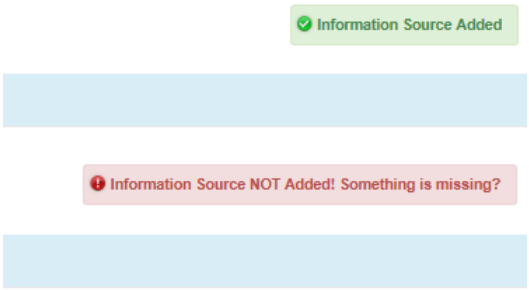
Note: Test data/information is displayed in the screenshots listed in this document

Contents

1. General remarks

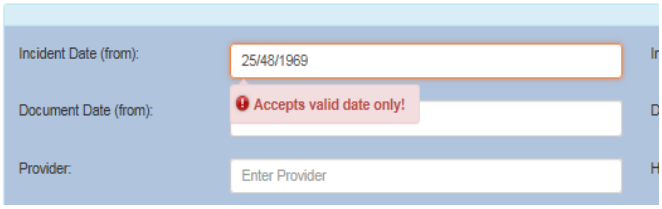
After each action, notification about the outcome with the appropriate message is displayed in the right upper corner of the screen. Successful actions will be in green and unsuccessful in red color. The message will automatically disappear from the screen after 5 seconds (*Figure 1.0*)

Figure 1.0



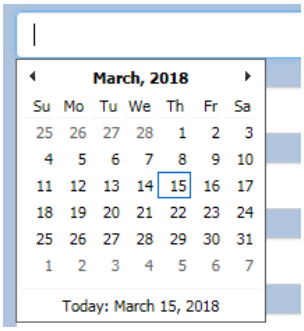
Validations are set for text fields that expect data input in certain format e.g. Date fields or number fields. If invalid data is entered in the field, an error notification will appear next to the field in question and will be visible for 5 seconds. The field will be marked with a red color drop shadow until the error is corrected (*Figure 1.1*)

Figure 1.1



Like the validations, new features and changes on the pages will be announced in the same manner. They will not disappear after 5 seconds and need to be dismissed by clicking on the notification. This is not an error; it is there to draw the user's attention to the new changes introduced in the new version.

All Date fields are date pickers which is a functionality that is activated by clicking anywhere on the field (*Figure 1.2*)
Figure 1.2



2. AHCCCS QM Portal Home Page

Access to the Quality of Care Reports is allowed only to Contractor/TRBHA, Health Plan, and AHCCCS users.

Below is the current AHCCCS QM Home Page with a description of each icon on the side menu (*Figure 2.0*):

Figure 2.0

User Admin: User Admin shows the user information or account information for the person currently signed in. This includes account information, user information, organization information, user authorization (including ability to sign off on documents), and if the person signed in can add or remove other accounts.

Create...IAD/IRF/QOC: This link begins the process of creating an IAD/IRF/QOC in the AHCCCS QM Portal. This button takes you to a screen where you can start searching for a member. Please see below sections for information on filing an IAD/IRF/QOC

Search...IAD/IRF/QOC: This link takes you to a search page to find already opened IAD/IRF/QOC. Please see the sections below regarding this feature.

My Exports: My Exports show any reports that have been generated inside of the QM Portal. These reports are in Excel format.

FAQ: This link leads to a library of documents regarding the AHCCCS QM Portal and other topics including the Office of Human Rights and the Independent Oversight Committee. If there are any questions, this is the first place to check out for information.

Technical Assistance: If your questions or concerns cannot be answered through the FAQ section, you can submit a request through the Technical Assistance link on the side menu. When clicked you will receive the following notification to submit your request.

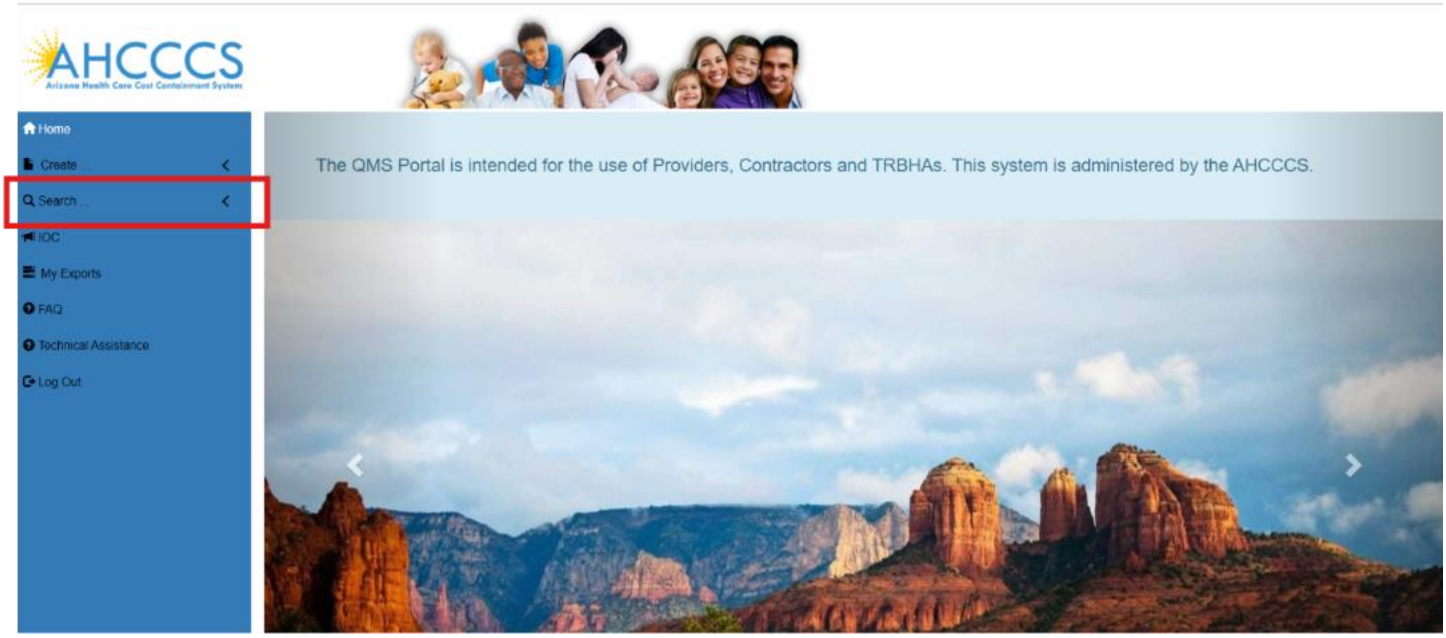
"To submit a request for technical assistance, go to https://servicenow.azahcccs.gov/gsp.
You will be required to have an active ServiceNow account. For information on registering a ServiceNow account, scroll down to the User Guides section. You can also contact our Customer Support Center at (602) 417-4451."

