

910 QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT PROGRAM SCOPE

REVISION: 10/01/2020

EFFECTIVE DATE: October 1, 2019

REFERENCES: Division contract, AMPM Policy 320-T1, AMPM Chapter 900, AMPM Policies 910-980, 9 A.A.C. 10, A.R.S. § 36-401(15), A.R.S. § 36-401(36), 42 CFR Part 438, 42 CFR 438.2, 42 CFR 438.208, 42 CFR 438.242, 42 CFR 438.310(c)(2), 42 CFR 438.320, 42 CFR 438.330(b), 42 CFR 438.400

Purpose

This policy applies to the Division of Disabilities' (Division) Administrative Services Subcontractors (AdSS). The Division oversees the AdSS and ensures implementation and compliance of all requirements in this policy throughout the year and during an annual operational review.

Definitions

Corrective Action Plan (CAP) - A written work plan that identifies the root cause(s) of a deficiency, includes goals and objectives, actions/tasks to be taken to facilitate an expedient return to compliance, methodologies to be used to accomplish CAP goals and objectives and staff responsible to carry out the CAP within the established timelines. CAPs are generally used to improve performance of the Contractor and/or its providers, to enhance Quality Management/Process Improvement activities and the outcomes of the activities, or to resolve a deficiency.

Evaluate - The process used to examine and determine the level of quality or the progress toward improvement of quality and/or performance related to AdSS' service delivery systems.

Health Information System - Data system that collects, analyzes, integrates and reports data and can achieve the objectives of 42 CFR Part 438, Managed Care. The systems must provide information on areas including, but not limited to, utilization, claims, grievances, and appeals, and disenrollments for other than loss of Medicaid eligibility [42 CFR 438.242].

Long Term Services and Supports (LTSS) - Services and supports provided to member of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the member to live or work in the setting of their choice, which may include the individual's home, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting [42 CFR 438.2].

Monitoring - The process of auditing, observing, evaluating, analyzing, and conducting follow-up activities, and documenting results via desktop or on-site review.

Performance Improvement/Quality Improvement - The continuous study and improvement of processes with the intent to better services or outcomes, and prevent or decrease the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement.

Performance Improvement Project (PIP) - A planned process of data gathering, evaluation and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery. Formerly referred to as Quality Improvement Projects (QIP).

Outcomes - Changes in patient health, functional status, satisfaction, or goal achievement that result from health care or supportive services (42 CFR 438.320).

Quality - As it pertains to external quality review, means the degree to which a contractor (described in 42 CFR 438.310(c)(2)) increases the likelihood of desired outcomes of its members through:

- A. Its structural and operational characteristics,
- B. The provision of services that are consistent with current professional, evidenced-based-knowledge, and
- C. Interventions for performance improvement. [42 CFR 438.320].

Quality Management/Performance Improvement Program

- A. AdSS shall establish and implement a Quality Management/Performance Improvement (QM/PI) Program that shall include at least the following elements [42 CFR 438.330(b)]:
 - 1. Performance Improvement Projects (PIPs),
 - 2. Collection and submission of performance measurement data,
 - 3. Mechanisms to detect both under and overutilization of services, and
 - 4. Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs.

Quality Management/Performance Improvement Program Components

- A. The AdSS shall adhere to the QM/PI Program requirements as specified in contract and AMPM Chapter 900. As part of the QM/PI Program, AdSS shall:
 - 1. Clearly define members' rights and responsibilities and ensure they are implemented and monitored.
 - 2. Ensure that medical records and communication are following AMPM Policy 940.
 - 3. Conduct credentialing processes for temporary/provisional, initial and recredentialing in accordance with the requirements of AMPM Policy 950.
 - 4. Implement a process for Quality of Care (QOC) concern, service issue resolution, and grievance or appeal tracking and trending that meets the standards as specified in AMPM Policy 960, 42 CFR 438.400, and 42 CFR 438.242.

