

960 TRACKING AND TRENDING OF MEMBER AND PROVIDER ISSUES

REVISION DATE: October 1, 2019

EFFECTIVE DATE: May 20, 2016

REFERENCES: A.R.S. § 36-517.02, A.A.C. R9-34, R9-21-401 et seq. CFR 431.300 et seq

DELIVERABLES: Advise of Significant Incidents/Accidents; Quality of Care (QOC) Concerns Opened Report

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The AdSS must develop and implement policies and procedures to review, evaluate, and resolve quality of care and service issues raised by members, contracted providers, and stakeholders. The issues may be received from anywhere within the organization or externally from anywhere in the community. All issues must be addressed regardless of source (external or internal).

Documentation Related to Quality of Care Concerns

As a part of the AdSS's process for reviewing and evaluating member and provider issues, there are written procedures regarding the receipt, initial and ongoing processing of these matters that include requirements that the AdSS perform the following:

- A. Document each issue raised, when it was raised, from whom it was received, and the projected time frame for resolution.
- B. Determine promptly whether one of the following processes will be used to resolve the issue:
 1. Quality management process
 2. Grievance and appeals process
 3. Process for making initial determinations on coverage and payment issues
 4. Process for resolving disputed initial determinations.
- C. Acknowledge receipt of the issue and explain to the member/responsible person or provider the process that will be followed to resolve their issue through written correspondence.
- D. For issues that are submitted to the Quality Management (QM) Unit but are determined to not be a Quality of Care (QOC) concern, inform the submitter of the process to be used to resolve the issue. QOC-related concerns must be addressed in the QM Unit.
- E. Assist the member or provider as needed to complete forms or take other necessary actions to obtain resolution of the issue.
- F. Ensure confidentiality of all member information.
- G. Inform the member or provider of all applicable mechanisms for resolving the issue that are external to the AdSS processes.

- H. Document all processes (including detailed steps used during the investigation and resolution stages) implemented to ensure complete resolution of each complaint, grievance or appeal, including but not limited to:
1. Corrective action plan(s) or action(s) taken to resolve the concern
 2. Documentation that education/training was completed. This may include, but is not limited to, in-service attendance sheets and training objectives.
 3. New policies and/or procedures
 4. Follow-up with the member that includes, but is not limited to:
 - a. Assistance as needed to ensure that the immediate health care needs are met
 - b. Closure/resolution letter that provides sufficient detail to ensure all covered, medically necessary care needs are met, and a contact name/telephone number to call for assistance or to express any unresolved concerns.
 5. Referral to the and AdSS's Corporate Compliance Units and/or AHCCCS Office of the Inspector General.
- I. Refer to A.A.C. R9-34 and the Division Contract for information regarding requirements for the grievance and appeal system for members and providers.

Process of Evaluation and Resolution of Quality of Care and Service Concerns

The quality of care concerns process must include documentation of identification, research, evaluation, intervention, resolution, and trending of member and provider issues. Resolution include both member and system interventions when appropriate.

The quality of care/service concerns process must be a stand-alone process completed through the Quality Management Unit. The process must not be combined with other agency meetings or processes. Work units outside of the QM Unit will not have the authority to conduct quality of care investigations but may provide subject matter expertise throughout the investigative process.

- A. The AdSS must develop and implement policies and procedures that address analysis of quality of care issues through:
1. Identification of the quality of care issues
 2. Initial assessment of the severity of the quality of care issue
 3. Prioritization of action(s) needed to resolve immediate care needs when appropriate
 4. Review of trend reports obtained from the AdSS's quality of care data system to determine possible trends related to the provider(s), including

organizational providers, involved in the allegation(s) including but not limited to types of allegation(s), severity, and substantiation

5. Research, including, but not limited to:
 - a. A review of the log of the events
 - b. Documentation of conversations
 - c. Medical records review
 - d. Mortality review
 6. Quantitative and qualitative analysis of the research, which may include root cause analysis
 7. Direct interviews of members, staff, and witnesses to a reportable event; when applicable and appropriate.
- B. The AdSS's Quality Management staff must conduct onsite visits in response to identified health and safety concerns, immediate jeopardy, serious incident situations, a request of the Division or AHCCCS.