Accessing Quality of Care Reports

Access to the Quality of Care Reports is allowed only to Contractor/TRBHA, Health Plan and AHCCCS users.

To access QOC reports, after logging in, follow the "Search" link from the side menu, to enter the "Search Page" (*Figure 2.1*).

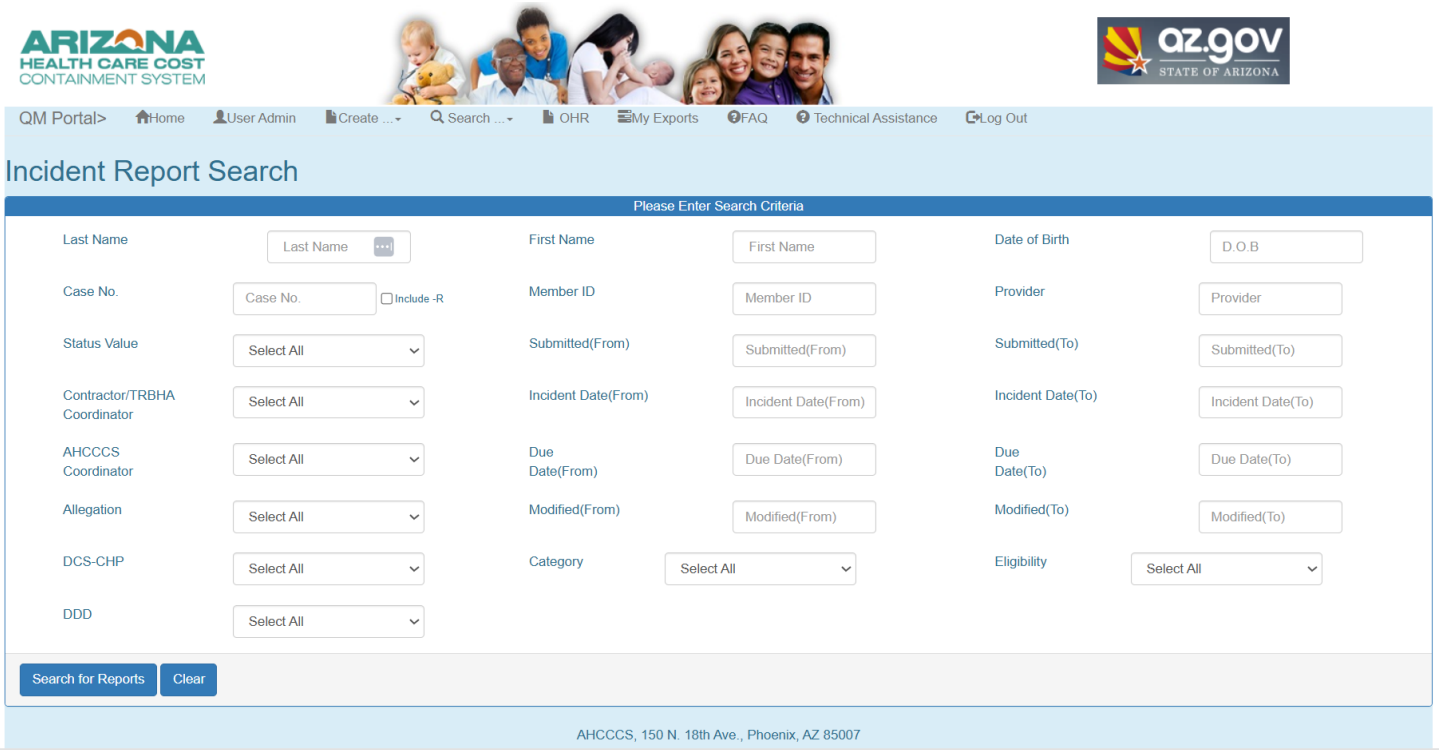
Figure 2.1



Once on the "Search Page", search for existing cases by entering criteria in the available search fields and click on the "Search for Reports" button (*Figure 2.2*). It is important to note that the full characters of a search criteria must be entered for successful results. For instance, if searching for "Smith" as a last name, you must type out "Smith". "Smi" or "Smit" will not provide results. Additionally, successful results should include ensuring that there are no spaces before, between, or after entering the search criteria.

