
Quality Improvement Program

The Quality Improvement Program (QI Program) is an ongoing, comprehensive and integrated system that exists to actively initiate, monitor and evaluate standards of health care practice and infrastructure essential to the delivery of quality clinical care, behavioral health and services to enrolled members.

The goals of the Program are to:

- Develop and maintain a well-integrated system that continuously measures clinical and operational performance, identifies the need for and initiates meaningful corrective action when appropriate and evaluates the result of actions taken to improve quality of care outcomes and service levels;
- Ensure availability and access to qualified and competent providers;
- Establish and maintain safeguards for member privacy, including confidentiality of member health information;
- Engage members in managing, maintaining or improving their current states of health through fostering the development of a primary care provider-patient relationship and also participation in care programs;
- Provide a forum for members, providers, various health care associations and community agencies to provide suggestions regarding the implementation of the QI Program; and
- Ensure compliance with standards as required by contract, regulatory statutes and accreditation agencies.

The WellCare of Ohio board of directors has chartered the Plan's Quality Improvement Committee (QIC) for the purpose of monitoring and evaluating the results of the QI Program initiatives and initiating corrective action

when the results are less than desired or when areas needing improvement are identified.

QI Program activities which involve physicians include but are not limited to:

- Member medical record reviews;
Types of reviews may include:
 - Medical record content;
 - Continuity of care;
 - Adult health screening;
 - Pediatric health screening;
 - Diagnostic specific screening;
 - Maternity care;
 - Healthcare Effectiveness Data and Information Set (HEDIS) Review;
 - State reviews;
 - Quality of care reviews to investigate a complaint, grievance or adverse unexpected event;
 - Requests for internal QI data from delegated credentialing entities; and
 - External Quality Review Organizations (EQRO).

- Disease management initiatives to improve health outcomes for members;

- Review of physicians' office sites;

- Participation in application of Clinical Practice Guidelines, as detailed by contract;

- State QI Projects as established by the EQRO;

- Completion of the re-credentialing process; and

- Corrective Action Plan (CAP) follow-up.

The Quality Improvement Program incorporates ongoing screening of the medical record to assure compliance with all regulatory and accreditation agency guidelines.

A plan of action will be instituted when opportunities to improve patient care or documentation are present. Providers may be asked to participate in formulating the plan of action, as collaborative input will provide the key for a workable solution.

The Quality Improvement department will assess the minimum guidelines of care and documentation, required by regulatory agencies, external quality review and accreditation organizations, for medical record review, health screening and high-risk diagnoses on an ongoing basis. A Plan representative will make an appointment to review these items in the provider's office, as necessary.

Upon completion of the review, providers will be provided with a preliminary summary of findings during the exit meeting to outline any deficiencies found during the review. The report will assist provider offices with making any necessary corrections. If the provider's aggregate score is less than 80 percent a corrective action plan will be requested.

Quality Improvement Participation

Providers contracted with the Plan are required to participate in all quality improvement functions and tasks required by the Ohio Department of Job & Family Services (ODJFS), federal laws and the Plan.

These activities may include, but are not limited to, the following:

- Compliance with requests for medical records for quality improvement studies and audits;
- Cooperation with quality improvement initiatives related to collaborative projects;
- Cooperation with efforts to improve care for chronic disease and/or preventive care measures;
- Compliance with requests for information and recommendations formulated by the Plan and ODJFS, in the process of reviewing/resolving

beneficiary and/or provider complaints.

The Plan and ODJFS may also perform annual audits. Providers will need to copy office records for these audits. It is very important that any time a copy of a record is requested the entire record is sent.

In addition to monitoring the guidelines in this manual, continuity of all patient care will be monitored (see the **Medical Records** section of this manual).

The results of all reviews are maintained in a Physician Profile and utilized at the time of re-credentialing.

**Provider
Participation
with QI
Activities**

The Quality Improvement Program seeks out and invites input from the physician community regarding the implementation of the Program. Ohio-licensed physicians are members of the following Program committees and work groups:

- Medical Advisory Committee
- Credentialing Committee
- Pharmacy and Therapeutics Committee

Provider input is also integral to the development of Preventive Health Guidelines, Clinical Practice Guidelines, Performance Improvement Projects (PIP's) and Care and Disease Management Programs.

In accordance with regulatory contracts and accreditation guidelines, the Plan and its providers contractually agree to participate in Quality Improvement projects and medical record review activities to:

- Promote the appropriate medical record documentation and management of patients with designated diagnoses;
- Identify areas of medical record documentation and management that may be improved;

- Oversee the quality of the medical record;
- Provide periodic feedback to the physicians;
- Identify areas of practice that require peer review;
- Provide a performance profile to be utilized during the credentialing process.

