

# Section 5

## Quality Management Program

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## Section 5

# Quality Management Program

### Overview

My Care Family is committed to improving the quality and safety of care and services to its patients. This commitment is demonstrated through the maintenance of a comprehensive Quality Management Program. The program's goals support the mission and objectives of My Care Family, relevant state and federal regulations, AllWays Health Partners' contract with MassHealth, accrediting agency standards (such as the National Committee on Quality Assurance [NCQA]), and the Massachusetts Division of Insurance's licensure requirements. The intent of the Quality Management Program is to improve the quality and safety of clinical care and services provided to patients and clinicians. It is based on the fundamentals of quality management: plan, monitor, improve, and evaluate, and the "Plan-Do-Study-Act" cycle approach to continuous performance improvement.

The Quality Management Program ensures a comprehensive, systematic, coordinated, integrated, and formal process for continuous assessing, monitoring, evaluating, and improving the quality of clinical care and quality of services provided to members (Use of the term "monitoring" shall refer to the monitoring, evaluation, and quality improvement cycle).

Quality monitoring and improvement activities are oriented around: routine reporting, management, and analysis of complaints and grievances; specific quality improvement projects; peer review; and the implementation and evaluation of the quality improvement plan.

Quality management and improvement activities are aimed at creating highly integrated collaborative partnerships, both

internally and externally, to ensure excellence in care and service—as well as to establish and share best practices.

The Advisory Commission on Consumer Protection and Quality in the Health Care Industry recommends that all health care organizations make it their explicit purpose to continually reduce the burden of illness, injury, and disability, and to improve the health and functioning of the people of the United States. In *Crossing the Quality Chasm: A New Health System for the 21 Century* (Committee on Quality Health Care in America, Institute in America, Institute of Medicine, 2001), the Institute of Medicine called upon all health care organizations to pursue six major aims and that, specifically, health care should possess the following qualities:

- *Safety*—Avoiding injuries to patients from the care that is intended to help them.
- *Effectiveness*—Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse).
- *Patient-centeredness*—Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- *Timeliness*—Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- *Efficiency*—Avoiding waste, in particular waste of equipment, supplies, ideas, and energy.
- *Equity*—Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

My Care Family is committed to achieving each of these quality aims and the Quality Management Program provides the specifications for that effort. Clinicians are expected to collaborate with AllWays Health Partners in all quality management efforts

including, but not limited to, compliance with Leapfrog Safety Measures for reducing hospital injuries and managing serious errors. More information on these safety standards is available at:

<https://leapfroghospitalsurvey.org/about-the-survey>.

## Scope

The scope of the Quality Management Program, which speaks to each of the major goals, is designed to continuously monitor, evaluate and improve the clinical care and service provided to its patients. The Quality Management Program is also designed to support and reflect My Care Family's commitment to continuous performance improvement in all aspects of care and services provided to its members.

The program is continuous, broad-based and collaborative, involving all departments, programs and staff. The components of the program are implemented by the actions of the leadership, directors, clinicians and support staff that design, measure, assess and improve their work processes. Other sources of guidance include input from patients, external benchmarks and aggregate data.

The review and evaluation of these components are coordinated by the Quality and Compliance Department to demonstrate that the process is cross functional, multi-disciplinary, integrated and effective in demonstrating improvements in the quality of clinical care and services provided. The quality management program includes quality planning, measurement and improvement functions. Each area of improvement focuses on the measurement and assurance of effective patient centered care.

All quality management and improvement activities can be viewed as a process, and processes link together to form a system. The linkage of the processes enables the focus of quality improvement to be on the processes in the organization and not on the individual

departments or people. As such, the organization measures and improves the performance of important processes in all organizational functions. Those processes that have the greatest impact on outcomes and customer satisfaction are given the highest priority. Quality Management retains responsibility and oversight for any quality management function that falls within the scope of the program and delegated to another entity.

The Quality Management Program maintains a strong linkage with the Care Management Program, fostering ongoing and enhanced quality improvement collaborations and interactions, including:

- Identifying opportunities to improve care and service and develop quality improvement interventions
- Translating quality into measurable terms and using data to drive improvements
- Identifying and addressing instances of substandard care including patient safety, member complaints and sanctioned providers
- Promoting a collaborative approach to performance improvement that uses the concepts and tools of Continuous Quality and Performance Improvement
- Measuring and evaluating the effectiveness of planned interventions in improving care and service
- Tracking the implementation and outcomes of quality improvement interventions
- Measuring and evaluating the effectiveness and impact of the enhancement of comprehensive health management programs in the areas of health promotion, asthma, diabetes, depression and high-risk pregnancy on the well-being and quality of life of our members.