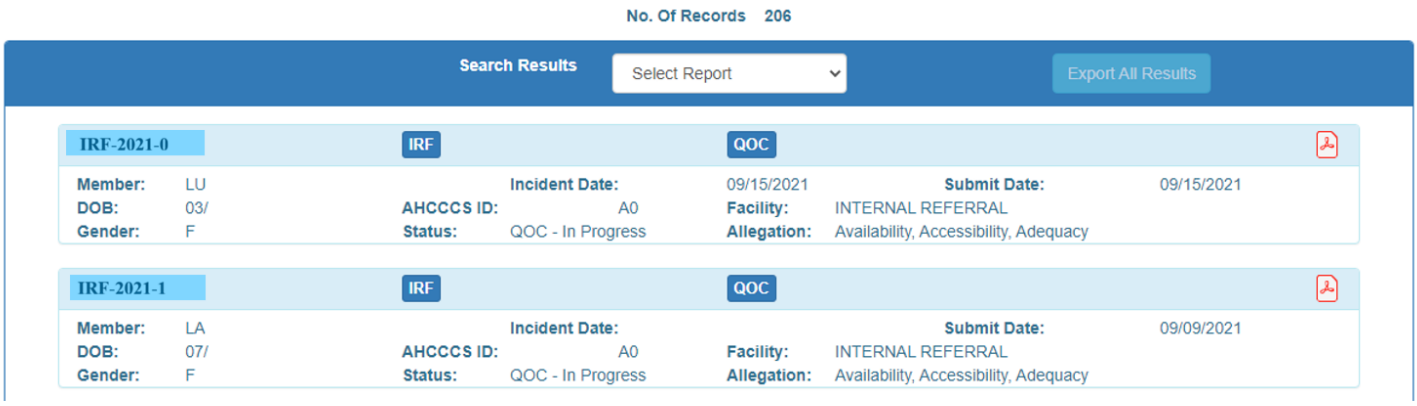
A member can be searched through a variety of information including AHCCCS ID number.

Figure 2.2



If successful, results will be listed in the "Search Results" section of the page. Cases which are escalated to a QOC will have the button "QOC" on the right side. Click on that button next to the desired Report and the Report will open to the Quality of Care Report Page (*Figure 2.3*)

Figure 2.3



If reports are not generated, it could mean either the criteria that was searched has an error such as a misspelling or that there are not reports for that member. Before creating another IAD/IRF/QOC or assuming there are no reports, please try another criteria search.

3. Quality of Care Page

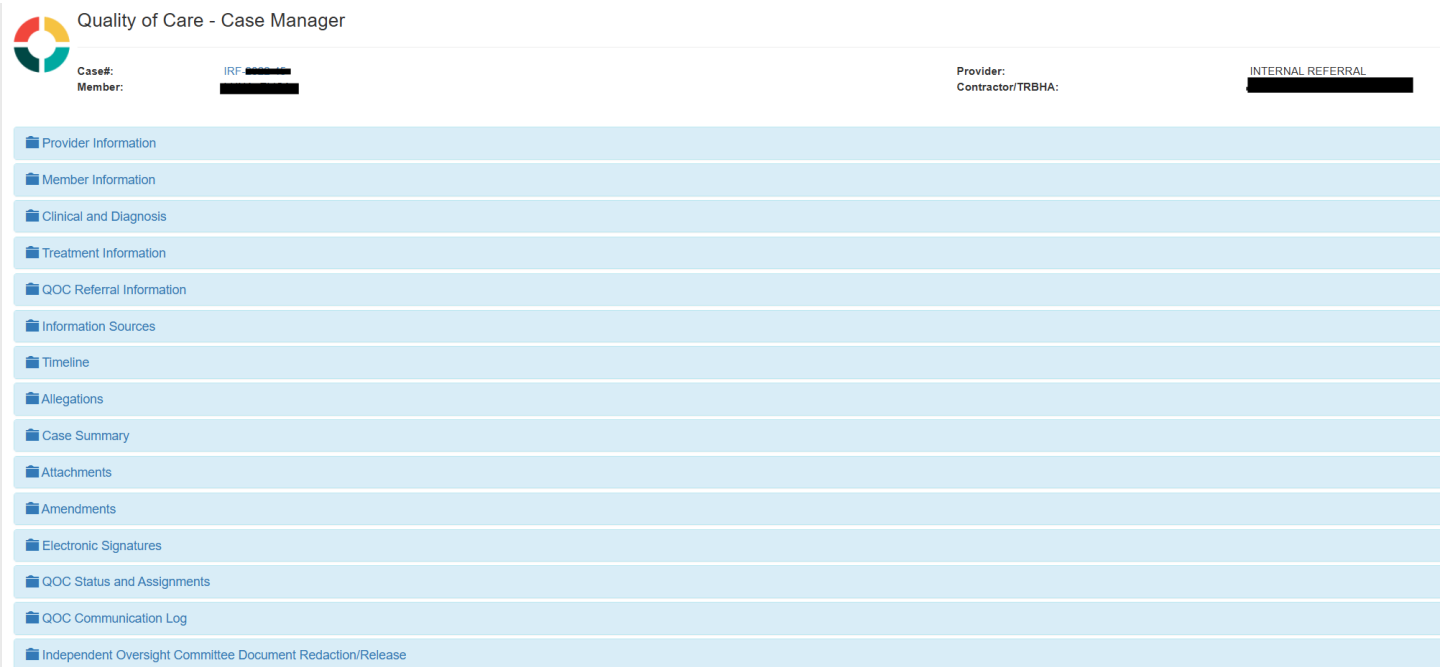
In the results of the search, clicking on the QOC Button would open the Quality of Care Page (*Figure 3.0*).

Figure 3.0

A separate portion of the QM Portal is used to manage and produce Quality of Care reports.

QOC Report sections are divided into separate panels. To access and manage information for a particular Reports section, click on the Title of the desired panel (*Figure 3.1*).

