

Arizona Department of Health Services Office for Children with Special Health Care Needs Children's Rehabilitative Services Administration	Effective Date: 03/02/2009 Last Review Effective Date: 03/11/2009
SUBJECT: QUALITY MANAGEMENT	SECTION: QM 1.5

SUBTITLE: CRSA Quality of Care Process

POLICY:

It is the policy of Children's Rehabilitative Services Administration (CRSA) to assure timely, responsive, and effective processes to identify and resolve Quality of Care concerns which may arise within the delivery system.

STANDARD:

- 1) CRSA, Division of Quality Management (QM) attempts to resolve all grievances as expeditiously as possible. Most grievances should be resolved within ten (10) business days of receipt, but in no case longer than ninety (90) days.
- 2) The QM Coordinators will have the necessary clinical, administrative, and quality assurance knowledge and expertise to facilitate CRSA's Quality Process.
- 3) CRSA will ensure the confidentiality of all member information. The Quality of Care Process is a protected process as provided by A.R.S. § 36-441, A.R.S. § 36-445, A.R.S. §§ 36-2401 to 2404, A.R.S. § 36-2917, and 42 C.F.R. § 434. Quality of Care concerns will be addressed with an Executive Session of the CRSA Quality Management Committee (QMC). Confidentiality will be attested by each member of the QMC and CRSA Peer Review Committee.
- 4) CRSA will assure member health records are made available and accessible to authorized staff and to appropriate State and Federal authorities or their delegates involved in assessing or investigating member or provider quality of care concerns, complaints, allegations of abuse, and grievances.
- 5) Quality of care and non-quality of care 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 and internal).

DEFINITIONS:

Action:

The denial or limited authorization of a requested service including:

- a) The type or level of service;
- b) The reduction, suspension, or termination of a previously authorized service;
- c) The denial, in whole or in part, of payment for a service;
- d) The failure to provide services in a timely manner;
- e) The failure to act within the timeframes required for standard and expedited resolution of appeals and standard disposition of grievances; or
- f) The denial of a rural Children's Rehabilitative Services (CRS) recipient's request to obtain services outside CRSA or its subcontractors' network under 42 C.F.R. § 438.52(b)(2)(ii) when CRSA or its subcontractors is the only contractor in the rural area.

Assess or Evaluate:

The process used to examine and determine the level of quality or the progress towards improvement of quality and/or performance related to CRS Contractor service delivery systems. (See AMPM 900, Definitions)

Corrective Action Plan (CAP):

A written work plan that includes goals and objectives, steps to be taken, methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the CRS Contractors and/or its providers, to enhance Quality Management/Project Improvement (QM/PI) activities and the outcomes of the activities, or to resolve a deficiency. (See AMPM 900, Definitions)

Grievance:

An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to: the quality of care or services provided or aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's rights. (See AMPM 900, Definitions)

Grievance Log:

Quality and non-quality of care concerns submitted by CRS Contractor.

Level of Severity:

The designation of a quality of care concern as to degree of life threat, disability, or other adverse outcome.

Non-Quality of Care Concern:

A grievance that has no possibility of impacting the member's health care status.

Quality of Care Concern:

If there is any possibility that the grievance/concern identified could impact the member's health care status in any way; it must be treated as a quality of care concern.

Quality of Care Database:

The database where all CRSA grievances and potential quality of care review and referrals are entered for monitoring, tracking, and trending purposes.

PROCEDURES:

- 1) **CRSA QM's Receipt of Quality of Care Concerns**

The CRSA QM Coordinator documents each concern raised, date of occurrence, and from whom it was received, and the resolution within the Quality of Care (QOC) Database.


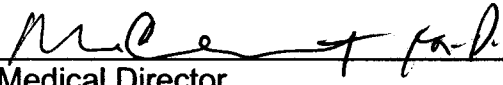
 - a) The CRSA QM Coordinator will determine whether the concern is to be resolved through:
 - i) The quality management program; or
 - ii) Grievance and appeals process, process for making initial determinations on coverage and payment issues, or process for resolution of disputed initial determinations. The CRSA QM Division collaborates with the CRSA Member and Provider Services, Education, and Advocacy to manage the non-quality of care concerns and complaints, determination of coverage, and disputed determinations (See CRSA Policy Manual GS 1.1, CRSA Non-quality of Care/Grievance Process).
 - b) After direct receipt of concern, the CRSA QM Coordinator will send an acknowledgement letter of the concern within five (5) business days explaining to the member, originator of the concern, or provider the process to be followed in resolving his or her concern.

