



QUALITY IMPROVEMENT

Section 10

Overview

The Quality Improvement Program (the Program) is an ongoing, comprehensive and integrated system designed to actively initiate, monitor and evaluate standards of health care practice and infrastructures essential to the delivery of quality clinical care and service to 'Ohana members.

The QI Program addresses the key areas of primary care provider selection, patient safety and confidentiality, network adequacy, preventive health education and utilization, disease management, behavioral health, medical and pharmacy utilization, clinical competence, credentialing, quality of care, adverse events, appeals and grievances, member satisfaction, provider satisfaction, components of operational service and also recognizes reporting requirements. All member demographic groups, care settings, and types of services are included in the QI Program.

The QI Program establishes indicators, standards, and benchmarks to use in the evaluation of these areas. Compliance with the established standards is measured, and the results of this measurement are profiled. The resulting information is used in the identification of opportunities for improvement in the quality of healthcare and other services, and the development of program initiatives. Evaluation of the effectiveness of actions taken and program initiatives is performed. QI Program activities are communicated to the Board of Directors, Quality Improvement Committee (QIC), Medical Advisory Committee (MAC), administration, staff, providers, and Members.

The QI Program incorporates continuous quality improvement processes. This strategy is demonstrated by the structure of the QI Program's committees and sub-committees, the QI Program Description, Work Plan and Annual Evaluation. The strategy incorporates the continuous tracking and trending of quality indicators to ensure outcomes are being measured and goals are attained.



QUALITY IMPROVEMENT

Section 10

Program Goals

The goals of the Program are:

- To develop and maintain a well integrated system that continuously measures clinical and operational performance, identifies the need for and initiates meaningful corrective action when appropriate and evaluates the results of actions taken to improve quality-of-care outcomes and service levels.
- To establish a mechanism for the safe, culturally sensitive delivery of health care that not only promotes efficient, appropriate and effective use of resources but also supports the physician-patient relationship.
- To ensure access to and availability of qualified and competent providers.
- To engage members in managing, maintaining or improving their current state of health.
- To provide a forum for members, providers and various health care associations and community agencies to provide suggestions regarding the implementation of the Program.
- To ensure compliance with standards as required by contract, regulatory statutes and accreditation agencies.

The Quality Improvement Program includes initiatives to ensure that members are receiving age-appropriate preventive health screenings and interventions to optimize health.

Quality Improvement Participation

The 'Ohana Quality Improvement Committee is charged by the Plan's board of directors with monitoring and evaluating the results of Program initiatives and initiating corrective action when the results are less than desired or when areas needing improvement are identified.



QUALITY IMPROVEMENT

Section 10

Current Program activities that involve network-contracted providers include, but are not limited to:

- Review of member medical records, focusing on patient safety, continuity and coordination-of-care practices;
- Review of physician office site;
- Review of member quality complaints and adverse, unexpected events;
- Review of office site accessibility and availability;
- Participation in quality improvement and utilization management activities. Within the scope of the program, providers are required to:
 - Cooperate with QI Activities;
 - Allow 'Ohana, or its representative, access to medical records without a fee, to the extent permitted by state and federal law; and
 - Maintain the confidentiality of medical records;
- Participation on focused performance-improvement initiatives, such as improvement of well-child visit rates, immunizations and lead screenings, as appropriate. Studies will also be conducted on the accessibility, availability, efficiency, safety, efficacy, appropriateness, effectiveness and continuity of the patient care and services ; and
- Completion of the re-credentialing process.

The results of all reviews are maintained in a centralized database for reference during physician re-credentialing and/or provider re-contracting.



QUALITY IMPROVEMENT

Section 10

Physician Involvement

The Program seeks out and invites input from the physician community regarding Program implementation. Hawai'i-licensed physicians are members of the following Program committees:

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

Provider input is also integral to the development of preventive health guidelines, clinical practice guidelines, performance improvement projects and disease management programs.

Medical Record Screening

The Program incorporates periodic screening of the medical record to ensure compliance with medical record documentation standards and also clinical practice guidelines for health screening and high-risk diagnoses such as diabetes and asthma. A Plan representative will make an appointment to assess for these items in the physician's office.