The care management programs strive to:

- Support the relationship between practitioners and their patients with a plan of care
- Emphasize prevention of exacerbations and complications use evidence-based guidelines

- Promote patient empowerment strategies such as motivational coaching and self-management, and continuous evaluation of the clinical, social and economic outcomes with the aim of improving overall health
- Maintain a multidisciplinary, continuum-based approach to health care management that focuses on populations at risk for selected conditions.

The Quality Management Program encompasses the entire organization and includes the following components:

- Evaluation of population-based systems of care that address the needs of vulnerable patients
- Access improvements, including provider availability and cultural competence
- Promotion of compliance with current preventive health recommendations
- Evaluation of care coordination activities
- Development and approval of clinical guidelines and standards
- Assessment of member perceptions of health care and service quality
- Member complaints and appeals
- Provider complaints and appeals
- Credentialing of physicians and other providers
- Evaluation of provider performance
- Medical record review
- Policies supporting members' rights, responsibilities, and confidentiality
- Assessment of new technology
- Development of a data collection system to evaluate outcomes of care, services and processes
- Risk management activities
- Structure and Quality Management Program oversight

### **MassHealth ACO Quality Measures**

ACOs are accountable for providing high-value, cross-continuum care, across a range of measures that improves member experience, quality, and outcomes. MassHealth will regularly evaluate measures and determine whether measures should be added, modified, or removed.

MassHealth's ACO quality measures cover the following domains:

- Prevention and primary care
- Chronic disease management
- Substance use disorder
- Member experience surveys
- Mental and behavioral health
- Care transitions
- SDOH care integration
- BH and LTSS care integration

### **AllWays Health Partners Board of Directors**

The AllWays Health Partners Board of Directors is responsible for the Quality Improvement Program. The Board delegates oversight responsibility for quality of care and services to the Quality Program Committee. This committee reports directly to the Board. Day-to-day oversight of the Quality Improvement Program is the responsibility of the Chief Medical Officer and the Vice President of Quality Management.

### **Quality Program Committee (QPC)**

This committee is responsible for the development, implementation and oversight of the Quality Improvement program, including oversight of other organizational committees involved in Quality Improvement initiatives.

QPC members include: decision makers who represent stakeholders within the Quality Department as well as representatives from other departments including Clinical Operations, Pharmacy Operations, Commercial Sales, Regulatory Affairs/Compliance, the Medicaid Office and Behavioral Health. Each member is responsible for contributing subject matter

expertise to ensure a balanced discussion of Quality Improvement programs and improvement initiatives. In addition to internal participants, QPC includes members from external organizations including Optum and participating network providers.

### **Clinical Care Committee (CCC)**

This committee develops, implements, and monitors the Quality Improvement (QI) program and functions by ensuring that performance improvement activities meet the needs of its members to support population health, and external regulatory requirements.

CCC members include: decision makers who represent stakeholders within the Quality Department as well as representatives from other departments including Clinical Operations, Customer Service, Pharmacy Operations, Marketing and Behavioral Health. Each member is responsible for contributing subject matter expertise to ensure a balanced discussion of Quality Improvement programs and improvement initiatives.

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## **Performance Reporting and Improvement**

### **Provider Profiling System**

AllWays Health Partners shall establish and maintain a profiling system for all providers rendering care for AllWays Health Partners for the purpose of obtaining and providing detailed information which includes, but is not limited to:

- Patient satisfaction
- Outcomes
- Access and utilization data for a provider

The provider agrees to cooperate and participate in such systems in a manner that is conducive to quality improvement activities.

### **Reporting**

On a regularly scheduled basis, selected primary care sites are provided with reports

outlining their performance in areas including but not limited to:

- Emergency room utilization
- Asthma
- Diabetes (hemoglobin A1c testing, retinal screening exam rates)
- Patient satisfaction\*
- Cost and utilization

\*Annually, AllWays Health Partners conducts a survey of patients' satisfaction with their primary care site. The survey focuses on patients' satisfaction with access to routine and urgent care, the effectiveness of communication with the practice staff, and the perceived level of courtesy and respect demonstrated by reception staff. Practice specific results are subsequently shared with practice sites.

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## **Clinical Practice Guidelines**

AllWays Health Partners participates in local and statewide forums to establish uniform guidelines that all state purchasers, payers and providers endorse.

