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INTRODUCTION

This section of the Provider Manual describes Quality Management activities, procedures, and functions.

Quality Management Department Contacts

Member Services Coordinator	(408) 937 - 3642
Quality Management Manager	(408) 937 - 3628
Utilization Management Manager	(408) 937 - 3628

Quality Management Department Fax: (408) 937 - 3637

QUALITY MANAGEMENT PROGRAM OVERVIEW

Purpose

The IPA is committed to delivering high quality and affordable health care to its members. Dedicated physicians and office staff provide personal and individualized care with special sensitivity to cultural needs.

In order to assist the individual providers in meeting these commitments, the Quality Management Program was developed to help meet and/or exceed health plan local, state, federal and national managed care standards. NCQA standards and tools provided by the National Committee for Quality Assurance (NCQA) and the health plans are incorporated in order to support these goals. EXCEL is contracted by the IPA to provide services in order to support and administer these functions.

Objectives

- Improve the quality of care and services provided to members by measuring outcomes and satisfaction to continuously improve all aspects of the applicable healthcare continuum
- Develop and maintain an ongoing monitoring system to detect problems of quality of care or service with individuals or systems encountered by members of the IPA
- Develop, implement, and evaluate corrective action plans when deficiencies have been identified
- Identify, implement and assess quality improvement initiatives in the areas of quality of care, service and member safety
- Incorporate internal and external regulatory standards related to quality improvement activities

- Utilize results from practitioner performance issues which are obtained from a variety of sources: quality of care and service issues reported during the appeal and grievance process, quality indicators, and audit/survey studies conducted throughout the year for credentialing, recredentialing and contracting of health care providers and facilities
- Design and maintain a quality management process that supports continuous quality improvement using the cyclical methodology of planning, doing, studying, and acting
- Pursue opportunities for improvement in the health status of the enrolled population by referring them to programs that include preventative care services, health promotion, and health education
- Pursue opportunities for improvement by measuring member satisfaction with providers, identifying and addressing sources of dissatisfaction through analysis of member complaint data, primary care physician changes by members and other focused surveys as needed
- Establish clinical and service indicators that reflect the demographic characteristics of the membership population
- Ensure quality management activities are linked and coordinated with other services including utilization management, claims, credentialing and recredentialing
- Develop a work plan at the beginning of the year that includes a schedule of activities for the coming year with measurable objectives and monitoring of previously identified issues
- Evaluate annually the effectiveness of the previous year's quality management program, activities and interventions
- Maintain and enforce a Conflict of Interest and Confidentiality policy for the protection of peer review activities and confidential information of members and providers
- Respect each members' rights, dignity and individual needs regardless of race, gender, socioeconomic level or sexual orientation

QUALITY MANAGEMENT

Scope

The scope of Physicians Medical Group's (PMG) Quality Management Program includes the entire spectrum of contracted providers, enrolled members, Committee members, and administrative staff of EXCEL. It encompasses the demography of the member population in terms of age groups, disease categories, those with special risk status and specific cultural needs.

The Quality Management Program addresses:

- A. Aspects of both medical care and service
- B. Continuum of care issues
- C. Sentinel Events
 - Admissions due to complications resulting from outpatient surgery or procedures
 - Admissions within 48 hours after an emergency room visit
 - Admissions within 30 days of a prior admission
 - Admissions with a diagnosis of asthma
 - Accident, injury, and falls during a stay at an acute or skilled nursing facility.
 - Decubiti
 - All deaths
 - Return to surgery as a result of a previous operation
 - Infection after invasive procedure or surgery
 - Surgery on normal organ, body part or tissue
- D. Member complaints, grievances, and appeals
- E. Provider access/availability
- F. Coordination of care obstacles
- G. Preventative health care education referrals
- H. Member satisfaction and dissatisfaction
- I. Provider satisfaction and dissatisfaction
- J. Medical record audit results

Authority and Responsibilities

The **Board of Directors** of Physicians Medical Group, through the Quality Management Committee, has the ultimate responsibility and authority for the quality of care and service delivered by member providers. The Board reviews and approves the Quality Management Program and the Quality Management Annual Work Plan on an annual basis.

The **Quality Management Committee** reports directly to the Board of Directors. The Quality Management Committee has primary responsibility for overseeing the implementation of the Quality Management Program and the Quality Management Annual Work Plan. The Quality Management Committee recommends policy decisions, reviews and evaluates the results of quality management activities, recommends corrective action plans and ensures that implemented plans are effective.

The Committee is interdisciplinary, with membership appointed by the Board of Directors in accordance with the bylaws. A Physicians Medical Group physician appointed by the Board of Directors chairs the Committee. There are five members in the Quality Management Committee which include network physicians from Primary Care, as well as specialty physicians. A quorum is achieved with three member Physicians present. EXCEL staff are non-voting participants. The QMC members are appointed annually to assure broad representation and may be re-appointed at the discretion of the Board. Health Plan Medical Directors or their designees may attend meetings with prior notification, and sign a confidentiality statement.

