QUALITY MANAGEMENT

Physicians Plus deploys quality management processes to promote prevention, improve health care outcomes and business processes, reduce variation, reduce total cost and provide value to the members we serve. The quality improvement initiatives involve objective and systematic monitoring and the evaluation of the quality of care and service provided to our members. This quality measurement process yields targeted initiatives to improve the health and service delivered to our members.

The Health Care Access and Improvement (HCAI) Division oversees clinical improvement activities, including but not limited to:

- Health promotion and disease prevention
- Chronic illness management
- Ambulatory care
- Acute hospital services
- Emergency and urgent care services
- Behavioral health and chemical dependency services
- Service to members, employers and providers
- Patient safety

In addition, multi-disciplinary teams work to improve the efficiency and effectiveness of core business functions and processes, thereby improving the services provided.

The Goals of the Quality Management Program

- Ensure that Physicians Plus members are provided with a network of available practitioners who meet or exceed defined standards of education and experience
- Conduct ongoing monitoring of important aspects of the care provided to members
- Identify and improve, where indicated, aspects of care, health status and health function that are important to members
- Identify and improve, where indicated, aspects of service that are important to members and providers
- Measurably improve the performance of the provider network and the healthcare services that members receive. Current HEDIS Effectiveness of Care results can be found at http://www.pplusic.com/about/index.asp?cid=97&scid=266

Quality Management Committee Structure

The Physicians Plus Board of Directors (BOD) has ultimate oversight and accountability for the implementation of quality management processes and the performance of the quality management program. The responsibility for adoption of quality management processes is delegated to the Chief Executive Officer (CEO). The CEO is accountable to the BOD for the quality of medical care and service delivered to Physicians Plus members and for providing and supervising the corporate resources of Physicians Plus' quality management processes and activities.

Five (5) standing committees support the Quality Management Program. These committees, whose membership includes practicing provider, are:

- Quality and Utilization Management (QUM) Committee
- Credentialing Committee
- Peer Review Committee
- Pharmacy & Therapeutics (P&T) Committee
- Grievance Committee

In addition to the standing committees, quality improvement project teams are working on issues such as improving the care of members with diabetes, heart failure, hypertension, hyperlipidemia, and depression. Project teams are also working to improve the rate at which members obtain preventive health services in the areas of immunizations and breast, cervical and colorectal cancer screenings.

Chronic Illness Management Programs

Chronic Illness Management Programs

Physicians Plus offers several proactive programs aimed at managing the health status of members who are at-risk for, or who have been diagnosed with, specific chronic conditions or diseases. The following chronic illness management programs are offered to members who meet eligibility criteria:

- Diabetes Management Program (including telephonic case management)
- Congestive Heart Failure Management Program (including telephonic case management)
- Hypertension Management Program (including telephonic case management)
- Cholesterol Management Program (including telephonic case management)
- Weight Loss and Management Program (including telephonic case management)

Members of these programs are screened for alcohol and tobacco use, and for depression. Self-care education is a key component of these programs and program materials are made available to program members via the mail (upon request), as e-mail attachments and via the Physicians Plus website at http://www.pplusic.com/members/index.asp?cid=95

Program interventions include:

- Self-management education
- Care reminders
- Case management
- Medication management
- Provider profiling
- Incentives
- Remote disease monitoring
- System-wide improvement efforts within provider network and community

In addition to these chronic condition management programs, Physicians Plus offers its members 24/7 access to *GO-TO Healthy Choices*, an on-line personal health management suite of services available to members ages 18 and older. This innovative offering includes a comprehensive health risk assessment, individualized action plan for health status improvement, and lifestyle and condition management programs.

For referrals and additional information, please contact Physicians Plus' Health Improvement Department at 608-260-7143.

Clinical Practice Guidelines

Evidence-based clinical practice guidelines are developed and implemented in collaboration with our provider network, and include the input of clinical professionals with expertise in the defined area. They are reviewed and revised every one to three years, depending on the guideline.

