

**PIMA HEALTH SYSTEM
QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT (QM/PI) PROGRAM
OVERVIEW**

Pima Health System (PHS) provides a comprehensive QM/PI Program in both the Acute and Long Term Care arenas. QM operates under the leadership of the system's Administrator and Medical Director. The program's purpose is to continuously improve the level of care and service provided to members.

PHS uses a combination of AHCCCS-required performance measures, performance improvement projects, standards and guidelines as well as components from the National Committee for Quality Assurance (NCQA) Standards for Accreditation for managed care organizations as the core of its QM/PI program.

NCQA and AHCCCS standards address the following areas:

- *Quality Management and Improvement*
- *Credentialing/Recredentialing*
- *Member Connections*
- *Member's Rights/Responsibilities*
- *Utilization Management*

Major components of the PHS QM/PI Program, which are a part of the standards noted above, include:

- *Medical Practitioner Credentialing/Recredentialing/Profiling*
- *Quality of Care/Medical Mismanagement Concern Investigation, Tracking and Trending*
- *Risk Management Investigation, Tracking and Trending*
- *Performance Improvement Projects (PIPs)*
- *Performance Measures (PMs)*
- *Provider/Staff Education*
- *Member Education*
- *Abuse Reporting/Education*

AHCCCS-required performance measures using designated criteria and reporting guidelines include, but are not limited to, the areas of:

<i>Mammography Screening</i>	<i>Member Satisfaction</i>
<i>Cervical Screening</i>	<i>Provider Satisfaction</i>
<i>Dental Visits</i>	<i>Initiation of HCB Services</i>
<i>Low Birth Weight</i>	<i>Chlamydia Screening</i>
<i>Pediatric/Adult Immunizations</i>	<i>Well-Child Care</i>
<i>EPSDT Participation</i>	<i>Well-Adolescent Care</i>
<i>Adult Ambulatory/Preventive Care</i>	<i>Management of Diabetes</i>

The PHS QM/PI Committee and Medical Director are responsible for the daily operational activities of the PHS QM/PI Program. The main responsibilities of the committee, which meets at least quarterly, include:

- *Assuring that all quality and utilization related activities of the organization are coordinated and functioning properly.*
- *Initiating action to improve quality of care and service issues identified by the QM Intra-Departmental Committee through tracking and trending activities.*
- *Reviewing and acting upon peer review recommendations, as necessary.*
- *Reviewing and acting upon credentialing/recredentialing recommendations, as necessary.*
- *Reviewing the QM/PI Plans annually, approving changes, providing updates, and evaluating its effectiveness.*
- *Reviewing annual QM Program evaluation reports.*

For further information regarding our program, contact (520)243-8250.

Reviewed/Revised 03/2009

CREDENTIALING/REREDENTIALING OF PIMA HEALTH SYSTEM (PHS) PRACTITIONERS

Credentialing/Recredentialing of practitioners is a part of the of the comprehensive Quality Management/Performance Improvement (QM/PI) Program at PHS. The purpose of this process is to ensure that practitioners, who are licensed by the state and who are under contract to, or employed by PHS, are qualified by training and experience to deliver quality patient care.

PHS uses a combination of AHCCCS required performance measures as well as the National Committee for Quality Assurance (NCQA) Standards for Accreditation for managed care organizations as the core of its QM/PI program.

All medical, dental and behavioral health practitioners contracted with PHS to provide direct care to members must be approved through an acceptable credentialing/recredentialing process. PHS uses a Credentialing Verification Organization (CVO) to assist in primary source verification. In addition, PHS also delegates credentialing/recredentialing, while reserving the right of final approval, to:

- *University Physicians Incorporated (UPI)*
- *Carondelet Health Network*
- *Children's Clinics for Rehabilitative Services (CCRS)*

Initial site visits to review physical accessibility, medical record keeping practices, vaccine/drug storage policies, emergency/resuscitation measures and appointment standards will be performed at, all PCP and OB/GYN offices.

All medical, dental and behavioral health practitioners will be recredentialled at least every three years. Record reviews will be performed on, at a minimum, PCPs with panels of ≥ 50 members, High Volume Specialists, including Behavioral Health and other practitioners as indicated. In addition, profiling information received from QM, UM, Member Services, and Contract/Provider Services will be used for all practitioners as a part of the profiling process. Following preliminary approval by the PHS Medical Director, the PHS Credentialing/Practitioner Advisory Committee (C/PAC) is the decision making body for PHS regarding credentialing/recredentialing activities.

As a part of the credentialing/recredentialing process, practitioners have the following rights:

- to review information submitted to support their credentialing application,
- to correct erroneous information, and
- upon request, to be informed of the status of their credentialing/recredentialing application.