The Committee is scheduled to meet every other month.

Issues that arise prior to a scheduled meeting requiring immediate action will be taken directly to the EXCEL Chief Medical Officer for review, who may refer to the Clinical Medical Director or call an ad hoc Quality Management Committee quorum. Operation of the Committee is by simple majority. No committee member shall vote on any case in which he/she is personally involved. The composition and number of voting members required for a quorum shall consist of three. Only IPA Quality Management Committee Physicians have voting rights. Active participation on the Committee includes consistent meeting attendance, involvement in discussions of agenda items, analyzing results, and assisting in follow-up and problem resolution.

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EXCEL MSO, LLC ADMINISTRATIVE STRUCTURE

EXCEL MSO, LLC (EXCEL) is contracted by the IPA to provide administrative services in order to carry out necessary quality management functions.

Chief Executive Officer

- EXCEL's Chief Executive Officer (CEO) has organizational responsibility for the Quality Management Department and ensures adequate resources and qualified staffing in order to execute the quality management functions.
- The CEO reports to the Physicians Medical Group Board of Directors.

Chief Medical Officer

- The Chief Medical Officer for EXCEL is responsible for the daily oversight of quality management activities including complaints, appeals, and grievances.
- The Chief Medical Officer reports to the CEO of EXCEL as well as the Quality Management Committee, the President and the Board of Directors.

Quality Management Manager

- Reports directly to EXCEL's Chief Medical Officer.
- Works in concert with and under guidance from the Chief Medical Officer.
- Directs, coordinates and manages ongoing daily activities of the Quality Management Program.
- Plans, organizes and implements quality improvement projects throughout the network.
- Ensures the Quality Management Program complies with health plan, state, federal and regulatory standards.

EXCEL MSO, LLC Administrative Structure (continued)

Quality and Member Services Coordinator

- Reports directly to the Quality Management Manager.
- Answers member inquiries and assists with resolutions.
- Documents member complaints or grievances if received by telephone.
- Assists with Quality Management studies and surveys as assigned.

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QUALITY MANAGEMENT COMMITTEE

1. Evaluates and approves reports sent to the Board of Directors.
2. Review the results of annual health plan audits and evaluates any need for actions that arise from the results.
3. Provides quarterly reports with an annual evaluation to the Board of Directors and the health plans according to the health plan contracts. A standardized format is used for reporting.
4. Ensures that the information and findings of studies, surveys and audits are used to detect trends, patterns of performance or potential problems and that corrective action plans are implemented. It ensures that necessary information is communicated to the relevant providers, departments, or institutions when problems or opportunities to improve care and/or service are identified.
5. Identifies findings appropriate for inclusion in provider quality files that are reviewed at the time of Recredentialing. The Committee may choose to send information to the Credentialing committee prior to reappointment, according to its discretion.
6. Maintains active responsibility for overseeing contracted member health promotion and education programs.

Committee Responsibilities

1. Identify quality improvement activities that should be implemented.
2. Analyze the results of quality management activities to determine if there are opportunities for improvement.
3. Ensure overall program effectiveness by evaluating the administration of the program throughout all service areas.
4. Review the Quality Management Program and Workplan on an annual basis and provide suggestions for inclusion of activities.
 5. Review, modify, and approve all quarterly reports and the annual evaluation.

Committee Responsibilities (continued)

6. Review, modify and approve:
 - Policies and procedures
 - Activities and reports
 - Standards for over and under utilization
 - Potential quality or risk management issues
 - Opportunities to improve care
 - Integration of quality management and utilization management activities
 - Preventive health guidelines
7. Recommends policy decisions; reviews and evaluates the results of quality improvement activities; initiates necessary program improvement and oversees corrective actions when needed.
8. The Committee is responsible for the approval of Preventive Health Guidelines and clinical practice guidelines based on scientific evidence. Methods are implemented to communicate the guidelines to providers when approved.
9. Ensures that the information and findings of quality management activities are used to detect trends, patterns of performance or potential problems, and to develop and implement corrective action plans. The Committee ensures that necessary information is communicated to recommended departments, committees or institutions when problems or opportunities to improve care and/or service are ascertained.
10. Reviewing complaints and grievances on issues of quality of care and service. After analyzing findings pertinent to the review, the Committee recommends actions and formulates a corrective action plan. The Committee may also decide to obtain a second opinion or specialty review.
11. Allocates resources to activities that will have the greatest potential impact on improving the quality of care and service provided to members, employers and providers.

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12. Reviews potential quality of care and quality of service issues referred from the Utilization Management Committee and Credentialing Committee.

Committee Minutes

A standardized agenda and minutes format is used for all meetings. Minutes are taken during the meeting to reflect all Committee activities, decisions and actions. Approved agendas and minutes of the Quality Management Committee are kept in a confidential manner at EXCEL's offices. A copy of the approved minutes is forwarded to the following Board of Directors meeting.