- 2) **CRS Contractor's Receipt of Quality of Care Concerns**
 - a) If the concern is received by the CRS Contractor and is a Level 2 or higher, the CRS Contractor's QM Coordinator will notify CRSA QM within one (1) business day, enter the concern into the QOC Database, assure an acknowledgement letter is sent, and monitor the concern through closure.
 - b) Level 1 quality of care concerns received by the CRS Contractor will be monitored and acted upon by the CRS Contractor. CRSA will review a sample of Level 1 quality of care concerns during the CRS Contractor's annual administrative review to ensure compliance to the CRS Contractors Policy and Procedure Manual (CPPM) standards.
 - c) The CRS Contractor is responsible for sending a log of quality of care concerns and non-quality of care concerns/grievances by the 15th of each month to CRSA. The CRSA QM Coordinator will review the logs to validate assignment of the appropriate level and the action(s) taken.

- 3) The CRSA QM Coordinator is responsible for facilitating the investigation, analysis, intervention, evaluation, resolution, reporting, closure, and trending of quality of care concerns received within the CRS system and reporting to the Executive Session of the CRSA QMC.
- a) The CRSA QM Coordinator will assist the member or provider as needed to obtain resolution of the concern.
 - b) The CRSA QM Coordinator will, as necessary, inform the member, originator of the concern, or provider of all applicable mechanisms for resolving the concern external to the CRSA process (e.g., file complaint with Arizona Health Care Cost Containment System (AHCCCS) or applicable regulatory agency).
 - c) Document all processes (include detailed steps used during the investigation and resolution stages) implemented to ensure complete resolution of each grievance, including but not limited to:
 - i) CAP(s) or action(s) taken to resolve the concern;
 - ii) In-service attendance and notes;
 - iii) New policies and/or procedures;
 - iv) Follow-up with the CRS Contractor to ensure that the immediate health care needs of the member are met;
 - v) A written response or a summary of documents received as a result of referrals made to outside agencies, such as accrediting bodies or the Arizona Medical Board, to be included as part of the closure of the review; and
 - vi) A closure/resolution letter will be sent 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.
 - d) Document the level of substantiation:
 - i) **Substantiated:** Defined as an allegation of abuse or complaint, Levels 1-4, which was verified or proven to have happened based upon available evidence. Substantiated allegations of abuse or complaints require a CAP.
 - ii) **Unsubstantiated:** Defined as an allegation or complaint, which was based on evidence and verified to not have occurred.
 - iii) **Unable to Substantiate:** Defined as insufficient evidence to prove or disprove the allegation of abuse or complaint.
 - e) An assessment of the level of severity of the quality of care concern will be made using the following levels:
 - i) Level 0 – Track only: No quality issue identified.
 - ii) Level 1 – Potential quality of care concern identified, but the incident did not cause harm to the member.
 - iii) Level 2 – Potential quality of care concern identified, the incident caused nonpermanent harm to the member.
 - iv) Level 3 – Potential quality of care concern identified, the incident caused permanent harm to the member.