5. Implement planned activities to meet or exceed AHCCCS-mandated performance measures Minimum Performance Standards (MPS), as specified in contract and required by AMPM Policy 970, and PIP goals, as required by AMPM Policy 980.
6. Ensure and demonstrate ongoing communication and collaboration between the QM/PI Program and other functional areas of the organization.
7. Develop and implement a process for monitoring the quality and coordination between physical and behavioral health services.
8. Promote timely engagement and appropriate service levels.
9. Identify protocols and practices to monitor appropriate use of methodologies for screening and identification of high needs adult members, maintain policies for monitoring and documentation of ongoing implementation of Division review; along with coordination of care between health care providers both mental and physical health.
10. Identify standards for adults with a Serious Mental Illness (SMI) diagnosis for all levels of service intensity (e.g. levels of care/case management).
11. Provide training and monitoring for provider use of Substance Abuse Mental Health Services Administration (SAMHSA) Fidelity Tools.
12. Provide training of clinical and general staff on:
 - a. Eligibility and use of services available for substance use prevention, and/or
 - b. Treatment through funds available for individuals that are Non-Title XIX/XXI eligible including but not limited to Substance Abuse Block Grant (SABG) and Mental Health Block Grant (MHBG) funding, as specified in AMPM 320-T1.
 - c. Promote Evidence Based Practices in Substance Use Disorder (SUD) Treatment Services.
13. Develop a process to identify and refer youth and young adults to the behavioral health system when identified as having a diagnosed SUD.
14. Ensure the implementation and completion of American Society of Addiction Medicine (ASAM) Criteria (Third Edition, 2013) in substance use disorder assessments, service planning, and level of care placement, and monitor fidelity of ASAM implementation in accordance with AHCCCS directed phased in approach.
15. Develop a process to increase and promote physical health care providers' knowledge of health-related topics including substance use screening, overdose reversal medications, and Medication Assisted Treatment (MAT) options available to members.

16. Promote suicide prevention (following the Zero Suicide Model) to support the identification and referral of members in need of behavioral health/crisis services.
 17. Implement policies and procedures that require individual and organizational providers to report to the proper authorities, as well as the AdSS, incidents of abuse, neglect, injuries (e.g. falls and fractures), exploitation, healthcare acquired conditions, and or unexpected death as soon as the providers are aware of the incident.
 - a. Behavioral health providers shall submit Incident, Accident, and Death reports to AdSS in accordance with 9 A.A.C. 10 and AMPM Policy 960.
 18. Implement policies and procedures that require individual and organizational providers to monitor and trend all suicides or suicides attempts procedures so that providers recognize the signs and symptoms of suicidal ideation and at-risk behaviors.
 19. Conduct new member Health Risk Assessments (HRA) within 90 days of the member's effective enrollment date [42 CFR 438.208].
 20. Ensure continuity of care and integration of services.
 21. Implement policies and procedures that specify:
 - a. Processes for provision of appropriate medication monitoring for members taking antipsychotic medication (per national guidelines).
 22. Implement measures to ensure that members are informed of specific health care needs that require follow up.
 23. Maintain a Health Information System that collects, integrates, analyzes, validates, and reports data necessary to implement its QM/PI Program [42 CFR 438.242]. Data elements shall include:
 - a. Member demographics and designations (e.g. CRS)
 - b. Encounter data and provider characteristics
 - c. Services provided to members
 24. Ensure the that requirements related to data integrity like information data, performance measures and results, QM/PI requirements etc. are included.
- B. All policies and procedures shall be specific to each line of business. All QM/PI Program component shall be supported through the development and maintenance of policies and procedures.

Quality Management/Performance Improvement Program Administrative Structure/Oversight

- A. The QM/PI body of work shall reside within the Quality Management Unit of AdSS

and shall adhere to requirements as specified in contract and AMPM Chapter 900.

1. The AdSS administrative structure for oversight of its QM/PI Program shall follow the requirements of this section, which outline the roles and responsibilities of the following:
 - a. The governing or policy-making body
 - b. The Chief Medical Officer (CMO)/designated Medical Director
 - c. The QM/PI Committee
 - d. The Peer Review Committee
 - e. QM/PI Staff
 - f. Delegated Entities
 - g. The AdSS executive management
- B. Governing or policy making body shall oversee and be accountable for the QM/PI Program.
 1. The Board of Directors, and in the absence of a board, the executive body, shall review and approve the QM/QI Program Plan.
 2. The Board of Directors, and in the absence of a board, the executive body formally evaluates and documents the effectiveness of its QM/PI Program strategy and activities, at a minimum basis annually, as demonstrated by an attestation of approval by the Board of Directors or executive body.
- C. The local CMO/designated Medical Director is responsible for implementation of the QM/PI Program Plan and shall have substantial involvement in the implementation, assessment, and resulting improvement of QM/PI Program activities. All QM/PI policies shall be approved and signed by the AdSS CMO/designated Medical Director.
- D. QM/PI Committee
 1. AdSS shall have an identifiable and structured QM/PI Committee that is responsible for QM/PI functions and responsibilities. At a minimum, the membership shall include the following:
 - a. The local CMO/designated Medical Director as the chairperson of the committee. The CMO/designated Medical Director shall designate the local Associate Medical Director as his/her designee only when the CMO/designated Medical Director is unable to attend the meeting. The local Chief Executive Officer (CEO) may be identified as the co-chair of the QM/PI Committee.
 - b. The QM/PI Manager(s).
 - c. Representation from the functional areas within the organization.