Practice guidelines are developed in collaboration with UW Health and have been reviewed and adopted by Physicians Plus Quality & Utilization Management (QUM) Committee.

- Guidelines are available to providers on Physicians Plus' website at http://www.pplusic.com/providers/index.asp?cid=8
- New guideline alerts are also included in the spring and fall issues of the provider newsletter.
- Provider Network Management Liaisons provide clinic managers with summary documentation of new programs and relevant guidelines.

ACCESS TO CARE

An important consideration of members when they are assessing the quality of care they receive, concerns their ability to receive appropriate care when they feel that it is required. The Board of Directors has adopted standards of access to routine, preventive, urgent, and emergency care. Member's actual experience in receiving access within these time frames is monitored by member surveys, office site visits, and provider telephone and paper surveys.

The current access standards adopted by the Physicians Plus Board of Directors are included in this material.

Member Access to Care and Services

Physicians Plus Insurance Corporation Policy

Document Number: 0038-PO-CORP-0010-PNM
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Accountable Department: Provider Network Management
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Author: Strasser, Mary D.
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Owner/Author

Accountable Department: Provider Network Management

Document Owner: Director of Provider Network Management

Author: Strasser, Mary D.

Typist: Strasser, Mary D.

Policy Description

Policy: To ensure members' timely access to needed and recommended medical care and services, Physicians Plus establishes and periodically reviews access standards for routine, preventive care, urgent, and emergency care for participating primary care, behavioral health and high volume specialty providers. Where there is an identified need for improvement, Physicians Plus Provider Network Development staff members work with the providers to develop and implements action plans and monitor results.

The standards for access are as follows:

- Routine Care (for non-interfering symptoms and follow-up care) is third next available appointment within 30 days with a 90% compliance rate.
- Preventive Care Appointments (for preventive screens and check-ups) is the third next available appointment within 90 days with a 90% compliance rate.
- Urgent Care Appointments (for an illness or injury) is the same day or by the end of the following day with a 90% compliance rate.
- Emergency Care is immediate to within 24 hours.
- After-hours Care is that all participating practitioners provide after hours access to medical consultation and care for their patients.
- Office Wait Time - the average office appointment wait time for primary care providers should not exceed 30 minutes beyond scheduled appointment time.

Responsibility: NACC

CREDENTIALING AND RECREDENTIALING OF PRACTITIONERS

Physicians Plus Insurance Corporation has established a systematic credentialing process for reviewing the education and training of practitioners who want to become participants in our network. This process also investigates the history and background of applicants to insure that they also meet the criteria for participation in the network. **Only practitioners who have fulfilled the requirements for credentialing or recredentialing are permitted to see Physicians Plus members and bill for services.**

Credentialing, recredentialing, ongoing monitoring of sanctions and complaints, facility reviews, and performance monitoring are integral to the Physicians Plus program for monitoring the care received by our members.

Purpose

Credentialing is intended to provide a systematic approach to the selection, evaluation, discipline or termination of Physicians Plus providers. Credentialing investigates the historical record of a provider to ascertain that he/she has the background required, but also has an acceptable record on issues of standard of care, ethics, character and judgment.

Providers are considered for selection based on member need, reputation in the community, and employer or member request. The final provider acceptance is contingent upon his/her successful completion of the credentialing review process.

MEDICAL RECORDS DOCUMENTATION/AUDITING

Documentation

Purpose

To define the standards for medical record documentation.

Policy Statement

The medical record for each member of Physicians Plus should be an organized, consistent record that accurately communicates information required to render timely, comprehensive medical care.

A copy of the standards follows later in this section.

Auditing

Purpose

To assess compliance with the "Medical Records Documentation" policy and procedure.

Policy Statement

Physicians Plus Insurance Corporation will conduct on-going audits of member's medical records to ensure that records meet the standards for adequate charting as described in Physicians Plus policies and procedures.