Upon completion of the review, a summary of findings will be created and shared with the physician. If opportunities to improve guideline compliance or record documentation are identified, a plan of action will be instituted. A corrective action plan is required for all deficiencies.

Please refer to the **Medical Records** section of this manual for additional information regarding documentation standards and requirements.

Regulatory and Accreditation Agency Review

Providers contracted with the Plan are required to participate in all quality improvement functions and tasks as may be required by regulatory and accreditation agencies, including the State of Hawai'i Department of Human Services (DHS). These activities may include, but are not limited to:

- Compliance with request for medical record



QUALITY IMPROVEMENT

Section 10

review for quality improvement studies and audits;

- Cooperation with quality improvement initiatives related to collaborative projects;
- Cooperation with efforts to improve care for chronic disease and/or preventive care measures; and
- Compliance with requests for information and recommendations formulated by DHS in the process of reviewing/resolving beneficiary and/or provider complaints.

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

Patient Safety Program

‘Ohana is committed to offer a network of providers that ensure the safe delivery of clinical care to its members. ‘Ohana’s Patient Safety Plan exists to establish the framework for demonstrating this commitment. Through execution of standardized internal processes and collaborative participation of providers, ‘Ohana seeks to promote improvement in network clinical safety.

In support of safe clinical practices, ‘Ohana’s policies and procedures define and provide for the monitoring of widely accepted quality-of-care indicators. Through tracking and trending of relevant Patient Safety metrics, ‘Ohana can identify opportunities for improvement and facilitate education of a specific practitioner and/or the provider community at large in order to reduce the potential for patient safety incidents.

The Plan addresses key elements of patient safety, such as the extent of coordination of care between providers, office site visit review results, medical record review findings, clinical practice guideline compliance, adverse event and quality of care grievance tracking/trending, disease management program



QUALITY IMPROVEMENT

Section 10

participation, pharmaceutical management practices and member interactions.

Annually, 'Ohana will define the specific areas of patient safety to be monitored, which may include, but not be limited to, the following metrics as indicators of safe clinical care:

- Number of member quality-of-care complaints per 1,000 members;
- Number of adverse events reported per 1,000 members;
- Percent of reviewed physician medical records compliant to standard: drug allergies or "NKA" recorded;
- Number of providers contacted quarterly regarding prescribed but duplicate drug therapies; and
- Number of providers contacted quarterly regarding potential drug interactions between prescribed drug therapies.

Following the objectives as outlined in the Patient Safety Plan, 'Ohana will utilize both the member and provider newsletters to periodically communicate the results of patient safety activities, including network patient safety performance data, and also any provider best practices identified in the promotion of patient safety.

Quality-of-Care Issues

Defined as quality complaints and adverse outcomes, quality-of-care referrals may be generated by the Administrative Review, Grievance, Risk Management and/or Utilization Management department or may be identified through routine record review. Issue types include items such as unplanned readmission for a same or similar diagnosis in less than 30 days, patient fall, serious complication of anesthesia, transfusion error or serious transfusion reaction, medication error or



QUALITY IMPROVEMENT

Section 10

adverse drug reaction with serious potential for harm, care or lack of care that could have resulted in a potentially serious complication, etc.

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

Peer review is categorized in the following manner:

1. Substantiated – there is evidence of a deviation in the standard of care; and
2. Unsubstantiated – there is no evidence of a deviation from the standard of care.

Once that determination is made, the outcome is classified as either “adverse event” or “no adverse event.” Results of peer review activity will be reported to state and regulatory agencies as appropriate.

Clinical Practice Guidelines

Clinical Practice Guidelines have been adopted to address the health care needs of the member population and to take advantage of opportunities for improvement in treatment and care as identified by the quality improvement program.

Addressing both preventive and chronic-care conditions, guidelines are reviewed on an annual basis, utilizing nationally recognized, evidence-based sources. The review process includes:

- A consistency check, assessing linkage with member educational materials, benefit plans and coverage parameters;
- Input from community physicians via the ‘Ohana Medical Advisory Committee.



QUALITY IMPROVEMENT

Section 10

Approval occurs through the Quality Improvement Committee. These guidelines can be found in the **Provider Education Materials** section of this manual.