Figure 3.1

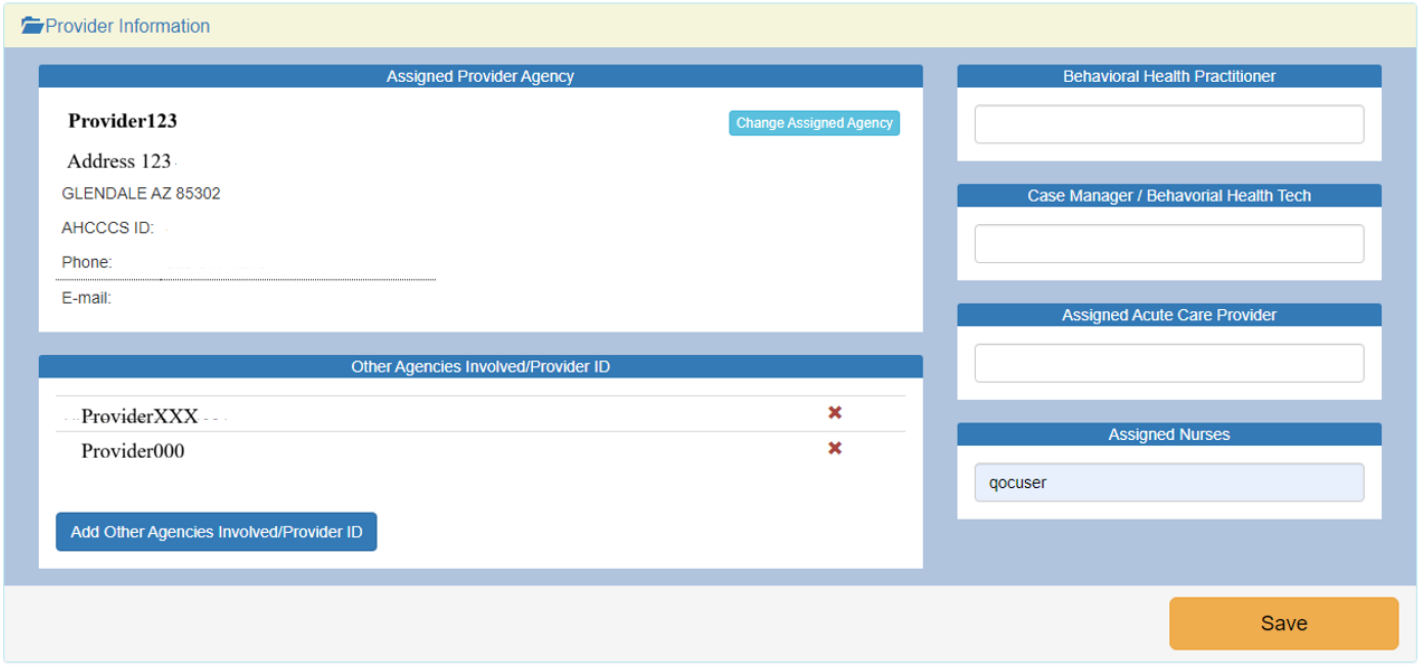


The following sections will review each of the Report panels above.

4. Provider Information Panel

This panel contains information about the Assigned Provider (*Figure 4.0*)

Figure 4.0



The Assigned Provider Agency information includes the information of the Provider Agency involved in the incident or where the incident took place. The Assigned provider Agency information can be changed if the Case is created as an **Internal Referral**. Change is initiated by clicking “Change Assigned Agency” button (*Figure 4.1*).

A new modal window will open, containing a form to search for Agencies using Name or AHCCCS ID. Clicking “Select” will change the Assigned Agency (*Figure 4.2*).

