13. QUALITY MANAGEMENT

A. Quality Studies Medical Records Access

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Providers, Delegates and Hospitals.

POLICY:

A. For the purposes of medical data processing, quality of care assessment and other research, all Providers, Delegates and Hospitals must provide IEHP access to Members' medical records, at no cost to the Health Plan.[1,2]

DEFINITION:

A. Delegate – For the purpose of this policy, this is defined as a medical group, Health Plans, IPA, or any contracted organization delegated to maintain and/or provide Member medical record access for use in quality studies.

PROCEDURES:

A. Quality Studies

1. IEHP performs quality studies to meet requirements of the California Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA). These studies cross over total IEHP Membership.
2. IEHP utilizes NCQA's Healthcare Effectiveness Data Information Set (HEDIS®) methodology for all applicable quality studies. For studies not addressed by HEDIS®, IEHP utilizes a format approved by the agency requesting the study.
3. To complete these studies according to required methodologies, IEHP must gather information both from administrative data (i.e., encounter data) and Members' medical records.

B. Delegate Pre-notification

1. IEHP notifies Delegates at least five (5) business days before Providers are contacted for medical record information.
2. Notification includes a description of the study purpose and requirements.

C. Provider and Hospital Notification

1. IEHP notifies Providers and Hospitals if any of their Members have been selected for inclusion in a quality study.

[1] California Civil Code (Civ. Code) § 56.10
[2] Title 22, California Code of Regulations (CCR) § 51009

2. Notification includes a description of the study purpose and requirements as well as a list of the Members whose records are needed and the method of data collection.
3. IEHP collects medical record data in one of the following ways, depending on the nature of the study and the location of the Provider's office or Hospital:
    a. IEHP staff may make appointments with the Provider's office or Hospital to visit the site for the purpose of medical record review and/or data collection. Data collection includes making photocopies and/or scanning hard copy medical records or downloading selected electronic medical records for study purposes.
    b. IEHP may request that the Provider's office or Hospital retrieve the requested records and mail, fax or email records to IEHP.

D. Confidentiality

1. IEHP maintains compliance with the Health Information Portability and Accountability Act (HIPAA) requirements with all Member medical record information, including information used for the purpose of a quality study.
2. IEHP maintains strict confidentiality when using Member records for quality studies.
3. Members' identities are not disclosed in quality study results.
4. Abstracted data is archived and saved for a period of time determined by the study on an IEHP secure server.

INLAND EMPIRE HEALTH PLAN		
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13. QUALITY MANAGEMENT

B. Quality Management & Health Equity Transformation Program Overview for Members and Providers

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members and Providers.

POLICY:

A. IEHP makes information about the Quality Management & Health Equity Transformation Program (QMHETP), including information on achieving established quality goals, available to all Members and Providers to keep them informed of quality improvement and quality management and health equity activities and outcomes.

PROCEDURES:

A. IEHP provides the following information regarding the QMHETP to Members and Providers via the IEHP website at www.iehp.org. QM Program information includes:

1. The "IEHP Annual Evaluation of Quality Management & Health Equity Transformation Program Executive Summary" addresses progress in achieving quality goals and contains yearly Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) results.
2. The "Quality Management & Health Equity Transformation Program Description" provides information on goals and objectives, QMHETP and Quality Improvement (QI) activities addressing access to care, experience surveys, clinical practice guidelines and IEHP monitoring activities.

B. Members or Providers who are not able to access the website or prefer a printed version of the QMHETP information can request it through the following:

1. Calling the IEHP Member Services Department at (800) 440-IEHP (4347), or (800) 718-4347 for TTY users.
2. Submitting a written request to IEHP at:

Inland Empire Health Plan
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800
Attention: Quality Management Department

Upon receipt of a written request for information letter, the QM Department staff mails a packet to the requesting party consisting of the QM Program information.

C. At least annually, IEHP reviews the results of the Quality Withhold measures in the IEHP D-SNP Model of Care Subcommittee that has representation from various departments across the organization. A brief summary of the results is included in the QMHETP information.

D. Members and Providers are advised to contact IEHP in writing if they have suggestions or would like further information on the QMHETP and QI activities.