AllWays Health Partners adopts regional and national clinical practice guidelines from recognized sources that are:

- Significance to our membership (prevalence of disease in our population)
- Based on sound scientific evidence or expert consensus
- Developed with practicing clinicians (local or national) in the applicable specialty
- Address documented variation in important care processes and outcomes

Annually, AllWays Health Partners establishes external benchmarks for important quality measures addressed by clinical practice guidelines and compares its performance relative to these benchmarks. AllWays Health Partners also uses Clinical Practice Guidelines for its Disease Management Programs. AllWays Health Partners selects at least two important aspects of care from the clinical practice guidelines that relate to its Disease Management Programs for quality

performance measurement and improvement activities.

Clinical Practice Guidelines are reviewed by AllWays Health Partners' clinical leadership at least every two years and/or as regional and national guidelines change.

Updates to the guidelines are posted on AllWays Health Partners' website, and written notification of update guidelines are provided in the next scheduled Provider Newsletter following Internet posting.

For a list of clinical practice guidelines currently endorsed by AllWays Health Partners, please visit [allwaysprovider.org](http://allwaysprovider.org). If you do not have access to the Internet, please contact Provider Service to request a copy.

### Health Care Access Standards

As part of its ongoing quality of care efforts and to meet regulatory and contractual requirement, AllWays Health Partners monitors and reports on member access to primary care and specialty services. This is done by the following methods:

- Office-based access and availability surveys administered by AllWays Health Partners Provider Relations Managers to provider office staff
- Member satisfaction surveys
- Site-based surveys
- Consumer Assessment of Health Care Providers and Systems (CAHPS) surveys
- Geographic and numerical assessment:
  - » Mileage from member's residence to provider location
  - » Ratio of provider to members

The survey seeks responses to verify a provider's compliance with the availability or wait time access for the following services:

- Emergency services (including all necessary care coordination with home health, case management, behavioral health or other providers involved in the care of member)

must be provided immediately and be available 24 hours a day, seven days a week

- Primary care
  - » *Urgent*—within 48 hours of the member's request
  - » *Non-urgent, symptomatic*—within 10 calendar days of the request
  - » *Non-symptomatic*—within 45 calendar days of the request, unless an appointment is required sooner in order to ensure the provision of screenings in accordance with the MassHealth Early and Periodic Screening, Diagnosis and Treatment and Preventive Pediatric Healthcare Screening and Diagnosis Periodicity Schedules.
- Specialty care
  - » *Urgent*—within 48 hours of request
  - » *Non-urgent, symptomatic*—within 30 calendar days of request
  - » *Non-symptomatic*—within 60 calendar days of the request
- Behavioral health
  - » Emergency and ESP services (including all necessary care coordination with home health, case management, mental health or other providers involved in the care of member) must be provided immediately and be available 24 hours a day, seven days a week.
  - » For services described in an inpatient or 24-hour diversionary services discharge plan:
    - *Non-24-hour diversionary services*—within two calendar days of discharge
    - *Medication management*—Within 14 calendar days of discharge
    - *Other outpatient services*—within seven calendar days of discharge
    - *Intensive care coordination services*—within the time frame directed by the Executive Office of Health and Human Services.
  - » *Urgent*—within 48 hours of request

- » *All other behavioral health care*—within 14 calendar days
- Children newly placed in the Department of Children and Family (DCF) custody— For enrollees newly placed in the care or custody of DCF—providers must make best efforts to provide a DCF Health Care Screening within seven calendar days of receiving a request, and provide an initial Comprehensive Medical Examination within 30 calendar days of receiving a request unless otherwise mandated by the MassHealth Early and Periodic Screening, Diagnosis and Treatment and Preventive Pediatric Healthcare Screening and Diagnosis Periodicity Schedules. Providers must make best efforts to communicate with the child's assigned DSS caseworker(s) and when appropriate, inform them of rendered AllWays Health Partners covered services that support the child's needs.

### **Waiting Room Wait Time**

In addition to these access standards, patients should be seen within a reasonable time after timely arrival. A reasonable time is defined as within 30 minutes from the appointment time.

For more details, call AllWays Health Partners Provider Service at 855- 444-4647.

### **Medical Records and Office Site Audits**

As part of the contracting and quality oversight processes, AllWays Health Partners conducts a pre-contracting site visit and medical records review of all primary care office provider offices (including those staffed by nurse practitioners practicing in an expanded role as PCPs), in addition to high volume behavioral health provider practices. When applicable, a facility review is also conducted for newly contracted facilities prior to enrollment with AllWays Health Partners.

Site visits are performed by the Provider Relations staff or outside consultants and provide a mechanism for practitioner education and facilitation of continuous improvement in the provision of patient care and service. During site visits, specific

established standards are applied which are reviewed and approved by AllWays Health Partners' Operations and Clinical Policy and Quality Committees. Site visits for potentially high-volume behavioral health practitioners are conducted by AllWays Health Partners' delegate, Optum, a fully accredited NCQA managed behavioral health care organization.