#D3924-003	PHYSICIANS PLUS INSURANCE CORPORATION Policy & Procedure Quality Management Department	Approval Needed by: __√ Dpt. Mngr. ___ CEO ___ Sr. Mngr. ___ Board _√ Medical Dir. _√_CR Com

MEDICAL RECORD DOCUMENTATION STANDARDS

APPROVAL SIGNATURES: SIGNATURES ON FILE Date:____________

POLICY STATEMENT: Physicians Plus Insurance Corporation (PPIC) has adopted documentation guidelines based on the recommendations of the State Medical Society of Wisconsin combined with NCQA requirements. A health care record serves as a legal document and is a critical risk management tool. Documentation is important to promote communication between health care providers, provides substantiation of services for reimbursement, allows concurrent and retrospective review of services and is essential for planning and coordinating of health care services.

PROCEDURE:

I. Medical Record Retrievability

a. PPIC requires all member medical records to be stored in a safe secured location away from public access.
b. Medical records are available and present at the time of the appointment.
c. Electronically stored medical records must be secured by authorized personnel.

II. Confidential patient information

a. PPIC requires each office and provider site to maintain medical record confidentiality policies and procedures. The PPIC staff reviewer or health care professional will request and review verification of this policy and procedure at the time of the medical record audit.
b. PPIC requires applicants for participation and current practitioners and their office staff to maintain confidentiality of member records and information. Confidentiality requirements are located in policy and procedure, "*Confidentiality of Patient Information in Clinical Sites",* the practitioner's contract, the PPIC Provider Manual and/or it is communicated to practitioners and staff at the time of the Provider Orientation visit with the Regional Network Liaison.
c. Member information shall only be discussed with the individual patient, those care givers involved with their care, the parent of a patient who is a minor, the patients legal guardian, an attorney as chosen by court orders, or those persons known to be authorized by the patient and involved physicians.
d. Employees may not photocopy and/or release confidential information without proper written consent from the patient.
e. Improper release of information may be a violation of state and federal confidentiality laws, and violators may be subject to civil and/or criminal penalties.
f. All disclosures of information should be documented in the file.

III. Process for performing medical record audit

a. PPIC may conduct a medical record audit for each physician or practice site where 50 or more members have designated the physicians at that site as his or her primary care practitioner (PCP). A practice site is defined as a clinic or suite if several clinics are housed within the same building. For primary care practitioners who practice at multiple sites, a medical record audit is required only at one site.

b. A list of members who have designated the physician(s) at a site as their PCP is compared to claims history in order to select patients who have seen their PCP on a regular basis.

c. The number of records audited per site is dependent on the number of primary care practitioners at that site or practice as follows:
- 1 to 5 physicians 10 records
- 6 to 9 physicians 15 records
- 10 or more physicians 20 records

d. The practice site shall be notified in advance and provided with the list of records to be audited. The physicians and practice site staff are informed that the goal is to achieve a score of 90% or better.

e. A designated PPIC office staff reviewer or delegated representative conducts all medical record audits at the practitioner / clinic site. PPIC has accepted NCQA's Guidelines for Medical Record Review. NCQA has identified six critical elements, indicated with an asterisk (see below). The medical records are reviewed for compliance following the instructions and criteria on the following pages and the Medical Record Audit tool. The results of the medical record audit will be reported using the following guidelines.