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Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
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13. QUALITY MANAGEMENT

C. Chaperone Guidance

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-DNP) 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.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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13. QUALITY MANAGEMENT

D. Reporting Requirements Related to Provider Preventable Conditions

APPLIES TO:

A. This policy applies to all IEHP network Providers who treat IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. IEHP and its IPAs ensure Provider-Preventable Conditions (PPC) are reported to the California Department of Health Care Services (DHCS).[1,2]

DEFINITIONS:

A. Provider-Preventable Conditions (PPC) - These include both Category One (1) – Health Care-Acquired Conditions (HCACs) for any inpatient hospital setting and Category Two (2) – Other Provider Preventable Conditions (OPPC) for any health care setting (See Attachment/ "Provider Preventable Conditions" found on the IEHP website. [3,4]

PROCEDURES:

A. All Providers must report PPCs through DHCS' secure online reporting portal, which is found at http://apps.dhcs.ca.gov/PPC/SecurityCode.aspx.[5,6]

B. On a monthly basis, IEHP reviews encounter data submitted by network Providers for evidence of PPCs. IEHP's HealthCare Informatics (HCI) team systematically screens and identifies potential PPCs among encounter data and ensure that confirmed PPCs are reported to DHCS Audits & Investigation (A&I) Division through its secure online reporting portal.[7] Potential PPC identified through the monthly encounter data mining are processed as a Potential Quality Incident (PQI) case.

C. Annually, IEHP reminds all network Providers of reporting requirements related to PPCs.[8]

D. All network Providers are responsible for providing IEHP with a copy of all PPCs submitted to DHCS. Copies must be sent by fax at (909) 890-5545 within five (5) business days of reporting to DHCS.

[1] Title 42, Code of Federal Regulations (CFR) § 438.3
[2] Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 17-002 Supersedes DPL 15-002, "Reporting Requirements Related to Provider Preventable Conditions"
[3] DHCS DPL 17-002
[4] https://www.iehp.org/en/providers/provider-resources?target=forms
[5] Ibid.
[6] 42 CFR § 438.3
[7] DHCS DPL 17-002
[8] Ibid.

E. All completed and submitted PPC submissions are retained by IEHP.[9]

F. IEHP reserves the right to recover or recoup any claim related to a PPC.[10]

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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[9] Ibid.
[10] 42 CFR § 438.3

13. QUALITY MANAGEMENT

E. Chronic Care Improvement Program (CCIP)

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) delegated IPAs and their assigned Members.

POLICY:

A. IEHP and its IPAs are required to have an ongoing Chronic Care Improvement Program (CCIP) that serves the most vulnerable population identified by IEHP.[1]

DEFINITIONS:

A. Most Vulnerable population – IEHP has mechanisms in place to monitor and stratify its current dual-eligible population into risk categories that allow identification of the most vulnerable Members. IEHP provides details on their most vulnerable population and D-SNP Model of Care (MOC) via the IEHP website at www.iehp.org.

PURPOSE:

A. The CCIP is intended to achieve the following objectives:[2]

1. To promote effective chronic disease management and the improvement of care and health outcomes for Members with chronic conditions.
2. Support the IEHP focused population outlined in the Medicare D-SNP MOC;
3. Include interventions that are above and beyond the Delegate's inherent care coordination role and overall management of enrollees;
4. Engage enrollees as partners in their care;
5. Increase disease management and preventive services utilization;
6. Improve health outcomes;
7. Facilitate the development of targeted goals and specific interventions, aimed to improve one of the identified targeted conditions;
8. Guard against potential health disparities; and
9. Produce best practices.

PROCEDURES:

A. IEHP and its IPAs must develop a methodology to identify Members with multiple or severe

[1] Title 42 Code of Federal Regulations (CFR) § 422.152
[2] Centers for Medicare and Medicaid Services (CMS) – Medicare Advantage (MA) – Chronic Care Improvement Program (CCIP) Resource Document (Updated 2020)

chronic conditions who would benefit from participating in the CCIP (or Providers of such Members) as the target population.[3]

1. The conditions in the CCIP must be appropriate to meet the needs of its Membership and be tied to its most vulnerable population.
2. IEHP and its IPAs are required to conduct the CCIP over a three-year (3) period.

B. IEHP and its IPAs must conduct a comprehensive analysis of their target population to develop meaningful CCIP interventions. The non-exhaustive list below includes examples of intervention types that should be included in CCIPs:[4]

1. Care coordination to ensure Members receive care according to accepted standards of practice (i.e., clinical guidelines);
2. Promotion of lifestyle changes and use of preventive services to slow the progression of the disease and/or prevent the development of complications and comorbidities;
3. Effective disease management programs;
4. Outreach to establish partnerships/collaboration with Providers, community groups, and stakeholders to leverage resources;
5. Effective communication across the care continuum; and
6. Education and outreach interventions to engage Members and caregivers as partners in care.