- Practice sites are assessed against the following standards:
- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining rooms
- Appointment availability.

At a minimum, the medical record keeping practices of each site are assessed against the following standards:

- Secure/confidential filing and storing system
- Legible file markers
- Records easily located

When a practice site passes AllWays Health Partners' threshold, the provider moves forward in the contracting process.

If a practice site fails to achieve a score of 80 percent on all three components of the office site visit (including the overall score) the practice is notified of the score, the need for a corrective action plan and that the site will be re-evaluated within six months. At the time the practice site achieves at least 80 percent on all components of the review, AllWays Health Partners moves forward with the contracting process. When full compliance is not achieved during a corrective visit following the initial site visit, an additional visit is scheduled within 30 days. If full compliance is not achieved during this visit, it may result in a decision by AllWays Health Partners to terminate the practice and affiliated practitioners.

Site visit outcomes apply to all clinicians practicing within the same office site. Provider practices are notified in writing of their score.

AllWays Health Partners reserves the right to conduct a site visit for other provider types when an identified quality of care issue arises or when member complaints about the provider or practice site reach a specified threshold. Site visits are conducted when three or more- member complaints/grievances are received or when AllWays Health Partners becomes aware of quality of care concerns deemed serious based on a severity rating and/or review by the AllWays Health Partners Credentialing Committee.

Such complaints include but are not limited to:

- Reported cases of a patient's concern when the time spent with the clinician is perceived as inadequate to have fully addressed the purpose for the specific visit
- Failure of clinicians to adhere to patient safety measures (e.g., washing of hands, wearing of protective gloves, etc.)
- Failure of the practice to ensure a patient's safety and confidentiality (e.g., exam rooms not adequately locked, etc.).
- Sharp containers located within a child's reach
- Inappropriate disposal of hazardous waste
- Changes in procedures or policies post passing of the initial site visit (e.g., medical records no longer adequately secured)

A site visit is scheduled within 60 days of the registered concern, and providers may be asked for a corrective action plan with continuing follow-up site visits until all deficiencies have been addressed.

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## Medical Records Documentation Standards

To streamline utilization and quality review, medical records must adhere to nationally accepted standards for paper and systematic documentation pertaining to the appropriateness, course and result of treatments/services and corresponding outcomes. As part of ongoing monitoring of

network practitioners, AllWays Health Partners conducts an annual review of medical records in a random sample of the network of PCPs and inpatient hospital sites. These medical record audit results are analyzed, and providers are notified of their results.

Documentation of the provision of effective patient care should contain all relevant information regarding the patient's diagnoses and overall health status, up to and including:

- Patient's primary language spoken
- Encounter date
- Clinical information/assessments
- Treatment/services provided
- Treatment plans
- Treatment goals and outcomes
- Contacts with the patient's family, guardians, and/or significant others

In monitoring adherence to medical records documentation standards, AllWays Health Partners staff conduct medical record audits at randomly selected primary care sites to review a sample of medical records.

Medical records are examined for evidence of compliance with each of the following essential medical record standards:

- Name, DOB, MR#, PCP identified on record
- History and physicals recorded on record
- Allergies and adverse reactions documented
- Problem list is present and updated
- Medications list is present and updated
- Visit notes contain clinical findings and evaluation
- Preventive services and risk screenings are recorded
- Lab, radiology and hospital reports are filed
- Advanced directives are discussed with patients 18 years and older



- Behavioral health screening completed at well child visit

The AllWays Health Partners reviewer must be given full access to a the randomly selected medical charts or direct access to an EMR system. Compliance for each element requires that the element be present and easily found. The percentage of compliance is calculated based on the number of elements passed divided by the total number of elements.

The following elements also must be updated regularly. This is verified by checking recent office visit notes:

- Allergies and adverse reactions, or their absence, documented
- Problem list is present and updated
- Medications list is present and updated
- Preventive services and risk screenings are recorded

When recording compliance, the AllWays Health Partners reviewers use the Documentation Standards Review tool. Upon the completion of the audit, Quality Management staff analyze the results and develop site-specific reports. These reports are then delivered to the previously identified “key contacts” at each PCP or inpatient hospital site.

### **Medical Records Documentation Guidelines**

In addition to the items referenced above, AllWays Health Partners reserves the right to audit member charts for compliance with all elements of medical records documentation requirements. The following guidelines are provided to assist network providers with ensuring and maintaining compliance with appropriate medical records documentation.