Figure 4.1

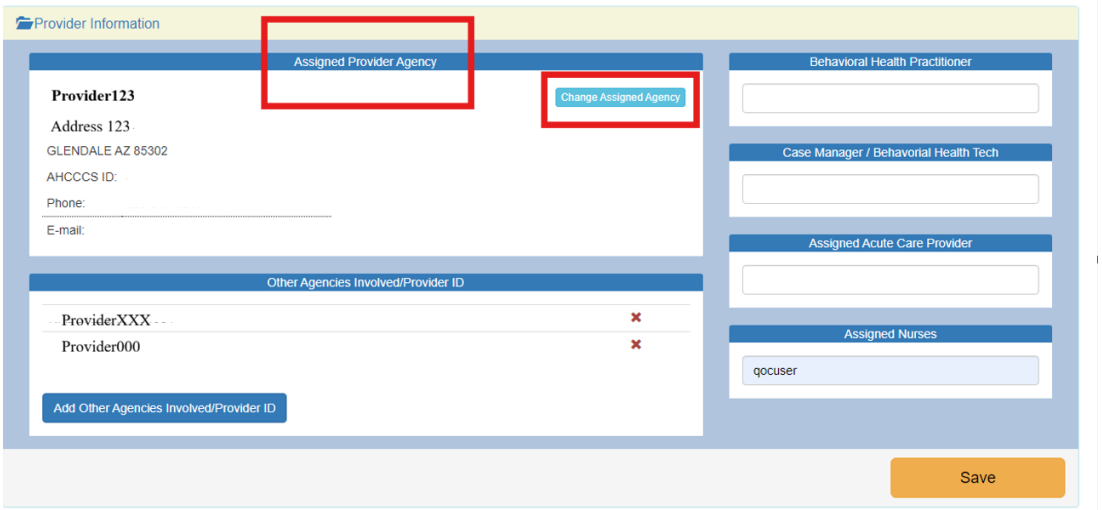
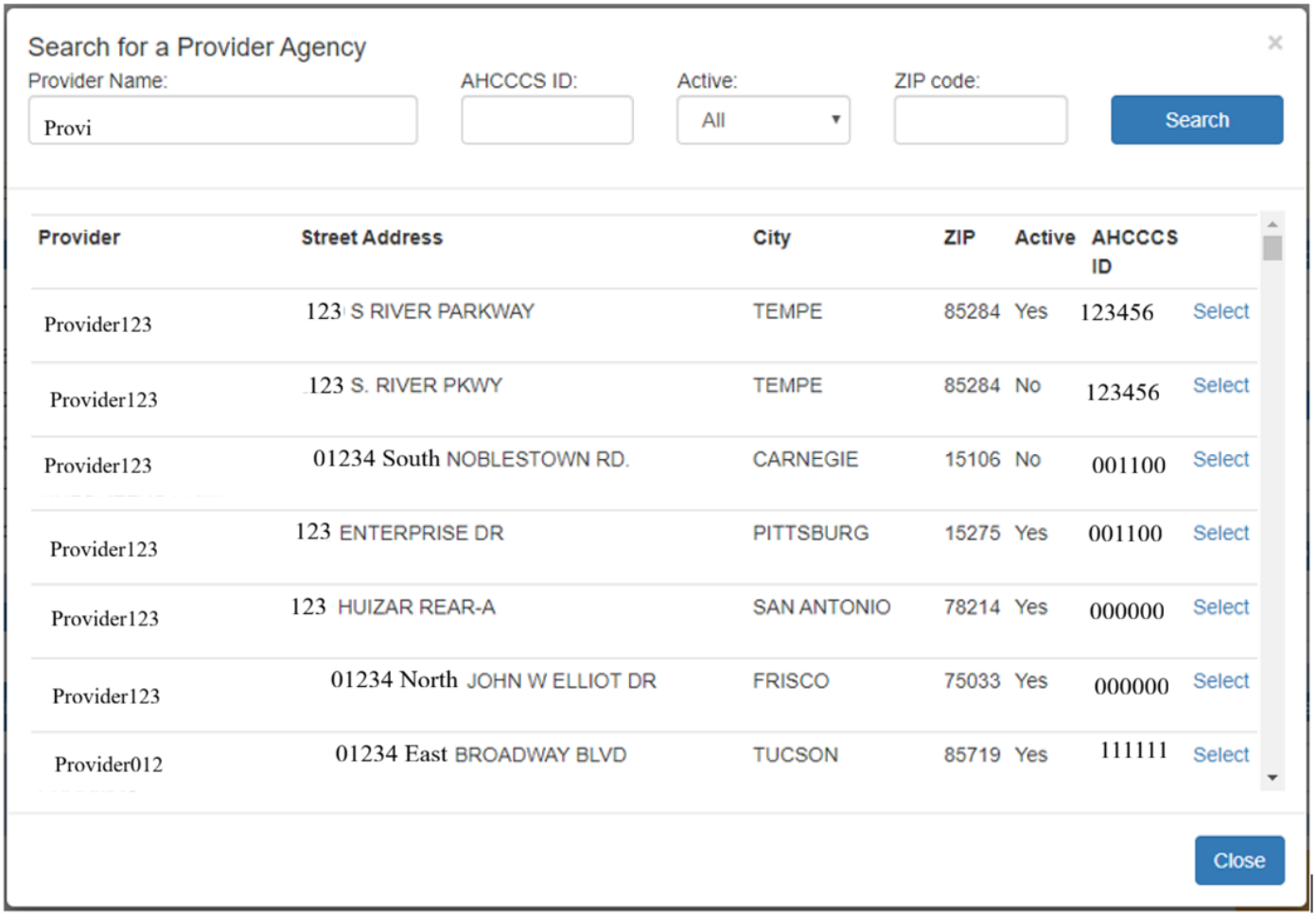


Figure 4.2



If another Provider Agency is involved in the incident, click on "Add Other Agencies Involved/Provider ID" button (Figure *4.3* for an example) and a new modal window will open containing detailed information about the chosen Other Provider Agency (*Figure 4.4*).