Minutes of the Quality Management Committee meeting shall include—but are not limited to the following subjects:

- Discussion of Quality Management Program issues
- Practitioner behavior
- Selection of important aspects of care and performance measures to monitor and evaluate
- Analyses of results of satisfaction surveys
- Analyses of results of quality accessibility, availability, and medical record audits
- Evaluation of quality of care and quality of service issues as well as of the results from corrective actions taken

To ensure follow-up on all agenda items, issues are carried on the agenda until resolved. The finalized minutes are reviewed by the Committee Chairperson and are submitted to the Quality Management Committee for approval at the next scheduled meeting. Minutes will reflect review, changes if necessary, and approval by the Committee.

Quality Management Activities

Standing annual activities included in the Quality Management Program include:

1. Access audits (e.g. a member's ability to receive an appointment with a provider within a specified time frame, depending on the type of appointment, as per IPA policy and procedure).
2. Availability audits (e.g. a member's ability to contact a provider according to protocols per IPA policy and procedure).
3. Office Waiting Time audits (e.g. members not waiting more than 30 minutes on the average per provider for their scheduled appointments) per IPA policy and procedure.
4. Member Satisfaction Survey results from CCAS.
5. Provider Satisfaction Survey (see IPA policy and procedure).
6. Ongoing quality of care and case reviews per policy and procedure.
7. Medical record audits as per criteria identified in policy and procedure.
8. Additional activities identified throughout the year.

Quality Management Annual Work Plan

The Quality Management Annual Work Plan is developed and implemented in order to assist in achieving the above goals in a manner that is organized, systematic and ongoing. The basic method of planning, doing, studying the results and implementing needed improvements is the approach that best supports quality management and quality improvement activities.

The Quality Management Annual Work Plan will include the following elements in its structure:

- Measurable objectives for all projects and activities.
- Name of person accountable for each activity.
- Time frame for completion for each activity.
- Monitoring of previously identified changes, issues and corrective actions.
- Scheduled date for program project and activity re-evaluation.

COORDINATION OF UM AND QM FUNCTIONS

The Utilization Management (UM) Program along with the Utilization Management (UM) Committee, with its emphasis on medical service utilization management, and the Quality Management (QM) Program which focuses on the concepts of quality management and continuous quality improvement, work in conjunction with each other. The IPA has created linkages between the two programs through committee structures and processes.

Defined potential quality issues are identified by all departments and committees. The UM department and the Quality Management Committee uses the established referral process of case management and concurrent review to refer any sentinel events and potential quality issues for review by the QM Department. Similarly, any potential UM issues identified by the QM Department are referred to the UM Department and UMC for review. The issues are investigated and reviewed by the respective departments and committees when corrective actions may be recommended. The UM and QM Committees provide an environment to ensure that each program is functioning in concert with the other.

The **Quality Management Process** includes ongoing evaluation of the overall effectiveness of the Quality Management Program. Actions are taken to implement the appropriate changes that demonstrate improvement in the quality of clinical care or service to members and providers. The process is implemented on a continuous basis with re-evaluation and subsequent corrective actions addressed. Elements of this process are:

Identification	Select an area for potential improvement
Measure	Satisfaction and other surveys if approved
	Audit against standards (e.g. access, availability, guideline, etc.) Outcome
Act	Implement corrective actions or improvement activities
Reassess	Re-measure to identify the effectiveness of the improvement activities.

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The **quality management process** is integrated across all departments. Key indicators of clinical and service quality that reflect the needs of members, providers, and health plans have been developed. Standards, goals, guidelines, or benchmarks will be defined for each indicator. Action plans are implemented and monitored to address those areas that fall below the indicated standards.

Annual Quality Management Program Evaluation

The Quality Management Committee provides an annual evaluation of the effectiveness of the Quality Management Program and Work Plan activities to the Board of Directors. The report includes:

- Progress made on achieving goals of the Program.
- Summary and trending of monitoring and evaluation activities.
- Special studies and reports.
- Follow-up actions taken on previous studies and reports.
- Effectiveness of those actions and demonstrated improvement in the quality of care and service provided.
- Descriptions of how the network has changed as a result of quality management activities.
- Suggestions for activities to be included in the program.

The report makes recommendations on future quality management activities, Work Plan revisions and changes to the overall Program. The report may include graphs, charts and narrative that emphasizes key findings and results. The Board of Directors may approve the recommendations and report or may make independent recommendations.

CONFIDENTIALITY

All members of the Quality Management Committee shall be required to sign a confidentiality statement at least annually. The confidentiality agreement will be kept on file at the offices of EXCEL. All Quality Management Committee records and proceedings are confidential and protected as provided by Section 1157 of the California Evidence Code, whether or not marked: “Confidential and protected as defined by Section 1157 of the California Evidence Code”. Signed minutes are maintained in a locked file at EXCEL offices, available only to authorized persons.