#### *Advance Directives*

All members 18 years of age and older are notified in writing of their right to execute advance directives. Members are provided information about their rights to:

- Make decisions concerning medical care
- Accept or refuse medical or surgical treatment
- Formulate advance directives (e.g., living wills, durable powers of attorney for health care, or health care proxy designations)

Participating PCPs are encouraged to discuss advance directives with adult patients and are required to document results of the discussion in the medical record. AllWays Health Partners audits practitioners’ medical records for documentation of education and information about Advance Directives.

AllWays Health Partners refers members and providers to the Massachusetts Medical Society’s website, [www.massmed.org](http://www.massmed.org), to the “Patients,” “Patient Education Materials,” and “Health Care Proxy Information and Forms” sections to obtain information and forms.

#### *Personal/Biographical Data*

Must include, at a minimum and if applicable, full name, date of birth, sex, marital status, race, primary language, address, telephone number (home, mobile, work), employer name, insurance name, insurance ID number and any disabilities, such as visually and/or hearing impaired, uses a wheelchair, and other information.

#### *Two Unique Identifiers*

Must be found on each and every page of the medical record. Examples of identifiers are patient name, medical record number, AllWays Health Partners ID number, and date of birth.

#### *Medical Record Entries*

All medical record entries, whether related to a visit or for other purposes, must be dated and author-identified (signed). Author identification signature may be handwritten stamped, unique electronic identifier or initials. Professional designation (credentials) should accompany the signature.

#### *Legibility*

The medical record must be legible enough for someone other than the author to

understand the content of each entry.

### *Allergies/Adverse Reactions*

Medication allergies and adverse reactions, or lack thereof, must be noted in a prominent location in the chart. Other allergies significant to the member's health status should be documented as well. If the patient has no known allergies and/or history of adverse reaction, the record should reflect this.

### *Drugs, Alcohol and Tobacco*

Documentation of an assessment for alcohol, tobacco and illicit drug use must be present for all members age 12 and older, including seniors. Members age 12–21 must, at a minimum, be assessed at each well child care visit.

### *Patient Medical History*

A comprehensive medical history including serious illnesses, accidents, surgeries/procedures and relevant family and social history. An appropriate entry with regards to immunization records should be noted in the chart. For children and adolescents, past medical history relates to prenatal care, birth, surgeries and childhood illnesses.

### *Problem List*

Significant illnesses and medical conditions (acute, chronic, active, resolved, physical and mental), surgeries and relevant family and social history must be documented on the problem list. Short-term illnesses (e.g., flu) and “rule out” conditions may be excluded. This form must be updated at the time a new significant problem is identified and confirmed.

### *Immunizations*

An immunization record (for children) is up to date and (for adult) an appropriate history has been made in the medical record.

### *Medication List*

A medication list must be present in the record that includes, at a minimum, the name of the prescription medication, dosage, frequency, and the date prescribed. Short-term, illness-

specific medications (e.g., antibiotics) need not be included on this list but should be documented in the notes of any visits that occur for the duration of the medication therapy. When a medication is discontinued, this should be noted on the medication list with the date that the medication was discontinued. In the absence of a structured medication list, all medications must be relisted in each visit note.

### *Under- or Over Utilization*

There is appropriate notation for under- or over-utilization of specialty services or pharmaceuticals.

### *Visit Note*

All visit note entries must contain the following elements, except where not applicable based on the nature of the visit: date of visit, purpose of visit, pertinent history, physical exam, diagnosis or clinical impression including under/over utilization of specialty services or pharmaceuticals, description of treatment provided including any medical goods or supplies dispensed or prescribed, plan of care and author identification. Author identification signature may be handwritten, stamped, a unique electronic identifier or initials. Professional designation (credentials) should accompany the signature. If the service is performed by someone other than the provider claiming payment for the service, the identity, by name and title, of the person who performed the service must be documented.

Some visits may not require all of the elements of a visit note. Examples of such visits include, PPD planting/reading, blood pressure check, flu shot, and medication counseling.

Standards for each clinical element of the visit, with examples, are as follows:

- Purpose of visit—Chief complaint; consists of the patient's reason for the visit. May quote the patient directly (e.g., “I have an itchy rash on my arm,” or “in for a blood pressure check”).
- Pertinent history—History of the condition

identifying subjective and objective information pertinent to the reason the patient presents (e.g., “Pt. complains of a stuffy nose and dry cough for three days. Cough is worse at night. Has been taking OTC cough medicine q 6 hours with no relief. No fever or sore throat. . .”).