Figure 4.3

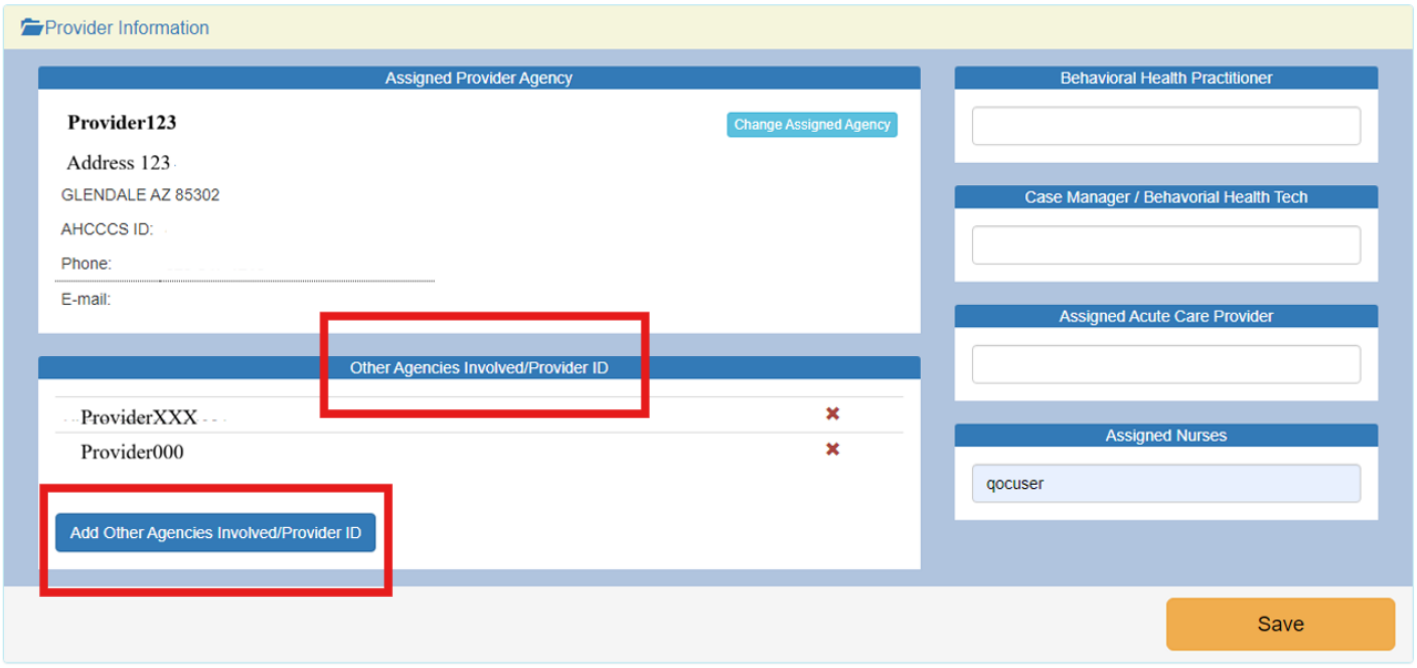
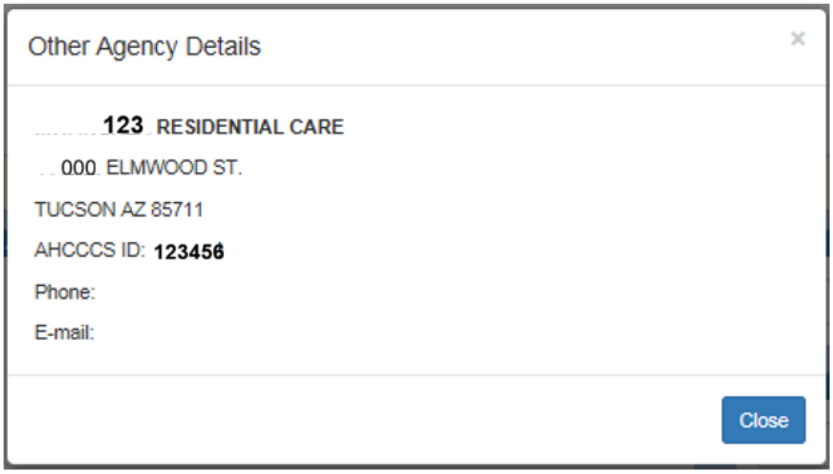
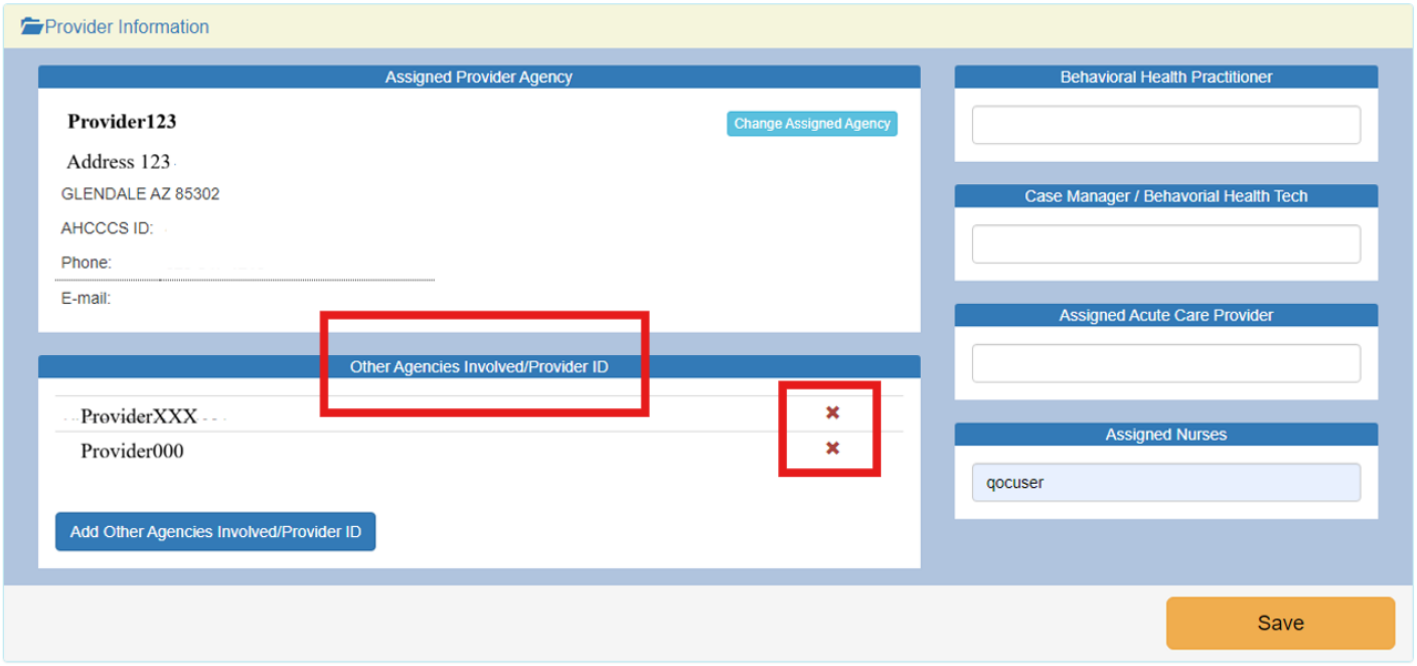


Figure 4.4



Clicking on the ✖ next to the Other Involved Agency name (*Figure 4.5*), and after the user confirms that the action is desired, the system will remove that Agency from the list.

Figure 4.5



Adding a new Agency Involved is done by clicking "Add Other Agency" button (*Figure 4.6*). A new modal window will open, containing a form to search for Agencies using Name or AHCCCS ID (*Figure 4.7*). Clicking "Select" will add the chosen Agency to the list.

