
CHAPTER 6 – QUALITY IMPROVEMENT AND ASSURANCE

Quality Improvement Program

Ultimately, the CHNCT Board of Directors has authority and responsibility for the overall quality of care and service provided to the HUSKY and Charter Oak member populations. The Board of Directors has designated the Quality Improvement Committee (QIC) as the body charged with development and direct oversight of the Quality Improvement (QI) Program. The QI Program addresses the quality of operations and programs in the following broad areas: subcontractor oversight, utilization management (including dental and pharmacy), care coordination, access to services, preventive health initiatives, disease management, and member and provider satisfaction. The Pharmacy and Therapeutics Committee and the Credentialing Subcommittee of the Board of Directors report their activities to the QIC as well.

Quality Improvement Committee (QIC)

The committee meets at least quarterly and is chaired by a clinician administrator from one of the FQHCs, who also sits on the CHNCT Board of Directors. The QIC is comprised of the following individuals:

- Clinicians and administrators from CHNCT's primary care sites
- Behavioral health provider
- CHNCT President and CEO
- CHNCT Vice President, Operations
- CHNCT Vice President, Medical Director
- CHNCT Director, Quality Improvement
- CHNCT Director, Provider Relations
- CHNCT Vice-President, Health Services
- CHNCT Director, Care Management

The role of the QIC is to oversee the quality management and quality improvement activities conducted at CHNCT, through the following functions:

- Annual review and development of the Quality Improvement Program and Work Plan
- Semiannual review of Quality Improvement Performance Reports
- Review and oversight of the activities of the Credentialing Subcommittee
- Review and oversight of the activities of the Pharmacy and Therapeutics Committee
- Review of Utilization Management performance data
- Review of member and provider satisfaction data
- Feedback to network providers about quality initiatives and performance on utilization and quality indicators
- Development of provider- and site-specific performance measures
- Identification of quality improvement initiatives (clinical and non-clinical)

Preventive Health and Clinical Quality Practice Guidelines

CHNCT adopts and disseminates preventive health and clinical practice guidelines to promote compliance with broadly-accepted preventive health and clinical practice standards of care. These include primary care guidelines for children and adults as well as for pregnant members, and are

based on nationally recognized standards as published by various professional organizations and on guidelines as set forth by the Connecticut Department of Social services for the HUSKY Program. Selected preventive health and clinical guidelines are reviewed, amended as indicated, and formally adopted by CHNCT's Clinical Quality Committee on a regular basis.

Please refer to the clinical guidelines posted on CHNCT's web-site.

Office and Facility Requirements

On-site office and facility evaluations are necessary to ensure that all CHNCT service delivery locations comply with defined standards and that each location is a safe, sanitary, and an accessible place in which to deliver health care services to all members. The visit also affords an opportunity for CHNCT staff to interact with the provider and the provider's office associates, to explain the workings of CHNCT's programs. The Quality Improvement staff uses on-site review tools and standards to evaluate a provider's office. For a provider to be considered as a CHNCT participant, all office areas must be compliant with the "conditions of participation". Offices that are found to be "marginally acceptable" receive a follow-up visit within 90 days of the original evaluation. CHNCT reserves the right to cancel a provider participation contract if office conditions do not meet CHNCT's defined standards after notice of required corrective action has been provided.

Medical Records Standards

Comprehensive and accurate medical records are necessary to ensure quality and continuity of care provided to HUSKY members. Each provider must maintain, and make available, medical records, in accordance with their HUSKY provider participation agreement with CHNCT. All entries in the medical record should be compiled systematically and filed in chronological order so that information is easily found. Each HUSKY patient's medical record must include the following information:

- 1. Patient Identification:** Each page of the record shall contain the patient's name or identification number.
- 2. Personal Information:** Each chart shall include the patient's full name, date of birth, address, employer, home and work telephone numbers and marital status.
- 3. Identification of Author:** All entries shall contain the author's identification, which may be handwritten, stamped and initialed, or a unique electronic identifier.
- 4. Entry Date:** All entries shall be dated.
- 5. Legibility:** The record shall be legible to someone other than the writer.
- 6. Problem List:** The chart shall contain a current problem list with significant medical conditions and illnesses noted. The chart shall also contain evidence that problems from previous visits have been addressed.
- 7. Allergies:** Allergies are prominently noted on the record. If the patient has no known allergies, this is noted in the record.
- 8. Immunizations:** A current immunization record shall be present for each pediatric patient.
- 9. Hospitalizations:** Each record shall contain summaries of hospitalizations, surgical reports and emergency room visits, if applicable. Discharge summaries shall also be included in each record.
- 10. Past Medical History:** Medical history shall be documented for each patient seen more than three times. Medical history documentation includes serious illnesses, accidents, and operations.
- 11. History and Physical Exam:** The chief complaint and history of the present illness shall be documented (vital signs appropriate to age and chief complaint). Physical findings are documented.

- 12. Risk Factors:** Risk factors shall be documented at physical examination visits (smoking, alcohol, home firearms, safety, substance abuse, domestic violence and child abuse/ neglect).
- 13. Diagnosis and Treatment:** A working diagnosis or assessment shall be noted and a treatment plan shall be described.
- 14. Tests and Reports:** All ordered diagnostic tests shall be noted in the chart. There shall be evidence (note, signature or initials) that a physician has reviewed test results and there shall be evidence of abnormal test result follow-up.
- 15. Follow-up:** Planned follow-up shall be documented. The specific time of return shall be noted in weeks, months or as needed. Patient phone calls and patient instructions shall be documented.
- 16. Prescriptions:** New prescriptions and refills shall be documented in the chart: drug name, dose and quantity shall be noted.
- 17. Ancillary Services:** There shall be documentation of referrals to specialists and notations of the specialist's findings and recommendations.
- 18. Non-Compliance Issues:** Member no-shows and other non-compliance issues shall be noted in the record and a plan for patient contact shall be documented.

Confidentiality of Medical Records

The relationship and the communication between provider and patient are privileged; therefore, the medical records containing information about that relationship are confidential. The physician's code of ethics, Connecticut and Federal laws and Federal regulations such as the Health Insurance Portability and Accountability Acts' (HIPAA's) Privacy Rule, protect against the disclosure of the contents of medical records to persons or agencies who are not properly authorized to receive such information. Providers may release a patient's health information without an authorization form for purposes of treating the patient, billing for treatment provided, certain health care operation activities and certain government oversight functions. For the provider to release the contents of a patient's medical record to a third party in all other situations, the patient must first authorize the disclosure by completing and signing an authorization form. In the case of minors or the infirm, a parent, guardian or legal representative must authorize the release. Family planning, HIV, behavioral health and substance abuse treatment information must be treated with particular sensitivity to confidentiality, and may be released only by the patient, even if the patient is a minor. (Consult your malpractice carrier for specific circumstances.) If the record is for a deceased individual, the executor of the estate must authorize the release.

To further assure members' privacy, CHNCT restricts access to a patient's health information to that which is the minimum necessary for an employee to perform his or her specific duties. Access to a patient's medical record will be given only to those employees who would require access as part of their daily work, such as medical record personnel and health professionals inside CHNCT who are directly involved in the delivery or evaluation of that patient's care. All requests for medical records information must be handled according to this policy.

Termination of a Practitioner

CHNCT contractually has the right to terminate, suspend or restrict a practitioner's participation in CHNCT's provider network upon determination that the practitioner does not meet CHNCT's credentialing standards or has breached any contractual obligations. The practitioner shall have ten (10) business days after such notice to cure such failure or breach to the satisfaction of CHNCT.