Subject matter experts outside the QM Unit may participate in the onsite visit but may not take the place of Quality Management staff during reviews. SMEs may arrive on site first if they are closer to the site, however, a clinical QM staff member must be the lead for the review/investigation and participate in the onsite visits.

The AdSS may not delegate quality of care investigation processes or onsite quality of care visits. Quality investigations may not be delegated or performed by the staff of the provider agency/facility where the identified health and safety concerns, Immediate Jeopardy, or AHCCCS-requested reviews have occurred. Contractors must complete and submit to AHCCCS Attachment 960-C for each onsite review.

Based on findings, the AdSS must:

1. Actively participate in meetings focused on ensuring health and safety of members.
2. Actively participate in meetings scheduled to develop work plans and corrective action plans to ensure placement setting or service sites compliance with ADHS Licensure and/or AHCCCS requirements.
3. Participate in scheduled and unscheduled monitoring of placement setting or service sites that are in an Immediate Jeopardy status, have serious identified deficiencies that may affect health and safety of members or as directed by AHCCCS.
4. Assist in the identification of technical assistance resources focused on achieving and sustaining regulatory compliance.

5. Monitor placement setting or service sites upon completion of the activities and interventions to ensure that compliance is sustained.
- C. The AdSS must develop a process to assure that action is taken when needed by:
1. Developing an action plan to reduce/eliminate the likelihood of the issue reoccurring
 2. Determining, implementing, and documenting appropriate interventions
 3. Monitoring and documenting the success of the interventions
 4. Incorporating interventions into the organizations QM program if successful
 5. Implementing new interventions/approaches when necessary.
- D. The AdSS must develop a process to ensure resolution of the issue. Member and system resolutions may occur independently from one another.
- E. The AdSS must develop a process to determine the level of severity of the QOC issue.
- F. The AdSS must develop a process to refer and/or report the issues to the appropriate regulatory agency(ies) identified below:
1. The Department of Child Safety
 2. Adult Protective Services
 3. Arizona Department of Health Services (AZDHS)
 4. The Attorney General's Office
 5. Law enforcement
 6. The Division or AHCCCS
 7. Other entities as necessary.
- Initial reporting may be made verbally, but a verbal report must be followed by a written report within one business day.
- G. The AdSS must have a process to refer the issue to the AdSS's Peer Review Committee when appropriate. Referral to the Peer Review Committee is not a substitute for implementing interventions aimed at individual and systemic quality improvement.
- H. If an adverse action is taken with a provider for any reason including those related to quality of care concern, the AdSS must report the adverse action to the Division's QM Unit within 24 hours of the determination to take an adverse action and to the National Practitioner Data Bank when needed.

- I. The AdSS must ensure a thoughtful process around member impact and care transition when acting on adverse actions. This is particularly important if a provider is being suspended or terminated. The Contractor must allow adequate time for identification of new providers, transition of members to those providers, impact to members (such as service plans, medications, etc.), and timely communication to members to prepare for the transition. While there may be instances where a move or transition must occur quickly, the MCO should work with AHCCCS to ensure member needs are met without potential gaps in care/services and or treatment disruption.
- J. The AdSS must have a process to document the criteria and process for closure of the review or investigation. Required documentation includes, but is not limited to, the following:
1. A description of the problems, including new allegations identified during the investigation/review process, and the substantiation and severity level for each allegation and the case overall.
 2. Written response from, or summary of, the documents received from referrals made to outside agencies such as accrediting bodies, or Medical Examiner.
 3. Interventions imposed as part of the investigation (such as education, root/cause analysis, and ongoing monitoring).
- K. The AdSS must document, in the QOC file, investigations that warrant ongoing monitoring or follow-up with the provider. All follow-up actions or monitoring activities as well as related observations or findings must be documented in the QOC file.
- L. The AdSS must notify the Division's QM Unit and take appropriate action with the provider, including suspension or corrective action plans and referrals to appropriate regulatory Boards including the Pharmacy Board, when an investigation identifies an adverse outcome, including mortalities, due to prescribing issues or failure of the provider to:
1. Check the CSPMP
 2. Coordinate care with other prescribers
 3. Refer for substance use treatment or pain management.