PHS utilizes a Peer Review process in addressing significant clinical issues. Activities for peer review are coordinated by the QM Division under the direction of the PHS Medical Director and presented to the PHS C/PAC. PHS offers a Fair Hearing process to contracted medical/dental practitioners whenever PHS chooses to reduce, suspend, or terminate a practitioner's privileges.

Further details or copies of the standards and procedures regarding credentialing/recredentialing, profiling, peer review, and the fair hearing process are available by contacting (520) 243-8251.

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**PIMA HEALTH SYSTEM (PHS)
CREDENTIALING ORGANIZATIONAL PROVIDERS**

Credentialing organizational providers is another part of the comprehensive Quality Management/ Performance Improvement (QM/PI) Program at PHS. The purpose of this process is to ensure that organizational providers:

- are licensed to operate in the Arizona and are in compliance with any other applicable State or Federal requirements as applicable.
- are reviewed and approved by an appropriate accrediting body or, if not accredited, Centers for Medicare and Medicaid (CMS) certification or State licensure may substitute for accreditation. In this case, PHS must maintain documentation of the following:
 - review by Arizona Department of Health Services (ADHS)
 - summary of ADHS findings including date of their review,
 - are in compliance with their participation agreement/PHS contract and
- have professional liability insurance.

Organizational providers include but are not limited to: hospitals, home health agencies, attendant/ home care agencies, group homes, skilled nursing facilities, assisted living facilities, inpatient/residential/ambulatory behavioral health facilities, dialysis centers, free-standing radiology and surgi-centers, hospice, urgent care facilities, labs and transportation companies.

As a result, a copy of the documents described above will be required upon contracting and at least every three (3) years thereafter. Following preliminary approval by the PHS Medical Director, the PHS Credentialing/Practitioner Advisory Committee (C/PAC) is the decision making body for PHS regarding the credentialing of organizational providers with the exception of Assisted Living Facilities (ALFs). ALFs are credentialed through the

For further details regarding credentialing organizational providers contact (520)243-8251 or (520) 243-8250.

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PIMA HEALTH SYSTEM LOCUM TENENS OVERVIEW

For non Arizona licensed physicians, PHS recognizes locum tenens arrangements but restricts them to the length of the locum tenens registration with the Arizona Medical Board as follows:

- A. Arizona Medical Board issues locum tenens registration for a period of 180 consecutive days once every three years to allow a physician who does not hold an AZ license to substitute for or assist a physician who holds an active AZ license.
- B. Locum tenens can have only one sponsoring practitioner during the 180 day period and they can only be a locum tenens once every three years in this state. If the practitioner has more than one site, the locum tenens can assist in these additional sites; however, he/she can not be a locum tenens for more than one practitioner at a time.

For Arizona licensed physicians serving as locum tenens, PHS recognizes locum tenens arrangements as follows:

- A. Valid Arizona license; locum tenens registration is not required.
- B. Locum tenens may assist more than one physician at a time.
- C. The time frame in which a licensed physician may serve as a locum tenens is not restricted.

When a provider uses a locum tenens, the provider must notify the PHS Credentialing Unit in writing (via fax or email). The PHS Medical Director will review the notification and all other information available. Upon completion of that review, he/she may approve or deny coverage in the network. Practices using locum tenens arrangements must maintain a log identifying which locum tenens physicians are substituting for or assisting which AHCCCS- registered providers. To assist PHS and AHCCCS in identifying the actual provider of service for claims payment and reporting purposes, **all services rendered by the locum tenens physician must be billed with the “Q6” modifier**. Further questions can be addressed to (520) 243-8251.

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**PIMA HEALTH SYSTEM
MEDICAL RECORDS OVERVIEW**

MEDICAL RECORDS SYSTEM

PHS has developed medical record standards, which comply with the National Committee for Quality Assurance (NCQA) and AHCCCS requirements as a part of its Quality Management/Performance Improvement (QM/PI) Program. All PHS practitioners are responsible for complying with these standards for record maintenance. As a part of the recredentialing process, record reviews will be performed on a minimum of all PCPs with panels of > 50 members and High Volume Specialists, including Behavioral Health. Record reviews will be conducted on other practitioners as indicated.

The medical/dental record is the property of the practitioner and adequate safeguards must be taken to ensure confidentiality of all information. A member is entitled to a copy of his/her record. When a member changes PCPs, the medical record must be forwarded within 10 working days from the receipt of the request. A copy of the Medical Records Standard and Procedure is available by contacting (520) 243-8250.

CONFIDENTIALITY AND RELEASE OF MEDICAL RECORDS

There are Federal privacy standards including the Health Insurance Portability and Accountability Act (HIPAA), State laws and AHCCCS rules and regulations that pertain to the safeguarding and release of confidential member information. Each provider and staff person employed by the provider is required to be familiar with the rules and regulations regarding confidentiality, to adhere to these rules in the performance of their duties, and to avoid disclosure of confidential information outside of the workplace. Each provider is responsible for the safeguarding of medical records and for the release of confidential information in accordance with the Uses and Disclosures of Member's Health Information Standard and Procedure which can be obtained by contacting (520) 243-8250. Additional information regarding HIPAA can be found in your PHS contract.