- d. Representation of contracted or affiliated providers serving AHCCCS members.
- e. Clinical representatives of both the AdSS and the provider network.
2. The QM/PI Committee shall ensure that each of its members is aware of the requirements related to confidentiality and conflicts of interest by having signed statements on file and/or QM/PI Committee sign-in sheets with requirements noted.
3. The QM/PI Committee shall meet, at a minimum, quarterly, or more frequently as needed. The frequency of committee meetings shall depend on the need to monitor all program requirements and to monitor any required actions. AdSS shall provide evidence of actual occurrence of these meetings through minutes and other supporting documentation.
4. The QM/PI Committee shall review the QM/PI Program objectives, policies and procedures as specified in contract and shall modify the policies when processes are changed dramatically.
 - a. The QM/PI policies and procedures, and any further modification to them, shall be available upon request for review by AHCCCS, Division of Health Care Management (DHCM), Division of Developmental Disabilities, Quality Management or Quality Improvement (QM/QI) teams.
5. The QM/PI Committee shall also:
 - a. Review, evaluate, and approve any changes to the QM/PI Program Plan;
 - b. Develop procedures for QM/PI responsibilities and clearly document the processes for each QM/PI Program function and activity;
 - c. Develop and implement procedures to ensure that AdSS staff and providers are informed of the most current QM/PI Program requirements, policies, and procedures; and
 - d. Develop and implement procedures to ensure that providers are informed of information related to their performance.
6. When deficiencies are noted, the QM/PI Committee meeting minutes shall clearly document discussions of the following:
 - a. Identified issues,
 - b. Responsible party for interventions or activities,
 - c. Proposed actions,
 - d. Evaluation of the actions taken,

- e. Timelines including start and end dates, and
- f. Additional recommendations or acceptance of the results as applicable.

E. Peer Review

1. AdSS shall have a peer review process with the purpose of improving the QOC provided to members by both individual and organizational providers.
 - a. The peer review scope includes cases where there is evidence of deficient quality, or the omission of the care or service provided by a participating, or non-participating, physical or behavioral health care professional or provider whether delivered in or out of state.
2. AdSS shall not delegate functions of peer review to other entities.
3. The Peer Review Committee shall schedule a meeting at least quarterly or more frequently, as needed (e.g. Ad Hoc meeting or more frequently recurring meetings).
4. Peer review activities may be carried out as a stand-alone committee or in an executive session of the AdSS Quality Management Committee.
5. At a minimum, the Peer Review Committee shall consist of the following:
 - a. AdSS local CMO/designated Medical Director as chair,
 - b. AdSS medical providers from the community that serve AHCCCS members, and
 - c. An AdSS behavioral health provider from the community that serves AHCCCS members.
6. The peer review process shall ensure that providers of the same or similar specialty participate in review and recommendation of individual peer review cases.
 - a. If the specialty being reviewed is not represented on the AdSS Peer Review Committee, the AdSS may utilize peers of the same or similar specialty through external consultation.
7. Peer Review Committee members shall sign a confidentiality and conflict of interest statement at each Peer Review Committee meeting.
 - a. Committee members shall not participate in peer review activities if they have a direct or indirect interest in the peer review outcome.
8. The Peer Review Committee shall evaluate referred cases based on all information made available through the quality management process.
9. The Peer Review Committee is responsible for making recommendations to the AdSS CMO/designated Medical Director. The Peer Review Committee shall