Quality Management Committee minutes and documents may be reviewed by authorized health plan representatives. However, no copies will be provided and confidentiality of the information will be preserved.

QUALITY MANAGEMENT

MEMBER RIGHTS AND RESPONSIBILITIES

IPA participating providers and members will abide by the rights and associated responsibilities of the members in the process of health care service delivery.

Member information will be well-designed, comprehensible, and written in languages that represent the major population groups served by the IPA.

Members have the right to:

- Make recommendations regarding the IPA's member's rights and responsibilities policies.
- Receive information about the IPA, its services, its practitioners and providers, and member's rights and responsibilities.

Goals

To ensure that the most appropriate cost-effective care is comprehensively provided by the IPA providers in the network, and that the care is responsibly received by the IPA members.

All IPA providers and members will be provided with a copy of the Member's Rights and Responsibilities Policy. The providers and members also will be notified of revisions or updates in these documented rights and responsibilities.

Member Rights Policy

The IPA member has the right to:

1. Exercise these rights without regard to gender, sexual orientation, or cultural, economic, educational, or religious background.
2. Be provided with comprehensible information about the IPA, its services, providers and the health care service delivery process. This information includes instructions on how to obtain care with various providers and at varied facilities (e.g., primary care, specialty care, behavioral health services, and hospital services.) Additionally, information will be included on how to obtain services outside the IPA system or service area.
3. Be informed of emergent and non-emergent benefit coverage and cost of care, and receive an explanation of the member's financial obligations as appropriate, prior to incurring the expense (including co-payments, deductibles, and co-insurance).
4. Be provided with information on how to obtain care after normal office hours and how to obtain emergency care including when to directly access emergency care or use 911 services.
5. Be informed of the name and qualifications of the physician who has primary responsibility for coordinating the member's care; and be informed of the names, qualifications, and specialties of other physicians and non-physicians who are involved in the member's care.
6. Have 24-hour access to their primary care physician (or covering physician).
7. Receive complete information about the diagnosis, proposed course of treatment or procedure, alternate courses of treatment or non-treatment, the clinical risks involved in each, and prospects for recovery in terms that are understandable to the member, in order to give informed consent or to refuse that course of treatment.
8. Candidly discuss appropriate or medically necessary treatment options for the member's condition, regardless of cost or benefit coverage.

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9. Actively participate in decisions regarding the member's health care and treatment plan. To the extent permitted by law, this includes the right to refuse any procedure or treatment. If the recommended procedure or treatment is refused, an explanation will be given addressing the effect that this will have on the member's health.
10. Be treated with respect and recognition of their dignity and right to privacy. Receive considerate and respectful care with full consideration of the member's privacy.
11. Receive confidential treatment of all member information and records used for any purpose.
12. Be afforded the opportunity to consent or deny the release of identifiable medical or other information except when such release is required by law. This activity includes nonmember-identifiable data shared with employers
13. Express opinions or concerns about the IPA or the care provided and offer recommendations for change in the health care service delivery process by contacting the IPA Member Services Department.
14. Be informed of the member complaint/grievance and appeal process. Be able to express a complaint, grievance, or appeal in writing or by phone.
15. May be offered the opportunity to be represented by someone of their choosing at any level of appeal and at a minimum the opportunity for representation, including an attorney, at the second level of appeal.
16. Review of first or second level appeal of a clinical issue by at least one *actively* participating practitioner from the same or a similar specialty who typically treats the medical condition or provides the procedure or treatment in question.(NCQA considers a practitioner "actively participating" if he or she provides direct member care)
17. Be informed of the availability of providers, termination of a primary care provider or practice site and receive assistance in selecting a new primary care provider or site in this situation.
18. Change primary care physicians by contacting the Member Services Department of health plan.

19. Be provided with information on potential health plan restrictions incorporated in the operational procedures, how the IPA implements new technology for inclusion as a covered benefit.
20. Receive reasonable continuity and coordination of care and be given timely and sensible responses to questions and requests made for service, care, covered benefits, non-covered services, and payment (including complaints and appeals).
21. Be informed of continuing health care requirements following office visits, treatments, procedures, and hospitalizations.
22. Have all member rights apply to the person who has the legal responsibility to make health care decisions for the member.

Members have the right to be represented by parents, guardians, family members or other conservators for those who are unable to fully participate in their treatment decisions.

Member Responsibilities

Each IPA Member has the responsibility to:

1. Be familiar with his/her benefits and exclusions of their health plan coverage.
2. Provide his/her provider with complete and accurate information, which is necessary for their care (to the extent possible).
3. Be on time for all appointments and notify the provider's office as far in advance as possible for appointment cancellation or rescheduling.
4. Report changes in his/her condition according to provider instructions.
5. Inform provider(s) of his/her inability to understand the information given.
6. Carry out the treatment plan, which has been developed and agreed upon by the health care provider and the member.
7. Contact his/her Primary Care Physician (or covering physician) for any care he or she needs after that physician's normal office hours.
8. Treat the health care providers and staff with respect.
9. Obtain an authorized referral from his/her Primary Care Physician for a visit to a specialist and/or to receive any specialty care.
10. Be familiar and comply with the IPA's health care service delivery system regarding access to routine, urgent, and emergent care.
11. Contact the IPA Member Services Department or his/her Health Plan Member Services Department regarding any questions or assistance.
12. Respect the rights, property, and environment of all physicians and IPA providers, staff and other members.