The case finding must be presented to the AdSS's Peer Review Committee for discussion and review.

Requests for Copies of Death Certificates

As part of the quality of care investigative process, the AdSS will request copies of member death certificates from the ADHS Bureau of Vital Records.

A. Authorization of Requestors

The AdSS must:

1. Create a letter, on AdSS letterhead, providing one or two names of employees who are authorized to make a request for a copy of the death certificate. The requestor should be someone at a manager or supervisory level position with the AdSS.

Only those individual(s) listed on the letter are eligible to apply/request a copy of the death certificate.

2. Ensure the letter includes original ink signatures and is mailed to:

Arizona Department of Health Records
Bureau of Vital Records
Office Chief
P.O Box 3887
Phoenix, Arizona 85030

3. Notify the AZDHS Office of Vital Statistics in writing of any termination of employment of those listed on the original letter. Include in the notification the name of the replacement managerial or supervisory staff person. Mail these changes to:

Operations Section Manager
Arizona Department of Health Services
Bureau of Vital Records
P.O Box 3887
Phoenix, Arizona 85030

B. Requesting Copies of Death Certificates

When requesting a death certificate, the AdSS authorized requestor must:

1. Include the following in the request:
 - a. The decedent's (member's) name
 - b. Date of death
 - c. Purpose of request (i.e. quality of care investigation process)
 - d. Signature of the authorized employee (requests must be mailed with original ink signatures)

- e. Documentation showing that the decedent was a member of the Division (copy of an eligibility screen with the Division's name, members name and date of eligibility is acceptable)
 - f. A payment of \$5.00 for each copy requested, in the form of a business check, money order, or credit card.
2. Send the request for a death certificate to:

Arizona Department of Health Records
Bureau of Vital Records
Office Chief
P.O Box 3887
Phoenix, Arizona 85030

Reporting to Independent Oversight Committee

The AdSS must provide Incident, Accident and Death Reports concerning issues including, but not limited to, reports of possible abuse, neglect or denial of rights to the Division's Independent Oversight Committee (IOC) as outlined in this policy. All incident, accident and death reports must have all personally identifiable information redacted in accordance with federal and state confidentiality laws.

- A. When the Division or a IOC requests information regarding the outcome of a report of possible abuse, neglect or violation of rights, the AdSS must do one of the following:
 1. Conduct an investigation of the incident if it has not already been conducted:
 - a. For incidents in which a person currently or previously enrolled as seriously mentally ill is the possible victim, the investigation shall follow the requirements in A.A.C. R9-21-401 et seq.
 - b. For incidents in which a currently or previously enrolled child or non-seriously mentally ill adult is the possible victim, the investigation shall be completed within 35 days of the request and shall determine: all information surrounding the incident, whether the incident constitutes abuse, neglect, or a violation of rights, and any corrective action needed as a result of the incident.
 2. If an investigation has already been conducted by the AdSS and can be disclosed without violating any confidentiality provisions, the AdSS must provide the final investigation decision to the Division and the IOC. The final investigation decision shall consist of, at a minimum, the following information:
 - a. The accepted portion of the investigation report with respect to the facts found,
 - b. A summary of the investigation findings, and

c. Conclusions and corrective action taken.

Personally identifiable information regarding any currently or previously enrolled person shall not be included in the final investigation decision provided to the IOC, unless otherwise allowed by law.