- v) Level 4 – Potential quality of care concern identified, the incident caused death of the member.
 - f) Determining Quality of Care Categories (See Attachment 1, Category and Subcategory Alpha Lists with Level Definitions)
 - i) Main category and
 - ii) Subcategory
 - g) The CRSA Quality Management Coordinator will ensure action is taken when needed:
 - i) Development of an action plan to reduce/eliminate the likelihood of the concern reoccurring;
 - ii) Implementation and documentation of appropriate interventions;
 - iii) Monitor and document the success of the interventions;
 - iv) Incorporate interventions into the organization's QM program if successful; or
 - v) Assign new interventions/approaches when necessary.
 - h) QOC concerns will be evaluated by the CRSA Medical Director during the Executive Session of the CRSA Quality Management Committee.
 - i) The CRSA QM Coordinator will assure appropriate concerns are referred to the CRSA Peer Review Committee (See CRSA Policy Manual QM 1.1 CRSA Peer Review Process) when appropriate.
 - j) The CRSA QM Coordinator will ensure appropriate concerns are referred/reported to the appropriate regulatory agency, e.g., Child or Adult Protective Services and AHCCCS, for further research/review or action.
 - k) The CRSA QM Coordinator will notify the appropriate regulatory/licensing board or agency and AHCCCS when a health care professional's organizational provider or other provider's affiliation with their network is suspended or terminated because of quality of care concerns.
- 4) Monthly grievance logs from CRS Contractor will be compiled into the QOC Database to document, track, and evaluate complaints and allegations received from members and providers, inclusive of quality of care concerns:
- a) The data from this system is analyzed and evaluated to determine any trends related to the quality of care and non-quality of care issues in the service delivery system and the provider network on a quarterly basis and annually. Data is distributed at the QMC chaired by the CRSA Medical Director.
 - b) Quality tracking and trending information from all closed quality of care concerns within the reporting quarter is submitted to AHCCCS/Division of Health Care Management (DHCM)/Clinical Quality Management (CQM) in quarterly reports, and include the following reporting elements:
 - i) Types and numbers/percentages of quality of care concerns;
 - ii) Interventions implemented to resolve and prevent similar incidences; and
 - iii) Resolution status of "substantiated," "un-substantiated," and "unable to substantiate" quality of care concerns.

- c) CRSA submits to AHCCCS/DHCM/CQM all pertinent information regarding an incident of abuse, neglect, and unexpected death as soon as CRSA becomes aware of the incident.
- 5) If at any time CRSA deems that trending a systemic improvement is required to improve processes, the responsible CRS Contractor is notified in writing of the need for a CAP to prevent further occurrences. CAPs from CRS Contractor must include the following:
- a) A description of the problem which requires improvement;
 - b) Improvement action to be taken on both an individual case basis as well as the system along with the responsible CRS Contractor personnel assignment;
 - c) Time frames for implementation; and
 - d) Monthly evaluation of progress towards goals.
- 6) The CRSA QM Coordinator monitors the CAPs and if the interventions and/or the corrective actions are not improving the process, CRSA may assign new interventions, impose sanctions, and/or other activities as identified by the CRSA QMC to the CRS Contractor until the concern is resolved.
- 7) Negative trends within quality of care may be considered when evaluating data to determine the annual Performance Improvement Project (See CRSA Policy Manual QM 1.2, Performance Improvement Projects (PIPs)) and or other performance improvement activity.
- 8) Closure of the concern will occur when at least one of the following conditions have been met:
- a) The quality of care process has been conducted and the concern is determined to be substantiated, unsubstantiated, or unable to substantiate by the CRSA Medical Director;
 - b) A CAP is initiated and accepted by the Medical Director (verification of implemented actions will occur during the Annual Administrative Review);
 - c) The concern is determined to be resolved through the peer review process;
 - d) The grieved party is satisfied with the resolution and/or there is no further immediate jeopardy based upon the quality of care concern which could impact the health care needs of the member or another member within the delivery system;
 - e) A concern may be closed if the grieved party is dissatisfied and the Executive Session of the CRSA Quality Management Committee determines the corrective action(s) are sufficient and further corrective action(s) are unjustified; and
 - f) When applicable, the appropriate regulatory and or licensing entities have been notified and no further action is required or requested.

Approved:	Date:
 CRSA Administrator	3/16/09
 CRSA Medical Director	3/10/09

Category and Subcategory Alpha Lists with Level Definitions

Severity Level Definitions	
Level 0	No quality issue identified.
Level 1	Potential quality of care concern identified, but the incident did not cause harm to the member.
Level 2	Potential quality of care concern identified, the incident caused nonpermanent harm to the member.
Level 3	Potential quality of care concern identified, the incident caused permanent harm to the member.
Level 4	Potential quality of care concern identified, the incident caused death of the member.