13. Be responsible to notify the health plan Member Services Department and the Primary Care/treating Physician, when there is a change in address and/or contact information.

All of these responsibilities apply to the person who has the legal responsibility to make health care decisions for the member.

MEDICAL RECORDS DOCUMENTATION STANDARDS

Medical Record Keeping Standards

The IPA has established the following medical record keeping standards to facilitate confidentiality of member information and availability of medical records appropriate to the practice site. Medical records must be maintained in a manner that is current, detailed and organized, and permits effective and confidential member care, and quality review. Available and accessible medical records also allow Practitioners to access information that is required for effective and continuous patient care.

In order to standardize medical records kept by all Medical Group Providers, providers shall maintain medical records in accordance with the current National Committee for Quality Assurance (NCQA) and established by the Quality Management Committees of the Health Plans. Medical records may be selected evaluation as part of the annual delegation oversight assessment.

Providers of the IPA shall have a written policy in place that provides for the protection of confidential member health information in accordance with the Health Information Portability and Accountability Act (HIPAA). This policy must include a mechanism for safeguarding records and information, kept in either hard copy or electronic format, against loss, destruction, tampering, and unauthorized access or use.

Key standards include:

- Availability and Accessibility
- Confidential Member Information
- Medical Record Documentation
- Medical Record Organization and Availability of Medical Records

Medical Record Documentation Standards (continued)

It is strongly recommended that the medical records shall be filed using a systematic method for easy retrieval, such as alphabetical or numerical filing and color-coding.

1. The medical record system must allow for prompt retrieval of medical records and availability to the provider at each member encounter.
2. The medical record system must allow for the tracking of the record when it is out of the filing system and must have a system for the incorporation of information in the chart between visits.
3. Medical records will be inaccessible to unauthorized persons and will be maintained to guard against unauthorized disclosure of confidential information and will protect confidentiality.
4. All medical records and member information shall be stored in an anonymous manner and / or disposed of in a manner that continues to protect confidentiality. Any medical record / member information will be disposed of or destroyed in a way such that information is not identifiable (e.g., shredded), when it is no longer in use, unless it is retained for regulatory purposes
5. There must be a system, as well, for the archiving of purged data, (e.g., marking records by the date that they are to be destroyed based on state and federal retention regulations.).
6. There is a medical record for each member seen by an IPA contracted provider.
7. The medical record pages are filed in a standard logical format. All pages in the record will be securely anchored and all pages will be filed chronologically.

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8. Each page in the record contains the member's name or identification number for identification.
9. Personal/biographical and demographic data includes age, sex, address, employer, telephone numbers, marital status, and is updated as appropriate.
10. A copy of a *Consent to Treat Form* is maintained in the medical record.
11. The medical record will document all aspects of member care, including use of ancillary services.
12. All entries are dated.
13. The author of all entries is identified. All entries in the medical record contain the author's identification, which may be in the form of a handwritten signature, unique identifier, or initials.
14. The records are legible (to someone other than the author), documented accurately, and in a timely manner.
15. Medication allergies and adverse reactions are prominently noted on the front of the record. Absence of allergies (no known allergies or NKA) is noted if the member has no allergies.
16. Past medical history is recorded and easily identified, including serious accidents, operations, and illnesses. For children and adolescents (age 18 and younger), past medical history also includes birth information and mother's prenatal care, any operations, and childhood illnesses.
17. A record of immunizations is documented for all age groups. For immunizations, the lot number, date, time, site, and education given to parents / members must be documented.

18. For Pediatric records (age 12 and under), there is a completed immunization record, plotted growth charts and documentation of neurological milestones.
19. For members 14 years and older, there must be a notation concerning depression, violence, the use of cigarettes, alcohol/substances, and anticipatory guidance.
20. All medications currently used must be listed. Medications prescribed must list name, dosage, frequency, and duration. Medications given on-site must list name, dosage, and site given.
21. Identification of current problems and significant illnesses, medical conditions, and health maintenance concerns are identified in the medical record, as well as a problem list.
22. The reason for the visit is noted, i.e., the chief complaint(s).
23. A history and physical examination identifies appropriate subjective and objective information pertinent to the members' presenting complaints.
24. Appropriate vital signs are documented at each visit.
25. Diagnostic information and a plan of treatment for each visit are to be documented.
26. Treatments, procedures, and tests, including results are to be documented and consistent with diagnosis.
27. There are specific follow-up notes and dates for a return visit or other follow-up plan for each encounter. The specific time of return is noted in weeks, months, or as needed.
28. Unresolved problems from previous office visits are addressed in subsequent visits.
29. There is review for under or over-utilization of consultants.