Figure 4.6

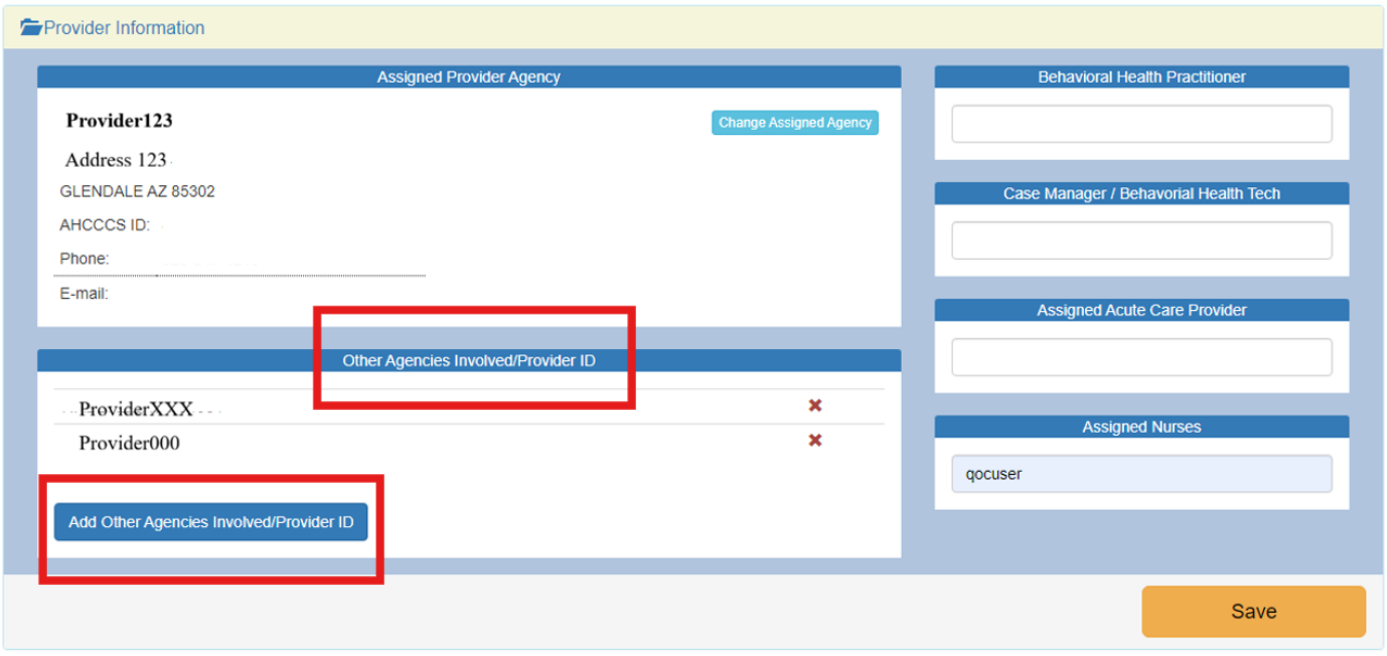
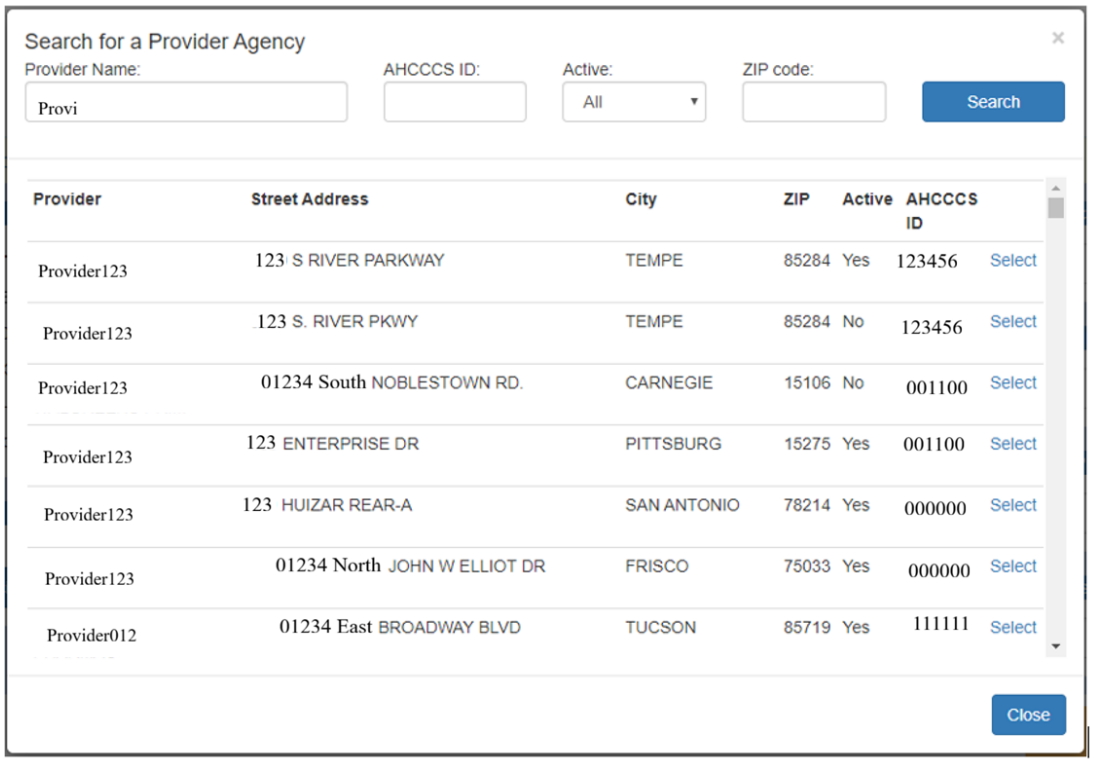
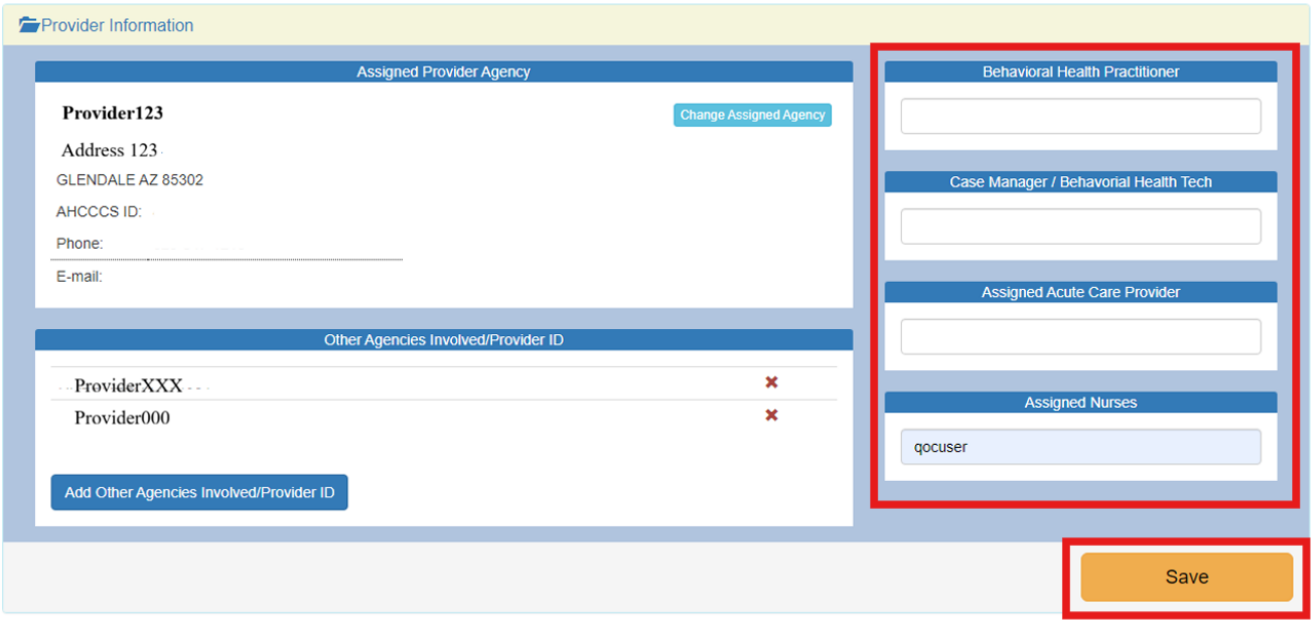