- Physical exam—Objective and subjective information, whether positive or negative, pertinent to the chief complaint (e.g., “Chest clear to auscultation. Normal breath sounds”).
- Diagnosis/clinical impression—Working diagnosis/assessment must be consistent with findings from history and physical (e.g., “otitis media,” “well-controlled hypertension,” “well child”).
- Plan of care—Plans for treatment of condition and/or follow-up care must be consistent with the diagnosis. Plans should include instructions to member as appropriate, and notation of when member is expected to return for next visit. (e.g., “amoxicillin t.i.d. x 10 days,” “Hct, Pb, dental referral. RTC 1 yr. or prn.”). Notes and/or encounter forms should reflect follow-up care, calls, or visits, when indicated, including the specific time of return recorded as weeks, months or as needed.
- Laboratory/radiology/other—Laboratory and other studies are ordered, as appropriate. Results/reports of laboratory tests, x-rays and other studies ordered must be filed in the medical record initialed by the ordering practitioner signifying review. The review and signature cannot be done by someone other than the ordering practitioner. When the information is available electronically, there must be evidence of review by the ordering practitioner. If a test or study ordered at the primary care site is performed at another location, these results must also be filed in the primary care site’s medical record. Abnormal reports must be accompanied by a documented follow-up plan.
- Consultation referrals—Referrals to consultants must be appropriate and clearly documented. Clinical documentation must be present in the chart, which supports the decision to refer to a consultant. Documentation of the referral should include the name, location and specialty of the consultant, the reason for the referral, the date of the referral and, whenever possible, the date of the scheduled appointment.
- Consultation reports—For each referral, there must be a corresponding report in the chart for the consultant, as well as documented acknowledgement of the report by the provider. Results/reports of all consultations must be initialed by the ordering practitioner signifying review. The review and signature cannot be done by someone other than the ordering practitioner. If the consultant’s findings are abnormal, there must be documentation in the chart of the follow-up plan. There must be no evidence of inappropriate risk to a patient as a result of diagnostic or therapeutic procedures from consultations or the provider’s procedures.
- Consultation, laboratory, 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 and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.
- Unresolved problems—Any problems identified at a visit that are not resolved during that visit must be addressed and documented in subsequent visits.
- Preventive Screenings—Evidence that preventive screenings and services were offered in accordance with the early periodic screening diagnosis and treatment EPSDT periodicity schedule for children and adolescents or, for individuals over the age of 21, in accordance with the provider’s own guidelines, including the administration of behavioral health screenings, is present.
- Advance Directives—Evidence that the provider attempted to discuss advance directives with all adult patients is in the patient’s medical record.

## **Additional Pediatric Documentation Standards**

The medical records of all AllWays Health Partners members under age 21 must reflect periodic health maintenance visits as defined by the [Massachusetts Quality Health Partners \(MHQP\) Pediatric Preventive Health Guidelines](#) in effect at the time of the visit. Some health maintenance standards below apply to pediatric members of all ages while others apply only to certain ages or are required once over a specified time frame.

AllWays Health Partners documentation requirements include, but are not limited to, the following. (The ages at which each standard applies will be noted below the definition of each standard, and will be followed by the documentation expectation.)

### *Initial/Interval Medical History*

For children and adolescents, past medical history relates to prenatal care, birth, surgeries and childhood illnesses. The initial medical history must contain information about past illnesses, accidents and surgeries, family medical history, growth and development history, assessment of immunization status, assessment of medications and herbal remedies, psychosocial history and documentation of the use of cigarette, alcohol and/or other substances.

The interval history must contain a review of systems and an assessment of the member's physical and emotional history since the last visit.

### *Comprehensive Physical Exam*

Documentation of a complete, unclothed physical exam, including measurement of height and weight, must be present. Head circumference should be measured until age two and documentation of blood pressure should begin by age three.

### *Developmental Assessment*

The member's current level of functioning must be assessed as concisely and objectively as possible in all of the following areas. Documentation such as "development on target" or "development WNL" is acceptable.

#### **PHYSICAL**

Gross motor, fine motor and sexual development

#### **COGNITIVE**

Self-help and self-care skills and ability to reason and solve problems

#### **LANGUAGE**

Expression, comprehension and articulation

#### **PSYCHOSOCIAL**

Social integration, peer relationships, psychological problems, risk-taking behavior, school performance and family issues. Ask about daycare arrangements for infants, toddlers and preschoolers. Follow-up should be documented, as appropriate, for developmental delays or problems.