Categories with Sub-Categories	
Quality of Care (QOC):	
Availability, Accessibility, Adequacy (AAA)	
	Accessibility issues - environmental, services, DME, pharmacy
	Adequacy of Provider Network
	Availability issues - appointment
	Delay in treatment/service/referral
	Other
	Refusal to provide care
Denial, Decrease, Discontinuance Covered Benefits (DDD)	
	Co-pay issues
	Decrease from previously covered service
	Denial inappropriate - potentially medically necessary
	Eligibility issues
	Prior authorization denial
Effectiveness/Appropriateness of Care (E/A)	
	Abnormal diagnostic findings not addressed/resolved
	Abortion
	Admission for adverse results ER/Outpatient surgery
	Appropriate referrals not requested
	Avoidable complication during or after surgery
	Cardiac/respiratory arrest, unanticipated
	Cardio/pulmonary complication
	Death during or after surgery
	Dehydration/malnutrition not addressed
	Delay in diagnosis
	Delay in treatment/service
	Delay of thrombolytic therapy
	Dental issues
	Failed to diagnose or symptoms not addressed by Provider
	Inadequate/inappropriate discharge planning
	Inappropriate procedure/treatment
	Inappropriate/unexpected transfer
	Incorrect/Misdiagnosis
	Known complication
	Lead levels, poisoning, related sickness
	Mortality review - expected death or non acute setting
	Neurological deficit post admit
	Nosocomial infection or Septicemia
	Pattern of omitted prescribed Treatment (I/O, we, access to MR)
	Physical therapy issues
	Post procedure complication
	Readmit with in 30 days for different diagnosis

Effectiveness/Appropriateness of Care (E/A) (continued page 2)	
	Readmit with in 30 days/complications treatment for previous diagnosis
	Skin integrity/Decubitus (stage I-V greater than 2 wks duration)
	Sterilization
	Timeliness of intervention with adverse effect
	Treatment is ineffective or below medical standards
	Unplanned removal, injury of organ or structure
	Unplanned return to OR for same condition/same admission
	Vascular spasm/nerve injury, following neurological procedure
Fraud, Member or Provider (Fraud)	
	Potential legal issue/Fraud (Member, Provider, or Financial)
Member Rights/Respect and Caring (MR)	
	Abuse, physical, emotional, sexual
	Advance directive not addressed
	Continuity or Coordination of Care
	Cultural insensitivity
	Disrespectful/Inappropriate conduct by member
	Disrespectful/unprofessional conduct by Provider/Staff
	Lack of denial/grievance process impacted care or treatment
	Member dissatisfaction with treatment or care
	Member refuses medical treatment
	Neglect
	No response to plan request for information
	Other
	Physician visit not completed in timely manner
	Restraints - Chemical, inappropriate use of
	Restraints - Physical, inappropriate use of
	Staff related issues (Provider/Practitioner)
Safety/Risk Management (Safety)	
	Documentation/medical records (altered)
	Fall with injury
	Injury or accident
	Intubation injury (dental, mouth, ocular)
	IV infiltration with adverse effect
	Medication error (toxicity, dose, omission, etc.)
	Member leaves AMA
	Other
	Pharmacy prescription error
	Poor operating equipment
	Transfusion Rx/Blood products with adverse effect
	Unsafe environment
Non Quality of Care (Non-QOC):	
Contractor Service Level	
	Delay in Service
	General Complaint
	Miscommunication
	Organizational Issue
	Uncooperative, Rude
Medical Service Provision	

Category and Subcategory Alpha Lists with Level Definitions

	Accessibility/Availability
	Billing
	Delay in Service
	Dental
	General Complaint
	Plan Change Request
	Provider Complaint
	Reimbursement
Transportation	
	Accessibility and Availability
	Delay in Service
	General Complaint
	Late Arrival
	No Show
	Rudeness, Abruptness
	Safety/Accident
Wheelchair	
	Manual: Purchase/Rental
	Manual: Repair
	Power: Purchase/Rental
	Power: Repair
	Other