

**Quality Improvement Program**

The Quality Improvement Program (QIP) is an ongoing, comprehensive and integrated system designed to actively initiate, monitor and evaluate standards of health care practice and infrastructures essential to the delivery of quality clinical care and service to members.

The goals of the program are:

- To develop and maintain a well-integrated system that continuously measures clinical and operational performance, identifies the need for and initiates meaningful corrective action when appropriate, and evaluates the result of actions taken to improve quality-of-care outcomes and service levels;
- To establish a mechanism for the safe, culturally sensitive delivery of health care that not only promotes efficient, appropriate and effective use of resources, but also supports the physician-patient relationship;
- To ensure access to and availability of qualified and competent providers;
- To engage members in managing, maintaining or improving their current state of health;
- To provide a forum for members, providers and various health care associations and community agencies to provide suggestions regarding the implementation of the Program; and
- To ensure compliance with standards as required by contract, regulatory statutes and accreditation agencies.

The Quality Improvement Committee is charged by the organization's Board of Directors with monitoring and evaluating the results of Program initiatives and initiating corrective action when the results are less than desired or when areas needing improvement are identified.

Current Program activities involving providers include but are not limited to:

- Reviewing member medical records;

- Reviewing provider office site(s);
- Reviewing member quality complaints and adverse, unexpected events;
- Reviewing office site accessibility and availability;
- Participating in quality improvement and utilization management activities, including applying clinical practice guidelines, as detailed by contract;
- Participating in focused performance improvement and disease management initiatives, as appropriate. Studies will also be conducted on the accessibility, availability, efficiency, safety, efficacy, appropriateness, effectiveness and continuity of patient care and services delivered by the health-care providers and Harmony; and
- Completion of the re-credentialing process.

The Quality Improvement Program incorporates ongoing screening of medical records to assure compliance with all regulatory and accreditation agency guidelines. Studies will also be conducted on the accessibility, availability, efficiency, safety, efficacy, appropriateness, effectiveness and continuity of patient care and services delivered by the health-care providers and the Plan itself.

When opportunities to improve patient care or documentation are present, a plan of action will be instituted. Providers may be asked to participate in formulating the plan of action, as collaborative input will provide the key for a workable solution.

The Quality Improvement department will assess the minimum guidelines of care and documentation required by regulatory agencies and accreditation organizations for medical record review, health screening and high-risk diagnoses on an ongoing basis. A Plan representative will make an appointment to review these items in the provider's office as necessary.

Upon completion of the review, providers will be provided

with a preliminary summary of findings during the exit meeting to outline deficiencies found during the review. The report will assist provider offices with making necessary corrections. If the Provider's aggregate score is less than 80 percent, a corrective action plan will be requested.

**Quality Improvement Participation**

Providers contracted with the Plan are required to participate in all quality improvement functions and tasks required by the Department of Social Services (DSS) and the Plan.

These activities may include, but are not limited to:

- Compliance with request for medical records for quality improvement studies and audits;
- Cooperation with quality improvement initiatives related to collaborative projects;
- Cooperation with efforts to improve care for chronic disease and/or preventive care measures;
- Compliance with requests for information and recommendations formulated by the Plan and the DSS, in the process of reviewing/resolving beneficiary and/or provider complaints;
- The Plan and DSS may also perform annual audits. Providers will be required to copy office records for these audits. It is very important that any time a copy of a record is requested the entire record is sent.

In addition to monitoring the guidelines in this manual, continuity of all patient care will be monitored (see the Medical Records Section). The results of all reviews are maintained in a Provider profile and utilized at the time of re-credentialing.