- determine appropriate action which may include, but is not limited to:
- a. Peer contact,
 - b. Education,
 - c. Reduce or revoked credentials, and
 - d. Limit on new member enrollment, sanctions, or other corrective actions.
10. The CMO/designated Medical Director is responsible for implementing any actions with entire process.
 - a. Adverse actions taken as a result of the Peer Review Committee shall be reported to Division's Quality Management Unit within 24 hours of an adverse decision being made.
 11. The Peer Review Committee is responsible for making appropriate recommendations to the AdSS CMO/designated Medical Director regarding initiation of referrals for further investigation or action to:
 - a. The Department of Child Safety (DCS),
 - b. Adult Protective Services (APS),
 - c. The Department of Health Services Licensure Unit, and
 - d. Any appropriate regulatory agency or board, and AHCCCS.
 12. Notification shall occur when the Peer Review Committee determines care was not provided according to the medical community standards.
 - a. Initial notification may be verbal but shall be followed by a written report to the Division's Quality Management Unit within 24 hours.
 13. AdSS shall develop a process to timely report the issue to the appropriate regulatory agency for further research, review, or action.
 - a. Initial report may be verbal but shall be followed by a written report within one business day.
 14. Peer review documentation shall be made available upon request to the Division and other regulatory bodies for purposes of quality management, monitoring and oversight.
 15. High-level peer review summaries shall be maintained as part of the original QOC file.
 16. AdSS shall demonstrate:
 - a. How the peer review process is used to analyze and address clinical

- issues,
- b. How providers are made aware of the peer review process, and
 - c. How providers are made aware of the procedure for grieving peer review findings.
17. Matters appropriate for peer review shall include, but are not limited to:
- a. Cases where there is evidence of deficient quality;
 - b. An omission of the care or service provided by a participating or nonparticipating physical health care or behavioral health care provider, facility, or vendor;
 - c. Questionable clinical decisions, lack of care and/or substandard care;
 - d. Inappropriate interpersonal interactions or unethical behavior, physical, psychological, or verbal abuse of a member, family, staff, or other disruptive behavior;
 - e. Allegations of abuse, neglect, and exploitation of a member or members;
 - f. Allegations of criminal or felonious actions related to practice;
 - g. Issues that immediately impact the member and that are life threatening or dangerous;
 - h. Suicide attempts;
 - i. Opioid-involved/related cases;
 - j. Unanticipated death of a member;
 - k. Issues that have the potential for adverse outcome; or
 - l. Allegations from any source that bring into question the standard of practice.
- F. QM/PI Staffing
- 1. The QM/PI Program shall have qualified local personnel to carry out the functions and responsibilities specified in AMPM Chapter 900 in a timely and competent manner.
 - 2. QM/PI positions performing work functions related to the contract shall have a direct reporting relationship to the local CMO/designated Medical Director and the CEO.
 - 3. The AdSS is responsible for contract performance, regardless if subcontractors or delegated entities are used.

4. Maintain an organizational chart that shows the reporting relationships for QM/PI activities and the percent of time dedicated to the position for each specific line of business:
 - a. The QM/PI Program organizational shall demonstrate the current reporting structures, including the number of full time and part time positions, staff names and responsibilities.
 - b. The chart shall also show direct oversight of QM/PI activities by the local CMO/designated Medical Director and the implemented process for reporting to Executive Management.
 5. Develop a process to ensure that all staff is trained on the process for referring suspected QOC concerns to the Quality Management team.
 - a. This training shall be provided during new employee orientation and, at a minimum, annually thereafter.
 6. Develop and implement policies and procedures outlining:
 - a. QM/PI staff qualifications including education, certifications, experience, and training for each QM/PI position; and
 - b. Mandatory QM/PI staff/management attendance at AdSS meetings unless attendance is specified as optional by monitoring body.
 7. Participate in applicable community initiatives, as well as implement specific interventions to address overarching community concerns, such as, but not limited to:
 - a. Quality Management and Quality Improvement
 - b. Maternal Child Health
 - c. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
 - d. Disease Management
 - e. Behavioral Health
- G. Delegated Entities
1. AdSS shall oversee and maintain accountability for all functions and responsibilities as specified in AMPM Chapter 900, which are delegated to other entities.
 2. AdSS shall provide a written analysis of its historical provision of QM/PI Program oversight function, which includes past goals and objectives.
 - a. The level of effectiveness of the prior QM/PI Program functions shall be documented.