B. General Requirements

1. The AdSS must provide to IOC's member information and records in accordance with A.R.S. §41-3804. The following items must be routinely provided to the IOC in redacted format:

- a. Seclusion and Restraint reports
- b. Incident/Accident/Death (IAD) reports, and/or
- c. Quality of Care (QOC) investigations as applicable.

Upon review of supplied information, the IOC may request documentation, supplemental information, or an investigation regarding alleged violation of rights.

2. The AdSS must provide Seclusion and Restraint Reports, and IAD Reports concerning issues including, but not limited to, reports of possible abuse, neglect or denial of rights to IOC's as specified in Section F3, Contractor Chart of Deliverables. All Seclusion and Restraint Reports and IAD reports must have all information removed that personally identifies members, in accordance with federal and state confidentiality laws, and

3. If a QOC investigation has already been conducted by the AdSS and can be disclosed without violating any confidentiality provisions, the AdSS must provide the requested documentation to the IOC via the Secured Quality Management System Portal.

Requests for Protected Health Information (PHI) of a Currently Enrolled Member

A. When an IOC requests PHI concerning a currently or previously enrolled member, the IOC must first demonstrate that the information is necessary to perform a function that is related to the oversight of the behavioral health system or the IOC must have written authorization from the member to review PHI.

B. If it is determined that the IOC needs PHI and has obtained the member's or representative's written authorization, the AdSS must first review the requested information and determine if any of the following types of information are present: Communicable disease related information, including confidential HIV information, and/or information concerning diagnosis, treatment or referral from an alcohol or drug use program. If no such information is present, the AdSS must provide the information adhering to the requirements of this policy.

1. If communicable disease related information, including confidential HIV information, and/or information concerning diagnosis, treatment or referral from an alcohol or drug use program is found, the AdSS must:

- a. Contact the member or representative if an adult, or the custodial parent or legal guardian if the member is a child, and ask if the member is willing to sign an authorization for the release of communicable disease related information, including confidential HIV information, and/or information concerning diagnosis, treatment or referral from an alcohol or drug use program. The AdSS must provide the name and telephone number of a contact person with the IOC who can explain the Committee's purpose for requesting the protected information. If the member agrees to give authorization, the AdSS must obtain written authorization as required below and provide the requested information to the IOC,
 - b. Authorization for the disclosure of records of deceased members may be made by the executor, administrator, or other personal representative appointed by will or by a court to manage the deceased member's estate. If no personal representative has been appointed, PHI may be disclosed to a family member, other relative, or a close personal friend of the deceased member, or any other person identified by the deceased, only to the extent that the PHI is directly relevant to such person's involvement with the deceased members health care or payment related to the individual's health care,
 - c. If the member does not authorize the release of the communicable disease-related information, including confidential HIV information and/or information concerning diagnosis, treatment or referral from an alcohol or drug use program, this information must not be included or must be redacted from any PHI that is authorized to be disclosed, and
 - d. Requested information that does not require the member or representative's authorization must be provided within 15 working days of the request. If the authorization is required, requested information must be provided within five working days of receipt of the written authorization.
- C. When PHI is sent, the AdSS must include a cover letter addressed to the IOC that states that the information is confidential, is for the official purposes of the Committee, and is not to be re-released under any circumstances.
- D. If the Division denies the IOC's request for PHI:
1. The Division notifies the IOC within five working days that the request is denied, the specific reason for the denial, and that the Committee may request, in writing, that the Division Director, or designee, review this decision. The Committee's request to review the denial must be received by the Division Director, or designee, within 60 days of the first scheduled committee meeting after the denial decision is issued,
 2. The Division Director, or designee, conducts the review within five business days after receiving the request for review,

3. The Division Director's or designee's decision is the final agency decision and is subject to judicial review pursuant to A.R.S. Title 12, Chapter 7, Article 6, and
4. No information or records can be released during the timeframe for filing a request for judicial review or when judicial review is pending.