C. IEHP and its IPAs must assess and internally document activities related to these quality initiatives on an ongoing basis, as well as modify interventions and/or processes as necessary.[5]

D. IEHP and its IPAs must follow the Plan, Do, Study, Act (PDSA) quality improvement model as the overall structure for implementation and monitoring of the CCIP (see Attachment, "Chronic Care Improvement Program (CCIP) Planning & Reporting Document" in Section 13).[6]

E. IEHP and its IPAs must comply with the CCIPs requirement of two (2) submissions per annual cycle (see Attachment, "Medicare Provider Reporting Requirements Schedule" found on the IEHP website.[7,8]

1. CCIP Program Launch Submission – Due as the first (1st) semi-annual submission.
    a. The CCIP program launch submission includes two (2) components:
        1) The CCIP Overview

[3] 42 CFR § 422.152(c)(1)(i)
[4] CMS MA CCIP Resource Document (Updated 2020)
[5] Ibid.
[6] Ibid.
[7] 42 CFR § 422.152(c)
[8] https://www.iehp.org/en/providers/provider-resources?target=forms

2) The CCIP Year 1 Intervention Plan section

b. The CCIP Overview describes the 3-year CCIP focus, including the targeted chronic condition, population details, CCIP aim including the data source(s), and intervention strategy.

c. The CCIP Year 1 Intervention Plan section includes CCIP criteria for identifying the focus population, the goal, planned interventions, and measurement methodology including applicable data sources.

2. Subsequent Submissions – Due semi-annually following the first (1st) submission of that year. Refer to the table below for submission details.

a. The Progress Update describes the Delegate's progress in implementing the CCIP, including systematic and ongoing follow-up.

1) First (1st) semi-annual submissions to include:

- Reporting CCIP intervention results, findings, and lessons learned, covering the Study/Act sections of the PDSA.
- The Delegate's Plan for the next CCIP cycle year.

2) Second (2nd) semi-annual submissions to include:

- Reporting the progress and status of the CCIP Plan, including timelines, barriers, and planned next steps.

CCIP Year	Submission*	Submission Component Due: (CCIP Cycle & PDSA Focus)
Year 1	1st Semi-Annual	***CCIP Program Launch –*** • CCIP Overview • Cycle 1 – Plan
	2nd Semi-Annual	• Cycle 1 – Do
Year 2	1st Semi-Annual	• Cycle 1– Study, Adjust/Act/Abandon • Cycle – 2 Plan
	2nd Semi-Annual	• Cycle 2 – Do
Year 3	1st Semi-Annual	• Cycle 2 – Study, Adjust/Act /Abandon • Cycle 3 – Plan
	2nd Semi-Annual	• Cycle 3 – Do
Year 3 Final Closeout/ Launch New CCIP	1st Semi-Annual	***CCIP Program Close-Out –*** • Cycle 3 – Study, Act • CCIP Close Out ***Launch NEW CCIP*** • ***Begin new CCIP Document***

13. QUALITY MANAGEMENT

E. Chronic Care Improvement Program (CCIP)

See Attachment, "Chronic Care Improvement Program (CCIP) Planning & Reporting Document" found on the IEHP website[9] for submission due dates & documentation requirements.

F. IEHP and its IPAs must make information on the status and results of ongoing CCIP projects available to IEHP at any time, upon request.[10]

G. CMS Annual Reporting:

1. IEHP utilizes the Health Plan Management System (HPMS) to report the status of their CCIP to CMS by December 31st, annually. Submissions include an attestation by IEHP regarding its compliance with the ongoing CCIP requirement.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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[9] https://www.iehp.org/en/providers/provider-resources?target=forms
[10] 42 CFR § 422.152(f)(1)(i)(iii)

13. QUALITY MANAGEMENT

F. Management of Critical Incidents

APPLIES TO:

A. This policy applies to IEHP and to Direct and Delegated 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:

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

B. 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.

C. 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.

D. 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.

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

F. The QM Department will communicate with the Provider/facility regarding the status of ongoing monitoring activities.

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

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Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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