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**PIMA HEALTH SYSTEM
SKILLED NURSING FACILITIES (SNFs)
QUALITY MANAGEMENT OVERSIGHT**

The Pima Health System (PHS) Quality Management (QM) Division has the following reporting requirements for SNFs:

- Pressure Ulcer Report: due by the 5th of the month for the previous month.
- Falls/Fractures Report: due by the 5th of the month for the previous month.
- Flu and Pneumococcal Immunization Data: due annually.
- Performance Measures Data: due as determined by methodology.
- Performance Improvement Project(s) Data: due as determined by methodology.
- Suspected or actual cases of Fraud/Abuse/Neglect: due verbally within one working day of the incident. A written report should be sent to the PHS Fraud and Abuse Coordinator as soon as any investigation is completed.
- Injuries (i.e., falls/fractures): as soon as possible to individual member's case manager
- Unexpected deaths : as soon as possible to individual member's case manager
- HIPAA violations as soon as possible to the PHS Compliance Officer
- Actions by ADHS/CMS when Substandard Quality of Care and/or Immediate Jeopardy is announced: due within one working day of announcement.
- Copy of facility's Summary Statement of Deficiencies (CMS form 2567) including Plan of Correction: due within five (5) working days.
- Change in Administrator/DON due: within five (5) working days of change.

Annually, QM staff perform site visits at each contracted SNF. Areas of review include, but are not limited to: the facility environment, privacy measures/corporate compliance, medications and infection control, emergency procedures, QM processes, staff education, MDS/QI profile report, and medical record keeping practices.

A concern investigation may be conducted at any time in a SNF using the following methods:

- appropriate staff, residents, resident's families may be interviewed,
- the medical record may be reviewed,
- applicable forms (i.e., Treatment Records, Medication Records, ADL sheets) and standards and procedures may be viewed,
- staffing levels may be reviewed, and/or
- other methods as needed.

The results of the investigation are presented to the PHS Intradepartmental QM Concern Committee where the concern is classed, categorized and interventions are determined if necessary. The SNF Administrator/Director of Nursing is notified of any additional recommendations or need for a corrective action plan.

PHS also has a Quality Resolution Committee which meets to determine a plan of action when one of the following has occurred:

- a SNF has findings of: not in substantial compliance during a CMS/ADHS survey,
- a SNF has been placed on a provisional license, and/or
- a SNF has a substantial quality management concern(s) identified by a QM Division associate during a concern investigation.

The SNF administrator/designee is notified of the committee's decision(s) verbally and in writing.

A copy of the standards and procedures related to the above may be found in the PHS Quality Management Standard and Procedure Manual. If you have any questions or need further information, call (520) 243-8250.

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PIMA HEALTH SYSTEM REPORTING FRAUD AND ABUSE

Pima Health System (PHS) and all contracted providers and their staff have the responsibility to protect PHS members and the Arizona Health Care Cost Containment System (AHCCCS) from any incident of fraud and abuse. The following definitions are presented to help you determine if there is a need to report:

- Abuse (of Member) means intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual, or emotional abuse or sexual assault. (ARS 46-451)
- Abuse (by Provider) means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the AHCCCS program. (42 CFR 455.2)
- Exploitation means the illegal or improper use of an incapacitated or vulnerable person's resources for another person's profit or advantage. An incapacitated person is a person who is mentally or physically impaired to the extent that he/she lacks sufficient understanding or capacity to make or communicate responsible decisions. A vulnerable person is a person who is unable to protect himself/herself from harm due to a mental or physical impairment. (ARS 46-451).
- Fraud (by member or Provider) means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the individual or some other person. It includes any act that constitutes fraud under applicable Federal or State laws. (42 CFR 455.2).

PHS contracted providers are required to report, verbally, any known/suspected incident(s) of fraud to the PHS Compliance Officer and member abuse/exploitation to the PHS Quality Management Program Manager within one working day of the incident. A written report should be sent as soon as any investigation is completed. A copy of the Prevention, Detection, and Reporting Fraud and Abuse Standard and Procedure may be found in the PHS Quality Management Standard and Procedure Manual. If you have any questions about what to report, contact the PHS Quality Management Program Manager at (520) 243-8250 or the PHS Compliance Officer at (520) 243-8032. Should you decide to remain anonymous, you can send a written report to:

PHS Compliance Office
PO Box 27895
Tucson, Arizona 85726

In addition and for your convenience, PHS also has a **Compliance Hot Line** [(520) 419-0317] which can be used to report Fraud and Abuse or obtain further information.

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