Provider Manual
Section 9.0
Quality Improvement

Table of Contents

9.0 Quality Improvement

9.1 Quality Improvement Program Description

The purpose of the Quality Improvement (QI) Program is to provide the infrastructure for the continuous monitoring, evaluation, and improvement in care, safety, and service.

Providers may obtain a copy of Lighthouse's complete "Quality Improvement Program Description," "Quality Improvement Program Evaluation," or "Quality Program Committee Structure" and/or a copy of a summary of its annual evaluation by visiting the Lighthouse website at www.lighthousehealthplan.com or by contacting their Provider Relations Specialist.

9.1.1 Performance Improvement Process

The Physician Advisory Council "PAC" reviews and adopts an annual QI program and QI work plan based on Medicaid managed-care-appropriate industry standards. The QI adapts traditional quality/risk/utilization-management approaches to problem identification with the objective of identifying improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area, and it includes targeted interventions that have the greatest potential for improving health outcomes or services. Performance-improvement projects, focused studies, and other quality-improvement initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each initiative is also designed to allow monitoring of improvement over time. The QI work plan serves as a continuous working guide for quality-improvement efforts. It integrates quality-improvement activities, reporting, and studies from all areas of the organization (clinical and service) to dictate timelines for completion and internal reporting, as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QI work plan. Lighthouse communicates activities and outcomes of its quality-improvement program to both enrollees and providers through avenues such as the enrollee newsletter, provider newsletter, and the Lighthouse web portal. At any time, providers may request additional information on programs including a description of the QI program and a report on plan progress in meeting the QI program goals by contacting the Quality Improvement department.

9.1.2 Healthcare Effectiveness Data Information Set

The ***Healthcare Effectiveness Data Information Set*** **(HEDIS)** is a group of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) that allows comparison across health plans. Comparisons are based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of NCQA health plan accreditation, as well as Lighthouse's contract with the AHCA for the provision of coordinated care services to Lighthouse enrollee populations. HEDIS measures are becoming increasingly important, as purchasers of healthcare use the aggregated HEDIS rates to evaluate a health insurer's ability to demonstrate improvement in preventive health and outreach to its enrollees.

9.1.3 Calculation of HEDIS Rates

HEDIS rates may be calculated using two methodologies: **administrative data methodology** or **hybrid methodology**. Administrative data methodology is calculated from claims or encounter data submitted to the health plan by providers. Measures typically calculated using administrative data methodology include: annual mammogram, annual chlamydia screening, annual pap test, asthma treatment, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and mental health services. Accurate and timely claims and encounter data submission and use of appropriate CPT and diagnosis codes are of paramount importance for the accuracy of these measures. The hybrid methodology consists of both administrative data and a sample of medical records. It requires review of a random sample of enrollees' medical records to abstract data for services rendered that are not reported through claims or encounter data. Measures typically requiring medical record review include: diabetic HbA1c, eye exam and nephropathy, controlling high-blood pressure, and prenatal care and postpartum care.

9.1.4 Patient Safety

The Quality Improvement (QI) Department, monitors patient safety and risk mitigation practices. The QI Staff is trained to identify, investigate, analyze, evaluate and prevent incidents that pose health and safety risk. All potential quality of care events and adverse incidents shall be reported by the Provider and/or Provider staff in all service delivery settings within forty-eight(48) hours of the incident by submitting the Provider Adverse Incident Form to the Quality Improvement (QI) Department at (Need email and fax). This form can be found on the Lighthouse website at www.LighthouseHealthPlan.com.

9.2 Quality of Care Concerns

Quality of care concerns may be reported by both internal and external customers such as enrollees, providers, and advocates. All reported concerns are investigated and monitored for trends.

In the event a quality of care concern is reported, Lighthouse requires full cooperation with the investigation of the concern. This includes the timely submission of requested written repose, medical records, and the implementation of corrective action plans, as applicable. Providers have the right to respond to reported concerns.

For more information regarding quality of care concerns, please contact the Quality Improvement department at 844-243-5181.

9.3 Provider Sanctioning Policy

In the event that Lighthouse identifies health care services rendered to a Lighthouse enrollee by a participating provider that are outside the recognized treatment patterns of the organized medical community and quality management and/or credentialing standards, the provider may be subject to sanctions. The **National Provider Data Bank (NPDB)** may be notified of all negative outcomes if formal sanctioning proceedings are implemented and if the outcome is to last thirty (30) days or more.

