8. QUALITY MANAGEMENT

A. Chaperone Guidance

APPLIES TO:

A. This policy applies to all IEHP Covered Members and Providers.

POLICY:

A. IEHP and its IPAs ensure Providers adopt a policy that Members are free to request a chaperone and ensure that the policy is communicated to Members.[1]

B. The presence of a chaperone during a clinical examination and treatment must be the clearly expressed choice of a Member; however, the default position should be that all intimate examinations are chaperoned.

PURPOSE:

A. To ensure respect for the Member's dignity by providing a comfortable and considerate atmosphere for both the Member and the Provider.[2]

DEFINITION:

A. Chaperone – A member of the Provider's medical staff whose job is to enhance the patient's and Provider's comfort, safety, privacy, security and dignity during sensitive exams or procedures.

PROCEDURES:

Provider's Responsibilities

A. Providers should always honor a Member's request to have a chaperone.[3]

B. Providers should in general, use a chaperone even when a patient's trusted companion is present.[4]

C. Providers should ensure that all Members are offered a chaperone during any consultation, or intimate examination or procedure.

D. The Member has the right to decline any chaperone offered. It is important to record in the Member's medical record that the offer was made, and that the Member declined.

E. Providers should provide the opportunity for private conversations with the Member without the chaperone present. Providers should minimize inquiries or history taking of a sensitive nature during a chaperoned examination.[5]

[1] American Medical Association (AMA), Code of Medical Ethics Opinion 1.2.4, Use of Chaperones, 04/26/2021
[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] Ibid.

F. In instances, where the Member requests or accepts the offer of a chaperoned visit and one is not available at that time:

1. The Member must be given the opportunity to reschedule their appointment within a reasonable timeframe.
2. Providers should contact the Member upon notice of unavailability of a chaperone, when necessary.
3. If the seriousness of the condition would dictate that a delay is inappropriate, then this should be explained to the Member and recorded in their medical record.
4. It is acceptable for the Provider (or other appropriate member of the clinical team) to perform an intimate examination without a chaperone if the situation is life-threatening or speed is essential in the care or treatment of the Member. This should be recorded in the Member's medical record.

Chaperone's Responsibilities

A. Chaperoning should not be undertaken by anyone other than medical staff. This applies to all healthcare professionals working within a clinical or medical office setting.

B. No family member or friend of a Member may be routinely expected to undertake any formal chaperoning role in normal circumstances.

C. The chaperone must sign the Member's medical record indicating their presence during the visit.

D. A chaperone who identifies unusual or unacceptable behavior by the Provider is expected to report to the IEHP Compliance Hotline (866) 355-9038 or the California Medical Board at (800) 633-2322.

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8. QUALITY MANAGEMENT

B. Quality Management Committee

ROLE:

A. The Quality Management (QM) Committee directs the continuous monitoring of all aspects of health care being administered to IEHP Members, with oversight by the IEHP Chief Medical, Chief Quality Officer or physician designee. All Committee findings and recommendations for policy decisions are reported through the IEHP Chief Medical, Chief Quality Officer or physician designee to the IEHP Governing Board on an annual basis, or as needed.

B. Objectives of the QM Committee include:

1. Review, oversight and evaluation of delegated and non-delegated Quality Management (QM) and Quality Improvement (QI) activities, including the accessibility of health care services and actual care rendered;
2. Ensuring continuity and coordination of care;
3. Oversight of delegated activities such as Utilization Management (UM), QM, QI, Population Health Management (PHM)) and Credentialing/Recredentialing;
4. Oversight of non-delegated Credentialing/Recredentialing activities, facility and medical record compliance with established standards, Member experience, quality and safety of care and services, access to care, and adequacy of treatment;
5. Identifying and tracking of problems using grievance information, peer review and utilization data and implementing corrective actions;
6. Monitoring Member interaction at all levels, representing the entire range of care, from the Member's initial enrollment to final outcomes; and
7. Reviewing quality of care, practitioner office site quality, interpreter services, and internal file review reports.