1. Critical elements (NCQA noted with asterisk) **[Problem list, Allergies, history, Diagnosis consistent with findings, treatment plans, appropriate treatment]**
   a. For documentation elements with a score less than 100% but more than 90% PPIC will make recommendations accordingly.
   b. For documentation elements with a score from 70-89%, PPIC will make recommendations; provide information to improve medical record keeping practices and request a corrective action plan from the practice site to implement those methods for improvement.
   c. For documentation elements with a score less than or equal to 69%, PPIC will make recommendations; provide information to improve medical record keeping practices and request a corrective action plan from the practice site to implement those methods for improvement. And, the office will be notified that a repeat medical record review audit will be conducted in six months.
   d. Offices and physician sites that continue to fall below the established standards after repeated audits and continued support from PPIC, will be sent a letter from the Vice President of Medical Affairs/Medical Director to discuss further action.
2. Non-critical elements
   a. An average score will be calculated for the non-critical elements. Recommendations will be made for scores of less than 90%.
   b. For documentation elements with a score from 70-89%, PPIC will make recommendations, provide information to improve medical record keeping practices and may or may not request a corrective action plan for improvement.
   c. For an average score less than or equal to 69%, PPIC will make recommendations; provide information to improve medical record keeping practices and request a corrective action plan for improvement. .

f. A report summarizing the results for all the medical record elements will be sent to the clinic manager. This report will also identify those elements for which an action plan is recommended.

g. In the case of a practice sites documentation scores remaining below 70% after the second review, interventions will be taken as deemed appropriate by the Vice President of Medical Affairs.

h. In addition to individual clinic reports, aggregate data from several clinics will be compiled and analyzed to identify opportunities for system-wide improvements.

i. At least biennially, the Quality Management Department will report aggregate medical record compliance to the PPIC Credentialing Committee and Quality Utilization Management Committee (QUM).

IV. Required Information

The health care record generally should follow the "SOAP" format for charting within the Progress Notes. This is defined as:

- Subjective Information – history or chief complaint.
- Objective Information – Physical findings.
- Assessment – Diagnosis.
- Plan – treatment and/or interventions, medications, and provision of patient education materials.

V. Content Standards of the medical record (Per NCQA)

1. Each page in the record contains the patient's name or ID number.
2. Personal/biographical data to include patient's address, employer, home and work telephone numbers, and marital status.
3. All entries in the medical record contain author identification. Author identification may be handwritten signature, unique electronic identifier or initials.
4. All entries must be dated and maintained in chronological order.
5. The record is legible to someone other than the writer.
6. * Significant illnesses and medical conditions are indicated on the problem list.
7. * Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
8. * Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
9. For patients 14 years and older, there is appropriate notation concerning the use of cigarettes, alcohol, and substances for (patients seen three or more times, query substance abuse history).
10. The history and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.
11. Laboratory and other studies are ordered, as appropriate.
12. * Working diagnoses are consistent with findings.
13. * Treatment plans are consistent with diagnoses.
14. Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months, or as needed.
15. Unresolved problems from previous office visits are addressed in subsequent visits.
16. Review for underutilization and over utilization of consultants.
17. If a consultation/referral is requested, is there a note/evidence of communication from the consultant/referred provider (i.e. nursing home, home health, hospital, behavioral health and other specialists) in the record?
18. Consultation, lab and imaging reports filed in the chart are initialed by the practitioner who ordered them to signify review. Review and signature by professionals other than the

ordering practitioner do not meet this requirement. If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation, abnormal lab and imaging study results have an explicit notation in the record of follow up plans.

19. ***** There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
20. An immunization record for children is up to date or an appropriate history has been made in the medical record for adults.
21. There is evidence that preventive screening and services are offered in accordance with the organization's practice guidelines. Should be documented in accordance with practice guidelines.

VI. Method of documenting in the medical record and filing of information

1. PROMPT/TIMELY

   Information must be promptly recorded.

   a. Late Entry

      Since records are to be chronologically organized and all entries are dated, a late entry should be dated with date of the occurrence (making it out of chronological order) and then labeled as "Late Entry". An explanation should follow why entry is late (i.e., Entry Date - The patient spoke with Dr. John Doe 1/1/00 for an office visit. Telephone conversation did not get documented until after the office visit because the patient was the first patient of the day and her immediate care took precedence over documenting the phone conversations from the previous day. Signature.

   b. If a chart is delayed due to presently being in transcription, a late entry could be documented as "Late Entry" – chart unavailable, in transcription.