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30. Referrals to specialty consultants and/or ancillary services are documented.
31. If a consult is requested, there is a note from the consultant in the record.

32. Laboratory and other studies are ordered, as appropriate. Consultation, lab, and imaging reports filed in the chart are to be signed or initialed by the provider signifying review (review and signature by professionals other than the ordering practitioner do not meet this requirement). If the reports are presented electronically or by some other method, there is representation of review by the ordering practitioner. Consultation and abnormal lab and/or imaging results have an explicit notation in the record for follow-up plans.
33. Discharge summaries, emergency department reports, specialty consultation reports, and specialty follow-up care notes must reflect the provider's review. The documents are to be filed in the chart within two weeks of service.
34. There must be evidence that failed appointments are followed-up.
35. Member health education, recommendations, instructions, and referrals are to be documented.
36. Preventive services are evident and are appropriately used.
37. There is documentation of whether the member has executed an Advance Directive, or a notation that the information about Advance Directives was offered / given to the member as required by Federal Law.

Advance Directive is a written instruction, such as a living will or durable power of attorney, for health care relating to the provision of health care when the individual is incapacitated.

A copy of the Advance Directives Form and a description in English and Spanish is included in the Appendix of this section.

38. If appropriate, a human sterilization consent form (PM330) is filed in the medical record.

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39. Initial health assessments and Child Health and Disability (CHDP) screenings must be documented.
40. A copy of the CHDP PM 160 Form will be placed in the medical record (CHDP Providers only).
41. The Health Behavior Risk Assessment will be completed for each member during the first appointment with the Primary Care Physician.
42. An initial health assessment will be performed and documented in the medical record within the first 120 days of membership for all Medi-Cal Managed Care members.
43. Standardized forms for documenting prenatal care will be used. Forms include documentation of medical, psychosocial, nutritional, and educational assessments, interventions, and referrals for prenatal services (Comprehensive Perinatal Services Program [CPSP] Providers only).
44. Medi-Cal members being seen by a non-CPSP provider, who do not wish to be referred, need to be provided with the same level of services (CPSP – like Services) that follow CPSP guidelines.
45. Adult and emancipated minor medical records must be stored for seven years (7) following the last encounter. Non-emancipated minor medical records must be stored until at least one year after the member reaches the age of eighteen (18), but at least seven years following the last encounter. (Section 70751(c) of Title 22 of the California Code of Regulations).

Medical Record Release and Confidentiality

Member information and records must be protected for confidentiality according to the Confidentiality of Medical Information Act, which prohibits a health care provider from disclosing any individually identifiable information regarding a member's medical history, mental or physical condition, or treatment without the member's consent or specific legal authority.

Medical records are released under the following conditions:

- a. Member, attorneys, or representatives of the member or attorney receive a copy of the medical records only after presenting a signed authorization from the member or his/her legal representative. The member presents identification when requesting a copy of their medical record. With member authorization, outside health care providers, Federal, State, County, or City agencies, employers, insurance companies or their representative may also receive a copy of the member's record.
- b. With a subpoena, an officer of the Federal, State, or municipal court has access to member records. Agencies such as the FDA or other authorities that comply with reporting requirements in Title 17 of the California Code of Regulations also may access confidential information.
- c. Any release of information in response to a court order or to other authorized persons is reported to the member within five (5) working days.
- d. Only assigned personnel responsible for the maintenance of medical records may provide written documents or copies of member records.
- e. Providers are responsible for following all State and Federal privacy requirements, including HIPAA.

Medical Record Release and Confidentiality (continued)

1. In addition, authorization forms permitting release of medical records specify to whom the information may be released, the type of information being requested, the date and signature of the member or representative. The member's name, medical record number, name and organization of the requester, date of request, and the date the record was released is documented and filed in the member's medical record.
2. Minors have the right to specific confidential services without parental consent under California Law, therefore medical records and/or information regarding medical treatment specific to defined confidential services cannot be released to parent(s) without the minor's consent.
3. All medical records released to authorized parties are legible copies.
4. Members are afforded the opportunity to approve or refuse the release of identifiable personal information, except when such release is required by law.
5. All member medical records obtained for use by the health plan or medical group for Utilization Management, Quality Management, or claims purposes may be released to the respective companies without member consent.

PROVIDER SITE VISITS

The purpose of the site visit is to ensure that provider member care sites meet IPA environmental standards for safety and cleanliness. The site visit will provide a mechanism for provider education and facilitate continuous improvement in the provision of member care and service.

All applying Primary Care, OB/GYN, and high volume mental health providers will have a medical office audit performed. Site visits are conducted at the time of application by a member of the Credentialing Staff.

Scope

Provider site visits are required for all primary care physicians who wished to be contracted with Medi-Cal health plans per Department of Health Care Services. These site visits are to be conducted by the contracted Medi-Cal health plans. In addition, as part of the Quality Management Program, PMGSJ will conduct provider site survey when there is a complaint from a member.

