

    b. If the member is a child and has a CALOCUS score of 4, 5, 6, a high needs case manager is assigned.

    c. There is evidence in the chart that there is one person who coordinates planning and delivery of services, collaboration is occurring, crisis or safety concerns are assessed and addressed, engagement or re-engagement for a BH crisis no later than next business day, evidence that transition age youth activities begin no later than 16 years of age, evidence that an initial SMI is present if necessary, members with SMI designation have been assessed for special assistance, services are continually evaluated with member/decision maker.

4. Cultural Competence documentation includes the following:
    a. Documentation demonstrates the provision of culturally informed services, provider assessed the need for qualified interpretation services and the need for qualified translator services to communicate in the preferred language of the member/family.

AHCCCS is not required to obtain written approval from a member before requesting the member's medical record from the PCP or any other organization or agency. Care1st may obtain a copy of a member's medical records without written approval of the member if the reason for such request is directly related to the administration of

the AHCCCS program. AHCCCS shall be afforded access to all members' medical records whether electronic or paper within 20 business days of receipt of request or more quickly if necessary.

Information related to fraud and abuse may be released, however, HIV-related information shall not be disclosed except as provided in A.R.S. §36-664, and substance abuse information shall only be disclosed consistent with Federal and State law, including but not limited to 42 CFR 2.1 et seq.

MEDICAL RECORD RETENTION

All providers shall maintain records relating to covered services and expenditures including reports to AHCCCS and documentation used in the preparation of reports to AHCCCS. Providers shall comply with all specifications for record keeping established by AHCCCS. All books and records shall be maintained to the extent and in such detail as required by AHCCCS rules and policies. Records shall include but not be limited to financial statements, records relating to the quality of care, medical records, prescription files and other records specified by AHCCCS.

Providers agree to make available, at all reasonable times during the term of this contract, any of its records for inspection, audit or reproduction by any authorized representative of AHCCCS, State or Federal government. In accordance with Arizona Administrative Code R9-22-512 (E) all providers shall furnish records requested by the Administration or a contractor to the Administration or the contractor at no charge. If the provider uses a vendor to store medical records, it is the provider's responsibility to work with the vendor and facilitate receipt of the requested records at no charge to Care1st or the Care1st delegate.

Providers shall preserve and make available, at no cost, all records for a period of five years from the date of final payment under this contract unless a longer period of time is required by law.

Providers shall comply with the record retention periods specified in HIPAA laws and regulations, including, but not limited to, 45 CFR 164.530(j)(2).

Providers shall comply with the record keeping requirements delineated in 42 CFR 438.3(u) and retain such records for a period of no less than 10 years.

For retention of patient medical records, the provider shall ensure compliance with A.R.S. §12-2297 which provides, in part, that a health care provider shall retain patient medical records according to the following:

1. If the patient is an adult, the provider shall retain the patient medical records for at least six years after the last date the adult patient received medical or health care services from that provider.
2. If the patient is under 18 years of age, the provider shall retain the patient medical records either for at least three years after the child's eighteenth birthday or for at least six years after the last date the child received medical or health care services from that provider, whichever date occurs later.

In addition, the provider shall comply with the record retention periods specified in HIPAA laws and regulations, including, but not limited to, 45 CFR 164.530(j)(2).

If the provider's contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available, at no cost, for a period of five years from the date of any such termination. Records which relate to grievances, disputes, litigation or the settlement of claims arising out of the performance of this contract, or costs and expenses of this contract to which exception has been taken by AHCCCS, shall be retained by the provider for a period of five years after the date of final disposition or resolution thereof.

Seclusion and Restraint

Seclusion and restraint are high-risk interventions that must be used to address emergency safety situations only when less restrictive interventions have been determined to be ineffective, in order to protect Members, staff members or others from harm. All persons have the right to be free from seclusion and restraint, in any form, imposed as a means of coercion, discipline, convenience or retaliation by staff. Seclusion or restraint may only be imposed to ensure the immediate physical safety of the person, a staff member or others and must involve the least restrictive intervention, and be discontinued at the earliest possible time (42 CFR §482.13).

This section includes seclusion and restraint reporting requirements for contracted behavioral health inpatient facilities (42 CFR §482.13) (A.A.C. R9-21) and behavioral health inpatient facilities serving persons under the age of 21 (42 CFR §483 Subpart E).

Seclusion and Restraint Reporting to Care1st

Contracted behavioral health inpatient facilities shall follow local, state and federal regulations and requirements related to seclusion and restraint.

Contracted behavioral health inpatient facilities authorized to use seclusion and restraint shall report the following to Care1st:

- Each occurrence of seclusion and restraint within five (5) calendar days of the occurrence, via email SM_AZ_qmnurse@care1staz.com. Failure to submit seclusion and restraint reports timely may result in corrective action for late submission of a contract deliverable.
    - Any incident that resulted in an injury or complication requiring medical attention must be reported within 24 hours of occurrence.
- Reports of seclusion and restraint are to be submitted using the form **962 Attachment A.** This form can be obtained by emailing SM_AZ_qmnurse@care1staz.com. The form **962 Attachment A, Seclusion and Restraint Reporting Form** must be completed in its entirety and include the required information detailed on AMPM 962.
- In the event that a use of seclusion or restraint requires face-to-face monitoring, a report detailing face-to-face monitoring must be completed and attached to the reporting form. The face-to-face monitoring form must include the requirements as per 42 CFR 482.13, 42 CFR § 483 Subpart 12, and R9-21-204.
- Care1st may also request copies of provider agency Policies and Procedures pertaining to the use of seclusion and restraint, evidence of staff trainings, and any corrective actions taken to reduce the frequency of usage.
- Each behavioral health inpatient facility or Mental Health Agency shall report the total number of incidents of the use of S&R involving AHCCCS members in the prior month to Care1st by the fifth calendar day of the month. If there were no incidents of Seclusion or restraint during the reporting period, the report should so indicate.