2. SPECIFIC AND COMPLETE

   All relevant information should be included or referenced in the chart. Unless acknowledged, it may be assumed that the health care provider was aware of relevant patient information. Unless, documented, it becomes the patient's word against the health care provider.

   a. All patient interactions are recorded; particularly telephone calls where prescriptions are called or advice is given.
   b. All labs, x-ray or other test request must be recorded. Reports should be initialed before inserted in the chart as proof they were read. Abnormal findings should be referred to in the progress record otherwise the assumption may be that no one was aware of it.

3. ACCURATE Information must be verifiable.

4. OBJECTIVE

   Use signs and symptoms rather than subjective conclusions. It should be clear to everyone who documents in the record that the patient or his or her representative has a legal right to access the record. The health care provider originating the record owns the physical record but the patient owns the information within. Therefore, the medical records are a combined ownership between the physician and the patient.

5. RELEVANT

   Only information relevant to the patient's health or treatment should be documented. Non-health care related information should be filed separately.

6. AUTHENTICATED
   Entries must be dated and signed.
   a. If providers other than physicians perform specific delegated medical acts (prescribing, diagnosing, transcribing orders); documentation should be countersigned by the physician on a timely basis (usually within 24 hours).
   b. Dictation should be reviewed and signed by the physician

7. STANDARDIZED
   There should be specific standards for record format, abbreviations and correction procedures.

8. UNDERSTANDABLE/READABLE
   The record must be legible. If documenting health care providers cannot write legible, dictation should be used.

9. PERIODICALLY REVIEWED AND REVISED
   Records should be regularly audited to check if documentation is proper and adequate. Documenters should be notified about problems as well.

10. FASTEN ALL LOOSE ITEMS SECURELY TO THE RECORD
    Pages could easily drop out of the record. Missing items are an immediate “red flag” to attorneys.

11. TABULATED
    Sections of the chart should be tabulated for quick reference and in chronological order.

NOTE: Taken from the National Committee for Quality Assurance (NCQA) Medical Record Review Guidelines 2000, and the State Medical Society of Wisconsin Legal Guidelines for Health Care Records 1999.

VII. Process for improving medical records, including any actions taken by PPIC

a. PPIC maintains and shares with our practitioner’s medical record documentation standards through provider mailings, provider newsletter, provider manual and Internet sources.
b. PPIC considers the site review an opportune time to assess and make suggestions for improvement as needed to the quality of medical record keeping practices.
c. All audited practitioner sites receive a letter that describes any deficiencies, identifies the compliance issues and a suggested action plan for improvement, if indicated, and noted follow up date(s).
d. Development of a model record keeping aid or creating and sharing forms to document problem lists or medication allergies in the medical record may be distributed.
e. Examples of best practices that meet the standards particularly well may be distributed.
f. Aggregate data from several clinics will be compiled and analyzed to identify opportunities for system-wide improvements.

FACILITY REVIEW POLICY

Purpose

Physicians Plus periodically evaluates the facilities of primary care providers and selected high-volume specialists.

Policy Statement

The term "facility" is described as a participating site, clinic or solo practice. Because most patient care is provided in practitioner offices rather than institutions such as hospitals, the credentialing process includes a facility review that reviews the quality of the facility within which the care is provided. The review is an important element to the quality of patient care, compliance with Physicians Plus standards and proactively identifying areas of needed improvement.

Each facility must provide an environment that is sanitary and functionally safe for patients and personnel. Each facility will be reviewed in the following categories.

- Access
- Physical Appearance
- Waiting/ Exam Rooms
- Policies and Procedures
- Fire/ Safety
- Infection Control Policies - *medical clinics only*
- Control of Medications
- Medical Records
- Continuity of Care - *behavioral health clinics only*
- Availability of Appointments - *newly contracted clinics only*

If deficiencies or other problems are identified subsequent to the initial facility review, a Physicians Plus reviewer will return to the facility for re-evaluation and action.