C. The QM Committee is responsible for annual review, updates, and approval of the QM Program Description including QM policies, procedures and activities, providing direction for development of the annual Work Plan and Calendar, and making recommendations for improvements to the IEHP Governing Board, as needed.

D. Ancillary Subcommittees are instituted to assist with study development as needed. The QM Committee reviews ancillary subcommittee activity reports and is responsible for periodic assessment and redirection of Subcommittee activities and recommendations.

1. The QM Committee receives updates from Peer Review, Credentialing, UM, Behavioral Health, Grievance and Appeals, Compliance, QI, and Pharmacy and Therapeutics Subcommittees at least quarterly or more frequently, as indicated.
2. IEHP may delegate QM and QI activities to those entities with current National Committee for Quality Assurance (NCQA) accreditation. The IEHP QM and Compliance Committees provide oversight of these delegated activities.

8. QUALITY MANAGEMENT

B. Quality Management Committee

FUNCTION:

A. The following elements define the function of the QM Committee in monitoring and oversight for care administered to Members:

1. Review
    a. Review, analyze, and evaluate results of QM/QI activities at least annually and revise, as necessary;
    b. Identify and prioritize quality issues, institute needed actions and ensure follow-up;
    c. Review behavioral health care reports for quality issues;
    d. Review and approve clinical practice and preventive health guidelines; and
    e. Review the Program Descriptions of delegated entities on an annual basis.
2. Evaluation
    a. Assess the direction of health education resources;
    b. Seek methods to increase the quality of health care for the served population;
    c. Design and direct QM Program objectives, goals, and strategies;
    d. Develop and assign responsibility for achieving goals;
    e. Develop and monitor Corrective Action Plan (CAP) performance;
    f. Recommend policy decisions;
    g. Ensure incorporation of findings based on Member and Provider input/issues into IEHP policies and procedures;
    h. Ensure practitioner participation in the QM/QI program through planning, design, implementation, or review;
3. Oversight
    a. Oversee the identification of trends and patterns of care;
    b. Provide oversight for the IEHP UM Program and Delegate UM functions;
    c. Provide oversight and direction for Subcommittees and related programs and activities;
    d. Provide oversight of behavioral health care services;
    e. Oversee the IEHP Credentialing Program and delegated credentialing functions;
    f. Oversee and direct IEHP Disease Management Programs;
4. Monitoring
    a. Monitor quality improvement;

b. Monitor clinical safety;

c. Monitor grievances and appeals for quality issues;

d. Report progress and key issues to the IEHP Governing Board, as needed;

STRUCTURE:

A. The QM Committee is designated by and accountable to the IEHP Governing Board for oversight and performance responsibility, the supervision of activities by the IEHP Chief Medical Officer or physician designee, and the inclusion of contracted physicians and contracted Providers in the process of quality improvement system development and performance review.

MEMBERSHIP:

A. Appointed Committee membership is comprised of the IEHP Chief Medical Officer or physician designee, IEHP Medical Directors, participating Plan Medical Directors, appointed representatives from the Public Health Departments of Riverside County and/or San Bernardino County, participating pharmacists. There are a total of 29 Quality Management Committee Members. This includes both internal and external participants and excludes the IEHP support team and guests.

1. The IEHP Chief Medical, Chief Quality Officer or physician designee serves as the Chairperson.
2. A Behavioral Health Practitioner representing the appropriate level of knowledge to adequately assess and adopt healthcare standards, is present to assist with behavioral health issues and aspects of the QM/QI Program. The Behavioral Health Practitioner must be a medical doctor or have a clinical PhD or PsyD and may be a medical director, clinical director or participating practitioner from IEHP or behavioral healthcare delegate (if applicable).
3. Prospective appointed Physician and non-physician members of the Committee are subject to verification of license, and malpractice history prior to participating on the Committee.
4. Prospective Physician and non-physician members not providing requested information to perform verification in a timely manner, or who do not meet IEHP's requirements upon verification may not participate on the Committee.

B. Any external committee members must be screened prior to joining the QM Committee to ensure they are not active on either the Office of Inspector General (OIG) or General Services Administration (GSA) exclusion lists.