#### **SENSORY SCREENING**

##### *Hearing*

- *Infancy*—The results of a formal newborn hearing screening, administered prior to a newborn's discharge from the birthing center or hospital should be documented in the chart. A gross hearing screening (e.g., "turns to sound," "hearing OK") must be documented for all members under age three. Newborns should be assessed before discharge or at least by 1 month of age. A subjective assessment should be conducted at all other routine check-ups.
- *1–17 (Early childhood–adolescence)*—Conduct objective hearing screening at ages 4, 5, 6, 8, and 10. A subjective assessment should be conducted at all other routine check-ups.

If testing is performed elsewhere (e.g., school), it does not need to be repeated by the provider, but findings, including the date of

testing, must be documented in the medical record. Follow-up should be documented, as appropriate, for abnormal findings.

### *Vision*

- *0–1 (Infancy)*—A gross vision screening (e.g., “follows to midline,” “vision OK”) must be documented for all members under three. Newborns should be assessed using corneal light reflex and red reflex before discharge or at least by 2 weeks of age. Evaluation of fixation preference, alignment and eye disease should be conducted by age six months.
- *1–17 (Early Childhood–Adolescence)*—Visual acuity testing should be performed at ages 3, 4, 5, 6, 8, 10, 12, and 15 years.
- *Screen for strabismus between ages 3 and 5*—A child must be screened at entry to kindergarten if not screened during the prior year per Massachusetts Preschool Vision Screening Protocol.

### *Dental Assessment/Referral*

Documentation of an assessment of dental care must be present in the chart. For members under age three, a discussion of fluoride and bottle caries must be present and for members age three and older, teeth must be checked for obvious dental problems and an assessment must be documented as to whether the member is receiving regular dental care. Referral to a dentist must be provided to those members with abnormal findings.

The documentation should include the following:

Standard: 0-1 Age Range:

- Counsel against bottle-propping when feeding infants and babies.
- Counsel against bottles to bed.
- Assess oral health at each visit and need for fluoride supplementation at 6 months based upon availability in water supply and dietary source of fluoride.
- Encourage brushing with a soft toothbrush/cloth and water at age 6 months.

- Encourage weaning from bottle and drinking from a cup by the first birthday.
- Apply fluoride varnish to primary teeth of all infants and children every 6 months if not applied at dental home and every 3 months if at high risk for caries.

Standard 1-21 Age Range:

- Apply fluoride varnish to primary teeth for all children aged 1-5 every 6 months if not applied at dental home and every 3 months if at high risk for caries.
- Assess oral health at each visit and need for fluoride supplementation up to age 14 based on availability in water supply and dietary source of fluoride.
- Counsel on good dental hygiene habits, including brushing twice daily.
- Counsel on the establishment of a dental home beginning at 12 months or after eruption of first tooth.
- Counsel on use of mouth guards when playing sports.

### *Health Education/Anticipatory Guidance*

Age-appropriate assessment, discussion and education relating to physical, developmental, psychosocial, safety and other issues must be documented at each well child care visit.

### *Immunization Assessment/Administration*

Updated documentation of assessment of immunization status, and administration of immunizations according to most current Department of Public Health (DPH) guidelines, must be present in the chart on an immunization flow sheet. For immunizations administered, the documentation must include, at a minimum, the name of the immunization, the initials of the person who administered the vaccine and the date administered. It is recommended that lot number also be documented. For immunization records received from prior providers, including the hepatitis B #1 received in the hospital at birth, review by the provider must be explicitly documented. “Immunizations up-to-date” is not adequate documentation to indicate review. For

hepatitis B immunizations received at birth, the name of the hospital and the date administered must also be documented.

### **Exposure to Lead Risk Assessment**

#### **0–10 (INFANCY–MID-CHILDHOOD)**

There must be documented evidence that the provider assessed the member for exposure to lead according to the following schedule:

- Initial screening between 9–12 months of age
- Annually at 2 and 3 years of age
- At age 4 if the child lives in a city/town with high risk for childhood lead poisoning
- At entry to kindergarten if not screened before

Documentation that the member is either “high” or “low” risk is acceptable. For members documented as “high risk,” results of a blood lead test must be present in the chart.

### **Tuberculin Test**

#### **0–21 (infancy–young adult)**

Tuberculin skin testing for all patients at high risk. Risk factors include having spent time with someone with known or suspected TB; coming from a country where TB is very common; having HIV infection; having injected illicit drugs; living in the U.S. where TB is more common (e.g., shelters, migrant farm camps, prisons); or spending time with others with these risk factors. Documentation of a reading of the results by a clinician must be present and dated 48–72 hours after testing.

Determine the need for repeat skin testing by the likelihood of continued exposure to infectious TB.