Process

The site visit is structured and is documented on the Site Visit Criteria and Check List Form which is completed at the time of the visit. The criteria for the site visit should include but not be limited to safety, physical accessibility, physical appearance, adequacy of waiting and examination room space, adequacy of the medical records keeping and filing, including maintenance of confidentiality, availability of appointments, storage of medications and narcotics, and emergency procedures.

A sample Site Visit Checklist is included in the Appendix of this section.

Provider Site Visits (continued)

Site Visit Findings

Site visit findings are maintained in the Provider's credentialing file and are shared with the provider for educational purposes and to assist in the continuous improvement of member care and satisfaction.

- The site visit is performed as part of the credentialing process for primary care physicians who wished to be contracted with Medi-Cal health plans. The site visit will be conducted by the health plan utilizing Department of Health Care Services survey tool.
- The site visit is also performed by the Credentialing Department representatives in response to a complaint by a member.
- Providers are informed in advance of the site visit and are given a copy of the Site Visit Criteria and Check List to facilitate the efficiency of the visit, to enhance the provider's understanding of the criteria, and to encourage continuous improvement.
- Site Visit findings will be reported to the appropriate Committees for review, conclusions, recommendations, action, and follow-up. Additional site visits may be conducted as a result of quality of care and service concerns.
- Documentation of site visits and Committee action are maintained in the appropriate department where they may be trended for use in selecting education programs for providers. The original completed Site Visit Criteria and Check List form is maintained in the provider's credentials file for the individual trending purpose.

**HEALTH INSURANCE PORTABILITY AND
ACCOUNTABILITY ACT (HIPAA)**

The **Health Insurance Portability and Accountability Act** was signed into federal law in August 1996 in order to improve the efficiency of health care delivery. HIPAA mandates computer standards for Electronic Data Interchange (EDI) transactions and code sets. In addition, it addresses privacy and security issues, as well as health care identifiers for providers, health plan, and employers.

HIPAA - Notice of Privacy Practices

The following document was written to inform members on privacy practices used to protect their “Personal Health Information”, how it may be used, and how it may be disclosed.

A member consent form is also included.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose of this Notice

In the normal course of doing business, this office and its business associates—Physicians Medical Group and EXCEL MSO, LLC—gather and retain personal health information about our patients/members for the purpose of providing medical care, billing, and health plan-related issues. Our physician(s) and staff respect the privacy of your personal information and understand the importance of keeping this information confidential and secure. This **Notice** describes how this office, along with Physicians Medical Group of San Jose and EXCEL MSO, LLC, protects the confidentiality of the personal health information we receive.

What is “Personal Health Information”?

“Personal Health Information” is private, protected information that identifies who you are and relates to your past, present, or future physical or mental health or condition, the provision of health care given to you, or past, present, or future payment(s) for the provision of health care given to you. Personal Health Information does not include information about you that is publicly available, or that is available or reported in summary form but does not identify who you are.

Types of Uses and Disclosures of Personal Information

Federal law allows this office and/or Physicians Medical Group of San Jose and EXCEL MSO, LLC to use and disclose your personal information in order to provide health care services to you as well as to bill and collect payments for the health care services provided to you by participating physicians. Federal law also allows this office, in conjunction with its business partners, to use and disclose your personal information as necessary in connection with usual and customary health care operations. For example, this office—along with Physicians Medical Group of San Jose and EXCEL MSO, LLC— may use your

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personal healthcare information in order to obtain authorized referrals to specialists, to review the quality of care provided to you and receive payment for services given. Your personal healthcare information may also be used by these entities in connection with any grievance or appeal that you file, either with us or with your health plan (your health insurance company). Certain governmental oversight agencies may also request access to your personal information in order to monitor the activities of certain physicians or providers, or to monitor your health plan or insurance company.

Physicians Medical Group with Excel MSO LLC and/or your health plan may use your personal health information in evaluating physician compliance with any applicable disease management programs or medical care guidelines. Required rules of privacy are observed.

This office, along with PMG/EXCEL MSO LLC, is also allowed by law to use and disclose your personal information without your consent or authorization for the following purposes:

1. When required by law, such as court-ordered subpoenas
2. For public health activities, such as reports about communicable diseases or work-related health issues (privacy of identity is utilized);
3. In reports about child abuse, domestic violence, or neglect;
4. For health oversight activities, such as reports to governmental agencies that are
5. responsible for licensing physicians or other health care providers;
6. In connection with court proceedings or proceedings before administrative agencies;
7. For tissue or organ donation;
8. For research, with the approval of certain oversight entities; otherwise, use and
9. disclosure of your personal information required for research requires your authorization;
10. To avert a serious threat to the health or safety of a person or of the public;

11. For national security and intelligence activities, including the protection of the President.

Access to Personal Information

As a matter of federal and state law, you have the right to review and/or receive a copy of the personal information received, created and retained (i.e. medical records) by this office. If you request to inspect or receive a copy of your health information held by this office, time to inspect and/or a copy will be provided. This office may reserve the right to charge a reasonable administrative fee, in addition to a per page copy fee for copying your personal information as allowed by applicable law. Under California law, this office has up to five working days to comply with a request for inspection and/or 15 days after receipt to comply with a copy request.