1. QMC members must be screened before being confirmed and monthly, thereafter. The Compliance department and QM department collaborate to ensure Committee members undergo an OIG/GSA exclusion screening prior to schedule QMC meetings.

2. QM notifies the Compliance department of any membership changes in advance of the QMC meeting so that a screening can be conducted prior to the changes taking effect.

C. IEHP staff that participate in the QM Committee include multidisciplinary representation from IEHP departments, including but not limited to: QM, UM, Behavioral Health and Care Management, Pharmaceutical Services, Member Services, Community Health, Health Education, Grievance and Appeals; and Provider Services. IEHP staff participating on the QM Committee have been selected to allow input and technical expertise related to Member and Provider experience, encounter data, and to provide links back to other IEHP departments.

D. The Quality System's Administrative Assistant acts as secretary to the Committee.

E. Non-appointed guests may attend QM Committee meetings but are required to sign the Committee attendance record, which includes a statement of confidentiality and conflict of interest disclosure form.

F. The IEHP Chief Medical, Chief Quality Officer or physician designee selects Medical Directors, Physicians, and non-physician members for Committee membership from the IEHP Provider Network.

TERMS OF SERVICE:

A. IEHP staff attend as permanent members of the QM Committee. The full term of service for a non-IEHP physician or non-physician member is two (2) years, with additional terms as recommended by the Committee. Public Health Department representatives serve for two (2) years and are selected by each County Health Department, with approval by the IEHP Chief Medical, Chief Quality Officer or physician designee. The determination of whether any Practitioner members or public health representatives may serve additional terms is at the sole discretion of the IEHP Chief Medical, Chief Quality Officer or physician designee.

VOTING RIGHTS:

A. Voting rights are restricted to the Chairperson and appointed Committee members. IEHP staff, except for the IEHP Chief Medical, Chief Quality Officer or physician designee and IEHP Medical Directors, do not have voting privileges.

B. Non-physician Committee members may not vote on medical issues.

QUORUM:

A. Voting cannot occur unless there is a quorum of voting members present. For decision purposes, a quorum is defined as the Chairperson or IEHP Medical Director and two (2) other appointed Physician Committee members.

1. A Behavioral Health Practitioner must be present for behavioral health issues.
2. Non- physician Committee Members may not vote on medical issues.

MEETINGS:

A. The QM Committee meets at least quarterly, with additional meetings as necessary. Issues that arise prior to the next scheduled QM Committee meetings that need immediate attention are reviewed by the IEHP Chief Medical Officer or physician designee and reported back to the QM Committee when applicable.

B. Interim issues requiring Committee approval may be approved by an ad hoc teleconference called by the Chairperson.

MINUTES:

A. IEHP has a standardized format and process for documentation of meetings, attendees, and action items for the QM Committee and related Subcommittees. Detailed minutes are recorded at each meeting, with review by the Chairperson. Minutes include recommendations, actions and activities addressed in committee meetings. Minutes are dated, signed, and reflect responsible persons for follow-up actions. Minutes are stored in a confidential and secure place with access only by authorized staff. The Committee approves minutes at the next scheduled meeting.

B. Meeting minutes are maintained and submitted to the Department of Health Care Services (DHCS) quarterly.

REPORTS:

A. QM Committee findings and recommendations are reported through the IEHP Chief Medical, Chief Quality Officer to the IEHP Governing Board as needed or as requested. Information in the QM Summary reports sent to the IEHP Governing Board may include but not be limited to: Overview of Delegation Oversight Activities, QM Reports, Review of QM Annual Evaluation, QM Program Description, and QM/QI Work Plan. The QM/QI Work Plan includes yearly comprehensive plan of reports to be performed including studies that adequately address the health care and demographics pertinent to IEHP Members.

CONFIDENTIALITY:

A. All appointed members of the QM Committee, participating IEHP staff and guests are required to sign the Committee attendance record, which includes a statement of confidentiality and conflict of interest disclosure form, at each meeting. IEHP complies with Health Insurance Portability and Accountability Act (HIPAA) regulatory requirements for confidentiality and avoidance of conflict of interest. All records are maintained in a manner that preserves the integrity in order to assure Member and Practitioner confidentiality is protected.