In addition to the above, Lighthouse will exclude and/or penalize a provider under any of the following conditions:

- The Plan has received recommendations to take such actions because of an investigation conducted by the Office of the Inspector General or other appropriate state and/or federal agency;
- The provider fails to cooperate with an investigation of alleged fraud and abuse; and
- The provider has been listed on the Medicare/Medicaid Sanctions Report.

Possible sanctions for deviation from accepted quality management and/or credentialing standards and program integrity violations include:

- Limiting a PCP’s panel, but not necessarily limiting the freezing of new enrollee assignments;
- Termination of participating provider status;
- Withholds from future claims payments of amounts that are improperly paid or reasonable estimates of such amounts; and
- Suspension of claims activity.

9.4 Clinical Practice Guidelines

The intent of the guidelines is to support the provider's efforts in the care and education of enrollees and to reduce variation in diagnosis and treatment. The Plan makes every effort to ensure that current scientific data and expert opinion are the basis for each guideline. Each guideline is evaluated as new data becomes available or at a minimum of every two years. For Quality Improvement initiatives, Lighthouse and AHCA will monitor provider compliance and enrollee outcomes related to these clinical guidelines by performing an annual medical record audit according to AHCA Contract Attachment II Section VII Quality and UM. These guidelines are intended to assist the provider in clinical decision-making and attempt to define clinical practices that apply to most patients in most circumstances. The treating provider should make the ultimate decision regarding the care of a particular patient.

9.4.1 Guidelines

These guidelines include:

- Preventative guidelines for children and adults;
- EPSDT Periodicity Schedule;
- Immunization schedules for adults and children;
- Guidelines addressing appropriate antibiotic use in adult and children;
- Behavioral Health guidelines; and
- Guidelines for Acute/Medical conditions

Providers may access the guidelines through Lighthouse's website at www.lighthousehealthplan.com or request a hard copy of the guidelines by contacting the Quality Improvement Nurse at 844-243-5181.

9.4.2 Improvement Program (QI) Scope and Goals

Lighthouse's QI Program addresses the quality of both clinical care and services provided to enrollees and providers. QA activities encompass all demographic groups, benefits, and care settings.

It also addresses all healthcare services, including: medical and behavioral, preventive, emergency, primary and specialty care; as well as acute care, short-term care, long-term care, home care, pharmacy, and ancillary services. Areas subject to quality oversight include:

- Acute and chronic care management and disease management;
- Adoption and compliance with preventive health and clinical practice guidelines;
- Behavioral healthcare management and coordination with medical practitioners;
- Continuity and coordination of care;
- Department performance and service;

- Network provider profiling;
- Employee and provider cultural competency, including monitoring to ensure enrollee linguistic and physical accessibility;
- Disparities in care;
- Enrollee grievance and appeals;
- Enrollee satisfaction;
- Health education and promotion;
- Network accessibility and appointment availability, including specialty practitioners;
- Patient safety, including appropriateness and quality of healthcare services;
- Provider satisfaction;
- Selection and retention of skilled, quality-oriented practitioners and facilities (credentialing and re-credentialing);
- Utilization management, including under and over utilization; and
- Compliance with preventive health and practice guidelines.

9.4.3 Quality Enhancements (QEs)

The Plan provides Quality Enhancements programs for our enrollees to improve enrollee health and promote quality outcomes. Our Quality Enhancements programs are:

- Care Coordination: Early Intervention Services
- Domestic Violence Reporting, Prevention and Support Services
- Healthy Start Referrals
- Maternity Care Support
- Pregnancy Prevention
- Remote Patient Monitoring and Store-and-Forward Policy

A more detailed description and requirements of these programs are listed below. We invite you to visit our website or contact our care coordination team, if you have questions, need additional information, or if you need assistance coordinating these benefits for our enrollees.

9.4.4 Remote Health Monitoring

The Plan offers remote patient monitoring for those enrollees who meet the criteria for enrollment. Enrollees with a diagnosis of COPD or Asthma may be eligible to participate, if they meet the following criteria:

- COPD Diagnosis and the following:
    - Home Oxygen Use,
    - Daily Nebulizer Use,
    - Red Risk Score for Readmissions,
    - COPD DX plus HTN DX,

    - COPD DX plus two or more medications, or
    - COPD DX plus a BMI greater than or equal to 30
- Asthma Diagnosis and the following:
    - Rescue and Maintenance Inhalers,
    - Daily Nebulizer Use,
    - Red Risk Score for Readmissions,
    - 1 or More Dose of Steroids or Antibiotics in the Past 6 Months,
    - Asthma DX plus HTN DX,
    - Asthma DX plus two or more medications, or
    - Asthma DX plus a BMI greater than or equal to 30
- Exclusion Criteria:
    - Enrollee is physically/cognitively unable to participate and has no caregiver to assist
    - Home environment is not conducive for home monitoring
    - Enrollee/caregiver refuses to participate
    - Enrollee weight exceeds scale limit of 440 pounds (consider eligibility for other monitoring)