Authorization Requirements

A written authorization for disclosure of information concerning diagnosis, treatment or referral from an alcohol or substance use program and/or communicable disease related information, including confidential HIV information, must include all of the following:

- A. The specific name or general designation of the program or person permitted to make the disclosure
- B. The name or title of the individual or the name of the organization to which the disclosure is to be made
- C. The name of the currently or previously enrolled member
- D. The purpose of the disclosure
- E. How much and what kind of information is to be disclosed
- F. The signature of the currently or previously enrolled member/legal guardian and, if the currently or previously enrolled member is a minor, the signature of a person authorized to give consent
- G. The date on which the authorization is signed
- H. A statement that the authorization is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it
- I. The date, event, or condition upon which the authorization will expire if not revoked before. This date, event, or condition must ensure that the authorization will last no longer than reasonably necessary to serve the purpose for which it is given
- J. A statement that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2) and state statute on confidentiality of HIV/AIDS and other communicable disease information (A.R.S. §36-664(H)) which prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the member to whom it pertains, or as otherwise permitted by 42 CFR Part 2 and A.R.S §36-664(H). A general authorization for the release of medical or other information is NOT sufficient for this purpose.

The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Problem Resolution

If any problems with receipt of requested information as provided in this policy arise, the AdSS must notify the Division and the IOC in writing within the first 30 days. If the problem is not resolved, the IOC may then address the problem to the Division Director or designee.

Duties and Liabilities of Behavioral Health Providers in Proving Behavioral Health Services

- A. The AdSS must develop and make available written policies and procedures that provide guidance regarding the provider's duty to warn under A.R.S. § 36-517.02. This statute supplements other immunities of behavioral health providers or mental health treatment agencies that are specified in law.

With respect to the legal liability of a behavioral health provider, A.R.S. § 36-517.02 provides that no cause of action or legal liability may be imposed against a behavioral health provider for breaching a duty to prevent harm to a person caused by a patient unless *both* of the following occur:

1. The patient has communicated to the mental health provider an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such threat.
 2. The mental health provider fails to take reasonable precautions.
- B. A.R.S. § 36-517.02 provides that any duty of a behavioral health provider to take reasonable precautions to prevent harm threatened by a patient is discharged when the behavioral health provider:
1. Communicates when possible the threat to all identifiable victims,
 2. Notifies a law enforcement agency in the vicinity where the patient or any potential victim resides,
 3. Takes reasonable steps to initiate voluntary or involuntary hospitalization, if appropriate, or
 4. Takes other precautions that a reasonable, prudent behavioral health provider would take under the circumstances.
- C. This statute also provides immunity from liability when the behavioral health provider discloses confidential communications by or relating to a patient under certain circumstances: The behavioral health provider has no liability resulting from disclosing a confidential communication made by or relating to a patient when a patient has explicitly threatened to cause serious harm to a person or when the behavioral health provider reasonably concludes that a patient is likely to cause harm, and the behavioral health provider discloses a confidential communication made by or relating to the patient to reduce the risk of harm.

All providers, regardless of their specialty or area of practice, have a duty to protect others against a member's potential danger to self and/or danger to others. When a provider determines, or under applicable professional standards, reasonably should have determined, that a patient poses a serious danger to self or others, the provider must exercise care to protect others against imminent danger of a patient harming him/herself or others. The foreseeable victim need not be specifically identified by the member, but he/she may be someone who would be the most likely victim of the member's dangerous conduct.

The responsibility of behavioral health provider to take reasonable precautions to prevent harm threatened by a member may include any of the following:

1. Communicating, when possible, the threat to all identifiable victims,
2. Notifying a law enforcement agency in the vicinity where the member or any potential victim resides,
3. Taking reasonable steps to initiate proceedings for voluntary or involuntary hospitalization, if appropriate, and in accordance with AMPM Policy 320-U , or
4. Taking any other precautions that a reasonable and prudent provider would take under the circumstances.