RECUSAL POLICY:

A. If a Committee member has an interest that may affect or be perceived to affect the member's independence of judgment, the member must recuse himself/herself from the voting process.

This recusal includes but is not limited to refraining from deliberation or debate, making recommendations, volunteering advice, and/or participating in the decision-making process in any way.

B. The Chairperson will review the criteria that Committee members should use to determine whether to recuse themselves from the voting process at the beginning of each meeting and ask whether any member needs to recuse themselves.

AFFIRMATION STATEMENT:

A. The QM Committee attendance record signed by all QM Committee members, IEHP participating staff and guests includes an affirmation statement acknowledging that utilization decisions made by the Committee for IEHP Members are based solely on medical necessity. IEHP does not compensate or offer financial incentives to Practitioners or individuals for denials of coverage or service. The affirmation statement also addresses conflict of interest and confidentiality issues:

B. "As a member of the IEHP (name of) Subcommittee charged with the duties of evaluation and improvement of the quality of care rendered to Members of IEHP, I recognize that confidentiality is vital to the free, candid and objective discussions necessary for effective management. Therefore, I agree to respect and maintain the confidentiality of all discussions, deliberations, records and other information generated in connection with all committees and other activities, and I understand that by signing this agreement, I am binding myself by contract to maintain such confidentiality. I agree that I will not make any voluntary disclosure of such confidential information except to persons authorized to receive such information. I also understand that as a Committee member I cannot vote on matters where I have an interest and that I must declare that interest and refrain from voting until the issue has been resolved. Utilization decisions for Members are based on medical necessity. There are no financial incentives for denial of coverage or service."

C. IEHP abides by the California Health and Safety Code that includes the following statement: "A health care service plan that authorizes a specific type of treatment by a provider shall not rescind or modify this authorization after the provider renders the health care service in good faith and pursuant to the authorization. This section shall not be construed to expand or alter the benefits available to the enrollee or subscriber under a plan."[1]

[1] California Health and Safety Code (Health & Saf. Code), § 1371.8

8. QUALITY MANAGEMENT

B. Quality Management Committee

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8. QUALITY MANAGEMENT

C. Management of Critical Incidents

APPLIES TO:

A. This policy applies to IEHP Covered Providers and facilities that provide care to IEHP Members.

POLICY:

A. The IEHP Quality Management (QM) Department receives, reviews, investigates and monitors Critical Incidents involving care provided to IEHP Members.

B. The QM Department will oversee, manage, conduct follow-up and act on Critical Incidents as well as determine actions and/or information needed from other internal departments and/or external sources.

PURPOSE:

A. To identify the process for ongoing oversight and monitoring of Critical Incidents involving care provided to IEHP Members.

DEFINITION:

A. Critical Incident (CI): An unintended event that occurs when a patient receives treatment in the healthcare setting, that results in death or serious disability, injury, or harm to the patient.

PROCEDURES:

C. Critical Incidents may be referred to the IEHP Quality Management (QM) Department from IEHP internal departments or from external sources.

D. When notified of a CI, the IEHP Quality Management Department will conduct an investigation of the event. In conducting the investigation, the QM Department may request specific and detailed information from the Provider/ facility where the CI occurred. The Provider/ facility must provide the information requested by the QM Department within 14 calendar days.

E. The Provider Quality Review Nurse (PQRN) will prepare a summary report on the CI, upon review of the information received. The Medical Director may request a Corrective Action Plan (CAP) from the Provider/ facility, as necessary.

F. The QM Department may require ongoing monitoring and/or evidence of process improvement after acceptance of a Corrective Action Plan (CAP). In these cases, the QM Department will notify the Provider/ facility of the need to submit reports containing specific data and/or the status of implementation of the CAP. The frequency and duration of documents/ reports will be determined by the Medical Director or Member Safety Subcommittee.

G. The QM Department will provide periodic reports to the IEHP Member Safety Subcommittee.

H. The QM Department will communicate with the Provider/facility regarding the status of

ongoing monitoring activities.

I. The QM Department will track and trend CIs in the QM database.

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