3. AdSS shall have policies and procedures requiring that the delegated entity report all allegations of QOC concerns and quality of service issues to the AdSS. The following shall not be delegated:
 - a. QOC or service investigation and resolution processes shall not be delegated.
4. AdSS shall evaluate the entity's ability to perform the delegated activities prior to delegation. Evidence of such evaluation includes the following:
 - a. Review of appropriate internal areas, such as Quality Management,
 - b. Review of policies and procedures and their implementation, and
 - c. Documented evaluation and determination that the entity effectively performed the delegated activities.
5. A written contract shall be established that specifies the delegated activities and reporting responsibilities of the entity to AdSS.
 - a. The agreement shall include the AdSS right to terminate the contract or perform other remedies for inadequate performance.
6. The performance of the entity and the quality of services provided are monitored on an ongoing basis and are annually reviewed by AdSS.
7. AdSS shall review on an annual basis a minimum of 30 randomly selected files per line of business for each function that is delegated.
8. Documentation shall be kept on file for Division and/or AHCCCS review. Monitoring shall include, but is not limited to:
 - a. Utilization
 - b. Member and provider satisfaction
 - c. QOC concerns
 - d. Complaints
9. The following documentation shall be kept on file and available for AHCCCS review:
 - a. Evaluation reports,
 - b. Results of the AdSS annual monitoring review of the delegated entity,
 - c. Corrective Action Plans (CAPs), and
 - d. Appropriate follow up of the implementation of CAPs to ensure that quality and compliance with AHCCCS requirements for all delegated activities or functions are met.

Quality Management/Performance Improvement Program Monitoring and Evaluation Activities

The AdSS shall develop and implement mechanisms to monitor and evaluate its service delivery system and provider network that demonstrates compliance with all the requirements included within this policy. The AdSS QM/PI Program includes a comprehensive evaluation of activities used by AdSS that demonstrates how these activities improve the quality of services and the continuum of care in all services sites. If collaborative opportunities exist to coordinate organizational monitoring, the lead organization shall coordinate and ensure that all requirements in the collaborative arrangement are met. Monitoring and evaluation activities include:

- A. Monitoring provider compliance with policies, training and signage requirements aimed at preventing and reporting abuse, neglect, and exploitation, as specified in AHCCCS Minimum Subcontract Provisions and contract. Refer also to the Report of the Abuse and Neglect Prevention Task Force to Governor Douglas A. Ducey (November 01, 2019) developed in response to Executive Order 2019-3.
- B. Using data from monitoring that shows trends in quality of care issues to select and develop performance improvement projects.
- C. Reporting all incidents of abuse, neglect, exploitation, and unexpected deaths to the Division's Clinical Quality Management Unit under established timeframes.
- D. Reporting identified quality of care, reportable incidents, and service trends to the Division's Clinical Quality Management Unit immediately upon identification of the trend, including trend specifications such as providers, facilities, services, and allegation types.
- E. Tracking and reporting Health Care Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC) to the Division's Clinical Quality Management Unit on a quarterly basis using the established AHCCCS format.
- F. Incorporating the ADHS licensure and certification reports and other publicly reported data, as applicable.
- G. Reviewing quality of care trend reports and incorporating the reports into the QM/PI evaluation.
- H. Ensuring the health and safety of members in placement settings or service sites that are found to have survey deficiencies that may impact the health and safety of members.
- I. The Division actively participates in both individual and coordinated efforts to improve the quality of care by taking appropriate and collaborative action regarding:
 1. Placement settings or service sites that have been identified through the Licensure Survey process or other mechanisms as having an immediate jeopardy situation; or have had multiple survey or complaint investigations resulting in a finding of non-compliance with licensure requirements;

2. Facilities, placement settings, or service sites that have been identified by AHCCCS or the Division as an Immediate Care Need;
3. Meetings scheduled to develop work plans and CAPs that ensures placement setting or service sites are in compliance with ADHS or AHCCCS Licensure requirements;
4. Scheduled and unscheduled monitoring of placement setting or servicing sites that are in an Immediate Jeopardy status or have serious identified or suspected deficiencies that may affect health and safety of members (Immediate Care Needs);
5. Assisting in the identification of technical assistance resources focused on achieving and sustaining licensure compliance; and
6. Monitoring placement setting or service sites upon completion of the activities and interventions to ensure that compliance is sustained.

- J. The following services and service sites shall be monitored at a minimum annually by the Division or the AdSS, and shall include the following:

SERVICES	SERVICE SITES
Behavioral Health Therapeutic Home Care Services	Behavioral Health Outpatient Clinics
Behavioral Management	Behavioral Health Therapeutic Home (Adults and Children)
Behavioral Health Personal Assistance	Independent Clinic
Family Support	Federally Qualified Health Center
Peer Support	Community Mental Health Center
Case Management Services	Community/Rural Health Clinic (or Center)
Emergency/Crisis Behavioral Health Services	Crisis Service Provider
Emergency Transportation	Community Service Agency
Evaluation and Screening (initial and ongoing assessment)	Hospital (if it includes a distinct behavioral health or detoxification unit)
Group Therapy and Counseling	Inpatient Behavioral Health Facility
Individual Therapy and Counseling	Behavioral Health Residential Facility
Family Therapy and Counseling	Residential Treatment Center
Marriage/Family Counseling	Psychiatric Hospital
Substance Use Treatment	Substance Use Transitional Center
Inpatient Hospital	Unclassified Facility
Inpatient Psychiatric Facilities (residential treatment centers and sub-acute facilities)	Integrated Clinic
Institutions for Mental Diseases	
Laboratory and Radiology Services	
Non-emergency Transportation	
Nursing	
Opioid Agonist Treatment	
Partial Care (supervised day program, therapeutic day program and medical day program)	
Psychosocial Rehabilitation (living skills training, health promotion and supported employment)	
Psychotropic Medication	

- K. The following services and service sites shall be monitored at a minimum every three years by the Division or AdSS, and shall include the following:

SERVICES	SERVICE SITES
Ancillary	Ambulatory Facilities
Dental	Hospitals
Emergency	Nursing Facilities
Early Periodic Screening, Diagnosis and Treatment (EPSDT)	
Family Planning	
Obstetric	
Pharmacy	
Prevention and Wellness	
Primary Care	
Specialty Care	
Other (e.g. Durable Medical Equipment (DME)/Medical Supplies, Home Health Services, Therapies, Transportation, etc.)	

- L. The following services and service sites shall be monitored at a minimum every three years or annually as noted (unless otherwise noted) by the Division or AdSS, and shall include the following:

SERVICES	SERVICE SITES
Adult Day Health Care*	Ambulatory Facilities
Ancillary	Behavioral Health Facilities
Behavioral Health	Hospice*
Dental	Hospitals
Durable Medical Equipment (DME)/ Medical Supplies	Institution for Mental Diseases*
Emergency	Nursing Facilities*
Emergency Alert	Residential Treatment Centers*
Environmental Modifications	Traumatic Brain Injury Facilities*
Early Periodic Screening, Diagnosis and Treatment (EPSDT)	
Family Planning	
Home Health Services	
Hospice	
Medical/Acute Care	
Obstetric	
Hospice	
Medical/Acute Care	
Obstetric	
Prevention and Wellness	
Respiratory Therapy	
Prevention and Wellness	
Respiratory Therapy	
Specialty Care	
<p>*These services shall be reviewed annually.</p> <p>† Defined in A.R.S. § 36-401(36)</p> <p>†† Defined in A.R.S. § 36-401(15)</p>	

Implementation of Actions to Improve Care

If problems are identified, AdSS shall develop and monitor a CAP required by AHCCCS and the Division and it may require the development and monitoring of a CAP by its service providers. The CAP addresses the following:

- A. Specified specific problem(s) requiring the corrective action. Examples include:
1. Abuse, neglect, and exploitation;
 2. Healthcare acquired conditions;
 3. Unexpected death;
 4. Isolated systemic issues;
 5. Trends;
 6. Health and safety issues, Immediate Jeopardy, and Immediate Care Need situations;
 7. Lack of coordination;
 8. Inappropriate authorizations for specific ongoing care needs;
 9. High profile/media events; and
 10. Other examples as identified by the Division or AHCCCS.
- B. All determinations regarding quality issues that are referred for peer review shall be made only by the Peer Review Committee chaired by the CMO/designated Medical Director. Per the ruling of the Peer Review Committee to refer a decision for review, the person(s) or body (e.g., board) shall be responsible for making the final determinations regarding quality issues.
- C. Type(s) of action(s) to be taken, including:
1. Education/training/technical assistance;
 2. Follow-up monitoring and evaluation of improvement;
 3. Changes in processes, organizational structures, forms;
 4. Informal counseling;
 5. Termination of affiliation, suspension, or limitation of the provider (if an adverse action is taken with a provider the Division reports the adverse action to the Division's Clinical Quality Management Unit within one business day);
 6. Referrals to regulatory agencies; and
 7. Other actions as determined by the Division.
- D. Method(s) for internal dissemination of findings and resulting CAPs to appropriate staff and/or network providers, and documentation of assessment of the effectiveness of actions taken.

- E. Method(s) for dissemination of pertinent information to the Division, AHCCCS Administration and regulatory boards and agencies (e.g., Arizona Department of Health Services, Arizona Medical Board, Arizona Board of Pharmacy, Arizona State Board of Nursing).
- F. AdSS maintains documentation confirming implementation of corrective action.