Right to Amend Personal Information

You have the right to request amendments to the personal health information (medical records) created by this office. A request to amend your personal information must be submitted to this office in writing, and the requested change must be no longer than 250 words in length. This office will attach the request for amendment to your medical record. You will be notified within in 30 days of receipt of request of our decision to amend or not amend the medical record. Either way, your request for amendment(s) becomes part of your medical record. This office, in its discretion, may choose to submit the request for amendment(s) to Physicians Medical Group's Quality Management Committee (via EXCEL MSO, LLC), the operating body designated to carry out the federal HIPAA privacy oversight function for this office.

Right to Receive an Accounting of Disclosures

You have the right to request an accounting of all disclosures of the personal information made by this office and/or Physicians Medical Group/EXCEL MSO LLC that are not directly related to your treatment, payment for treatment or

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health care operations as outlined above. You must request this accounting in writing. This office will provide the accounting to you within a reasonable period of time after your request and in accordance with applicable law(s).

Right to Request Restrictions on Disclosures of Personal Health Information

You may request restrictions on the use and disclosure of your personal health information by this office. This office has the right to accept or reject your request for restrictions. All requests for restrictions must be made in writing. All requests for restrictions will be made part of your medical record. After receipt of your request, and within 30 days of receipt, this office will notify you in writing of its decision to accept or reject the request. Acceptance of restrictions will be in effect until any written notice to the contrary. If you should decide to terminate with this office or with Physicians Medical Group of San Jose, your personal health information will be used in accordance with applicable State and Federal law, with the most restrictive rule being in effect in the event of any contradiction.

Right to Receive this Notice

You have the right to request and receive a copy of this Notice in written or electronic form. You may contact this office, or Physicians Medical Group Member Services at (408) 937-3642 for a copy. A copy will be provided to you at no charge.

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Right to Confidential Communications

You have the right to request that your personal health information be sent to you in a confidential manner. For example, you may request that this office sends your personal information by alternate means or to an alternate address, such as by telephone to a different telephone number or to an office address rather than your home address.

Right to Complain

This office, as well as its business associates, are obligated to comply with the privacy practices set forth in this Notice. If you believe that this office, or one of its business associates has violated this privacy policy, you have the right to file a complaint with Physicians Medical Group of San Jose (408) 937-3642, your Health Plan, the California Department of Managed Care or the United States Department of Health and Human Service, Office of Civil Rights.

Contacting Physicians Medical Group Regarding Your Rights

If you should have any questions regarding your rights, or wish to make a request or complaint, you may direct your inquiries to:

Member Services
Physicians Medical Group of San Jose/EXCEL MSO LLC
75 East Santa Clara Street, Suite 950
San Jose, CA 95113
(408) 937-3642

Rights Reserved

This office, Physicians Medical Group of San Jose, and EXCEL MSO, LLC reserve the right to amend or change the terms of this Notice at any time and to make the provisions of the new notice effective for all personal health information we maintain. You may request updates to this Notice at this office and at the above address for Physicians Medical Group/EXCEL MSO LLC.

****Per the Health Insurance Portability and Accountability Act of 1996***

(“HIPAA”)

HIPAA - Consent to Use and Disclose Health Form

The following is a sample form that should be used for members to complete.

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following is offered for your information and consent. Please be aware that it is this office's policy to require your reading and signing this consent prior to the provision of treatment or any other medical services. If you have any questions, please call your Member Services Department at the phone number located on the back of your health card.

I, _____, currently residing at _____ in (city) _____, _____ County, CA, do hereby consent to the use and disclosure of my individually identifiable health information ("Health Information") by Dr. _____ for the purpose of providing treatment to me, receiving payment from responsible parties for health care services rendered by Provider, and/or engaging in health care operations, such as office management, credentialing case management and quality management.

I understand that "Notice of Member's Privacy Rights ("Notice") describes in more detail the types of uses of disclosures of Protected Health Information involved in treatment, payment or health care operations, and that I have received a copy of this Notice prior to signing this consent. I understand that if I choose to not sign this consent, this provider may withhold medical services other than emergency services.

I understand that if I sign this consent, I still have the right to request a restriction on Provider's use or disclosure of any and/or all Personal Health Information to any and/or all locations, entities or persons. I further understand that Provider is not obligated to agree to my request. However, if Provider does agree to my request, the agreement will become binding.

I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that Provider has already relied on this consent, and that any revocation will become effective on the date it has been received by Provider and will apply to uses and disclosures of Health Information after the date of receipt.

Dated this _____ day of _____, 20_____.

Name