### **Early and Periodic Screening and Diagnostic Testing (EPSDT)**

Primary care providers (PCPs) caring for AllWays Health Partners MassHealth members under age 21 must offer to conduct periodic and medically necessary inter-periodic screens as defined by Appendix W of MassHealth’s Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and Preventive Pediatric Healthcare Screening and Diagnosis (PPHSD) Periodicity

Schedules. For more information, please see the Behavioral Health Provider Manual.

### **Other Testing**

There should be documentation for other screening tests, such as sickle cell, cholesterol, urinalysis/ culture and for sexually transmitted diseases, as appropriate to the member’s risk and the provider’s judgment. At a minimum, the date and results of the test must be documented.

### **Additional Inpatient Hospital Documentation Standards**

- Member identification
- Admission date
- Dates of application for and authorization of Mass Health benefits, if applicable
- Emergency admission justification, if applicable
- Dates of operating room use, if applicable
- Dates of initial and continued stay review
- Physician Name
- Plan of care
- Reason and plan for continued stay

In accordance with AllWays Health Partners Member Rights and Responsibilities, members have the right to ask for and receive a copy of their medical record and request that it be changed or corrected.

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### **Serious Reportable Events/Occurrences**

A serious reportable event (SRE) is an event that occurs on the premises of a provider’s site that results in an adverse patient outcome, is identifiable and measurable, has been identified to be in a class of events that are usually or reasonably preventable, and is of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the provider.

Potential SREs or quality of care (QOC) occurrences may be identified by members, providers, or AllWays Health Partners staff and may come into AllWays Health Partners

through AllWays Health Partners Customer Service or any other department. The duty to report a SRE is the responsibility of the individual facility or provider. The facility or provider must document their findings, and provide a copy of the report to both DPH and the AllWays Health Partners Manager of Quality Improvement within the required time frame.

Issues of concern may also be found through claims data or when medical record audits are performed by AllWays Health Partners. Claims data are reviewed on a monthly basis to identify possible SREs. Any problems identified include both acts of commission and omission, deficiencies in the clinical quality of care, inappropriate behavior during the utilization management process, and any instances of provider impairment documented to be a result of substance abuse or behavioral health issues. All contracted providers must participate in and comply with programs implemented by the Commonwealth of Massachusetts through its agencies, such as, but not limited to the Executive Office of Health and Human Services (EOHHS), to identify, report, analyze and prevent SREs, and to notify AllWays Health Partners of any SRE.

AllWays Health Partners promptly reviews and responds within 30 days to actual or potential QOC occurrences. The provider will have within seven days to report SREs. AllWays Health Partners uses the National Quality Forum's (NQF) definition of SREs and the NQF's current listing of "never events."

AllWays Health Partners does not reimburse services associated with SREs that are determined to be preventable after a root cause analysis (RCA) has been completed. To administer this policy, AllWays Health Partners recognizes but is not limited to the SREs identified by the National Quality Forum, HealthyMass, and the CMS Medicare Hospital Acquired Conditions and Present on Admission indicator reporting.

This policy applies to all hospitals and sites covered by their hospital license, ambulatory surgery centers, and providers performing the billable procedure(s) during which an "event" occurred.

AllWays Health Partners will reimburse eligible providers who accept transferred patients previously injured by an SRE at another institution (facility) or under the care of another provider.

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## **Clinical Performance Improvement Initiative (CPII)**

As a participating Group Insurance Commission (GIC) plan, AllWays Health Partners tiers providers at the group level for PCPs and individually for select physician specialties.

In an effort to promote quality improvement and cost efficiency in the delivery of health care, in 2003 the Massachusetts GIC established the Clinical Performance Improvement Initiative (CPII).

CPII involves aggregation of a consolidated multi-plan claims database of over 150 million claim lines submitted by GIC participating carriers to be analyzed by the GIC consultants Resolution Health Inc. and Mercer/Vips. Subsequently, GIC participating plans use the findings provided by these GIC consultants to construct quality of care and efficiency profiles and in developing "tiered" networks.

AllWays Health Partners continues to work collaboratively with the GIC, its participating carriers and their consultants on the CPI Initiative. The original methodology has been updated by GIC as a result of feedback from members, providers and other key stakeholders to make it easier to understand, include more quality data measures, and produce greater consistency across the plans.

AllWays Health Partners' tiered network applies only to GIC enrollees. Tier

assignments affect only copayment amounts and have no impact on current contract terms and/ or reimbursement rates.

A tier designation is not an endorsement or recommendation by AllWays Health Partners and does not suggest high quality or substandard care for an individual patient by any given practice or provider. In addition to such quality designations, other factors such as a provider's medical training, hospital affiliation, malpractice history, appointment access and interpersonal skills should also be considered by a member when selecting a provider.