Access to Records

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

Other Requirements

- Copying and providing office records as needed for quality review activities;
- Requests for internal QI data from delegated credentialing entities;
- Copying and providing office records for state, federal or Plan review.

Quality Improvement Activities

The following are Quality Improvement activities performed by the Plan on an ongoing basis:

- Access and availability studies:
 - PCP turnover rates
 - Children's access to primary care
 - Adults access to preventive/ambulatory health services;
- Hospital readmission reviews;
- Referrals for quality issues;
- Mortality reviews;
- HEDIS[®] reviews and initiatives;

- Performance Improvement Projects (PIP's):
 - Identifying children with special health care needs
 - Well-child visits during the first 15 months of life
 - Dental visits for children 2 through 21 years of age;

- Care management outcomes;

- Disease management outcomes;

- Appointment availability;

- After-Hours availability;

- Accuracy, timeliness and completeness of encounter/claims submissions;

- Over- and under-utilization of services;

- Member satisfaction surveys;

- Provider specific issues identified through tracking and trending of complaints or referrals; and

- Medical Record Content Reviews – See the **Medical Records** section of this manual for specific documentation standards and requirements and the **Provider and Member Education Materials** for associated materials.

Results of all reviews will be housed in a Provider Profile to utilize during re-credentialing and re-contracting.

Quality of Care Issues

Quality of care referrals may be generated by the Appeals and Grievances department, Risk Management department, Utilization Management department, member or family complaint department or may be identified through routine record review.

Record review identifying possible quality of care issues will be referred for peer review. In the event the peer reviewer/panel feels there is a possible quality of care issue, the physician will be asked, in writing, to provide additional information to address the issue. The response is reviewed and a final determination is rendered.

Quality of Care Categories:

- Procedural issues
- Medication issues
- Delay/Omission of care
- Death or serious disability
- Post-op complications
- Patient safety during confinement
- Member perception

Quality Of Service Categories:

- Access/Availability issues
- Referral issues
- Billing issues
- Environmental
- Interactions

Determination:

- Substantiated
- Unsubstantiated
- Unable to make a determination based on available information

Outcome:

- No adverse outcome
- Adverse outcome
- Sentinel event

Action:

- Close Case
- Track & Trend
- Request additional information
- Refer to peer reviewer for recommendation
- Refer to external review organization
- Refer to the Credentialing (Peer Review) Committee

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- Corrective Action Plan

Reporting By Action*Reportable:*

- Termination as a result of a quality of care issue
- Imposing restriction on privileges

Not Reportable:

- Track & Trend
- Focus review
- Deferment of members
- Requiring CMEs
- Counseling

HEDIS® Indicators

The following HEDIS indicators may be reviewed and reported on an annual basis. Based on ODJFS and/or the Plan initiatives, performance indicators may be added or deleted.

- Adolescent Well-Care Visits
- Adult Access to Preventive/Ambulatory Health Services
- Appropriate Treatment of Children with URI
- Appropriate Testing for children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection
- Use of Appropriate Medication with People with Asthma
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening for Women
- Childhood Immunization Status
- Children and Adolescents' Access to Primary Care Practitioners
- Comprehensive Diabetes Care
- Controlling High Blood Pressure
- Frequency of Ongoing Prenatal Care
- Prenatal and Postpartum Care
- Weight Assessment and Counseling for Nutrition

and Physical Activity for Children/Adolescents

- Well-Child Visits for Children Ages 3-6
- Well-Child Visits in the First 15 months of Life
- Annual Dental Visits
- Lead Screening
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Pharmacotherapy Management of COPD Exacerbation
- Cholesterol Management for Patients with Cardiovascular Conditions/LDL-C Screening Performed
- Follow Up After Hospitalization for Mental Illness

Health Quality Improvement and Disease Management Initiatives

The Quality Improvement Program includes programs for the Covered Families and Children (CFC) population for Care and Disease Management for members with asthma, diabetes, HIV/AIDS, elevated lead levels, teen pregnancy, high-risk pregnancy, pediatrics and other complex conditions. In addition, programs to ensure members are receiving Healthchek screenings, lead screenings and immunizations are instituted to encourage members to obtain needed preventive health care screenings.

Included in the **Provider and Member Education Materials** are items ranging from Adult Health Screening guidelines, Tools for Documentation, Guidelines for Medical Record Review to Fax Alerts, which are faxed to provider offices, regarding members' unique health care needs.