Tracking and Trending of Quality of Care Issues

- A. The AdSS must develop and implement a system to document, track, trend, and evaluate complaints and allegations received from members and providers or as requested by AHCCCS, inclusive of quality care, quality of service and immediate care need issues.
- B. The data from the quality of care data system must be analyzed and evaluated to determine any trends related to the quality of care or service in the AdSS's service delivery system or provider network. The AdSS must incorporate trending of quality of care issues in determining systemic interventions for quality improvement.
- C. The Division documents quality tracking and trending information and documentation that the information was submitted, reviewed, and considered for action by the Division's Quality Committee and Chief Medical Officer, as Chairman of the QM Committee.
- D. The AdSS submits quality tracking and trending information from all closed quality of care issues within the reporting quarter to the Division's QM Unit, utilizing the Quarterly Quality Management Report template provided by AHCCCS. The report is due 30 days after the end of each quarter, the Division line(s) of business must be reported separately and must include the following reporting elements:
 1. Types and number/percentages of substantiated quality of care issues
 2. Intervention implemented to resolve and prevent similar incidents
 3. Resolution status of "substantiated," "unsubstantiated," and "unable to

substantiate” quality of care issues.

If significant negative trends are noted, the AdSS may consider developing performance improvement activities focused on the topic area to improve the issue resolution process itself, and to make improvements that address other system issues raised during the resolution process.

- E. The AdSS submits to the Division all pertinent information regarding an incident of abuse, neglect exploitation, unexpected death (including all unexpected transplant deaths), and other serious incidents as determined by the Division or AHCCCS, via a written Incident Report to the Division no later than 24 hours after becoming aware of the incident. For more information regarding Incident Reporting see Section 6002 in the Division’s Operations Policy Manual. Pertinent information must not be limited to autopsy results and must include a broad review of all issues and possible areas of concern. Delays in receipt of autopsy results must not result in delays of the AdSS’s investigation of a quality of care concern. Delayed autopsy results must be used by the AdSS to confirm the resolution of the quality of care concern.
- F. The AdSS must ensure member health records are available and accessible to authorized staff of its organization and to appropriate state and federal authorities, or their delegates, involved in accessing quality of care/service or investigating member or provider quality of care concerns, complaints, allegation of abuse, neglect exploitation, serious incidents, grievances, Provider Preventable Conditions and Healthcare Acquired Conditions (HCAC). Member record availability and accessibility must be in compliance with federal and state confidentiality laws, including, but not limited to, Health Insurance Portability and Accountability Act (HIPAA) and CFR 431.300 et seq.
- G. The AdSS must maintain information related to coverage and payment issues for at least five years following final resolution of the issue and must be made available to the member, provider, and/or Division or AHCCCS authorized staff upon request.
- H. The AdSS must proactively provide care coordination for members who have multiple complaints regarding services.

Provider-Preventable Conditions

- A. Payments are prohibited for services related to Provider-Preventable Conditions. Provider-Preventable Condition means a condition that meets the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC).

If an HCAC or OPPC is identified, the AdSS must:

1. Conduct a quality of care investigation, and maintain case files containing findings..
2. Report the occurrence and results of the investigation to the Division’s QM Unit quarterly, as specified in the Contract.

- B. The terms HCAC and OPPC are defined as follows:
1. Health Care Acquired Condition (HCAC) – means a Hospital Acquired Condition (HAC) under the Medicare program that occurs in any inpatient hospital setting and is not present on admission. (Refer to the current CMS list of Hospital-Acquired Conditions, located at www.cms.gov.)
 2. Other Provider Preventable Conditions (OPPC) – means a condition occurring in the inpatient and outpatient health care setting which is limited to the following:
 - a. Surgery on the wrong member
 - b. Wrong surgery on a member
 - c. Wrong site surgery.