Eligible enrollees are assigned a Program Coordinator and/or a Care Advisor to guide them through the program and coordinate their program progression with the PCP or ordering physician. Should you want to refer an enrollee for inclusion in a remote monitoring program, please contact our Care Management team at <<Insert Care Coordination telephone number>>

9.4.5 Care Coordination: Early Intervention Services

The Plan's associates are trained to identify and facilitate referrals for enrollees in need of access to early intervention services. The Plan's care coordination team collaborates and coordinates with the enrollee's Primary Care Physician (PCP) to facilitate referrals to early intervention services that include the local Early Steps program.

The plan covers early intervention services including screening and evaluation services, and individual and group sessions. The plan participates in MDT meetings upon notification from the Early Steps provider and supports development of the Individualized Family Support Plan (IFSP) in collaboration with the treatment providers.

9.4.6 Domestic Violence Reporting, Prevention and Support Services

The Plan requires you to report all instances of domestic violence to the appropriate state agencies. If you have reason to suspect a child, adult or elderly person has been harmed, abused, or neglected in any way, you must file a report immediately. Please contact the Florida Protection Report Center at 1-800-962-2873 (1-800-96-ABUSE). You can also file a report with your local law enforcement agency. The Plan offers annual Domestic Violence screening training to all contracted providers to include Primary Care Providers (PCP). We require providers to screen all enrollees for signs of domestic

violence and offer referral services to applicable domestic violence prevention community agencies. The Plan's care management team can help you educate enrollees on available community resources and supports for victims of domestic violence. Should you need to refer an enrollee for The Plan to coordinate community-based resources for domestic violence, please contact our Care Management team.

9.4.7 Healthy Start Referrals

The Plan requires providers to offer the Healthy Start Risk Prenatal Risk Screening to each pregnant enrollee as a part of the enrollees first prenatal visit. Plan providers must perform the Healthy Start Prenatal Risk Screening Tool as part of the initial prenatal visit. Providers are required to:

- Maintain a copy of the completed Healthy Start Prenatal Risk Screening Tool in the enrollee's medical record
- Provide the enrollee with a copy of the completed Healthy Start Prenatal Risk Screening Tool
- Submit a copy of the completed Healthy Start Prenatal Risk Screening Tool to the County Health Department (CHD) in the county where the prenatal screen was completed within 10 days of completing the screen

In addition, The Plan requires hospitals to electronically file the Healthy Start Postnatal Risk Screening Certification of Live Birth with the CHD in the county of birth within (5) business days of the birth.

For birthing facilities not participating in the Department of Health Birth Registration System, all required birth information must be filed with the CHD within (5) business days of birth. It is also required that you maintain a copy of the Healthy Start Postnatal Risk Screening in the enrollee's medical record and provide the enrollee with a copy of the completed Postnatal Risk Screen.

For all prenatal and postpartum enrollees and their infants who test HBsAg-positive, Plan providers are required to complete and submit a Practitioner Disease Report Form (DH Form 2136) to the Perinatal Hepatitis B Prevention Coordinator at the local CHD.

9.4.8 Maternity Care Support

The Maternity Care and other related pregnancy programs are aimed at promoting early prenatal care to decrease infant mortality, low birth weight, preterm deliveries, decrease cesarean section rates and enhance healthy birth outcomes.

Providers are required to supply voluntary family planning, including a discussion of all methods of contraception, as appropriate, and provide all women of childbearing age HIV counseling and offer HIV testing.

Additionally, it is the responsibility of the provider, who is managing the enrollee's pregnancy to complete and submit the initial assessment and notification of pregnancy (NOP) to the Plan. The assessment should include, the enrollee's medical and obstetric history and any care management needs that were identified during the initial prenatal visit.

Our Maternity Care Management Team can assist you with enrollee referrals to appropriate community resources to include Healthy Start, WIC, and other community-based agencies, based on the needs of the enrollee.

9.4.9 Pregnancy Prevention

The Plan covers free family planning services for our enrollees. You can supply these services and supplies to enrollees and no authorization or referral is needed. The Plan also requires you to educate enrollees regarding the benefits of long-acting reversible contraceptives (LARCs). LARCs are methods of birth control that provide effective contraception for an extended period without requiring the user to take any additional action. They include injections, intrauterine devices (IUDs), and subdermal contraceptive implants.