Figure 4.7



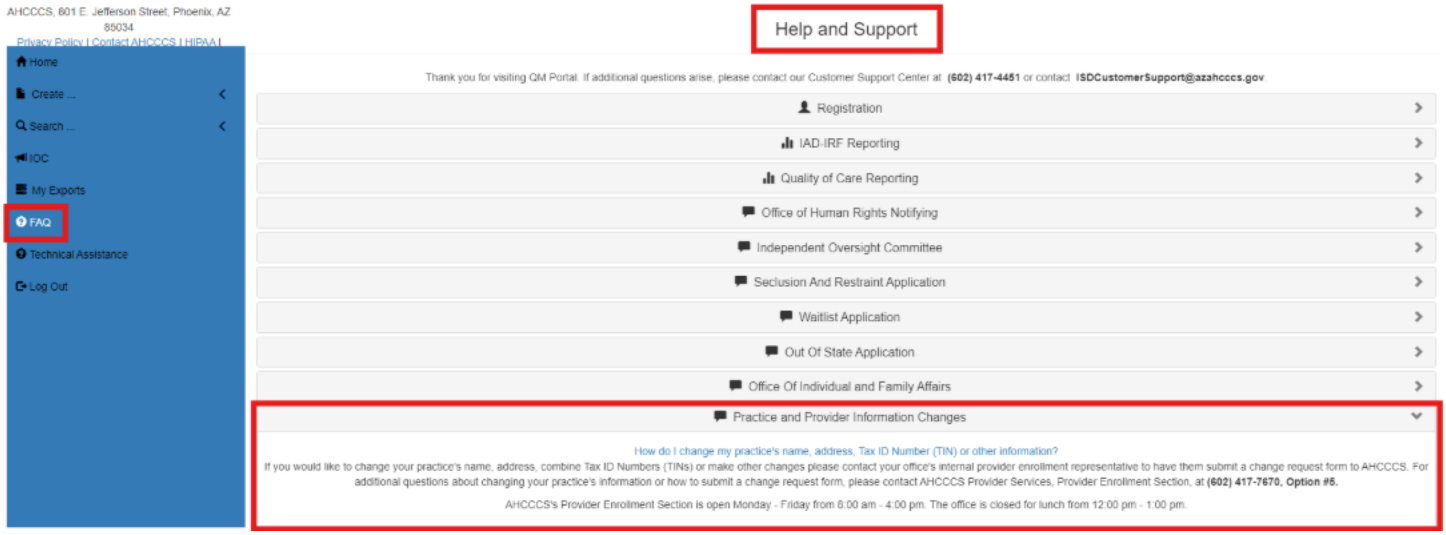
Pressing the “Save” button located in the footer section of the panel will store data entered in the Behavioral Health Practitioner, Case Manager / Behavioral Health Tech, Assigned Acute Care Provider, and Assigned Nurses sections (*Figure 4.8).*

Figure 4.8



If searching for a provider that is not coming up in the new modal window or a new Provider needs to be added, click on FAQ on the home page of the QM Portal and select Practice and Provider information Changes under the Help and Support page, then click on the link, "How do I change my practice's name, address, TAX ID Number, (TIN) or other information," and follow the steps (*Figure 4.9*).

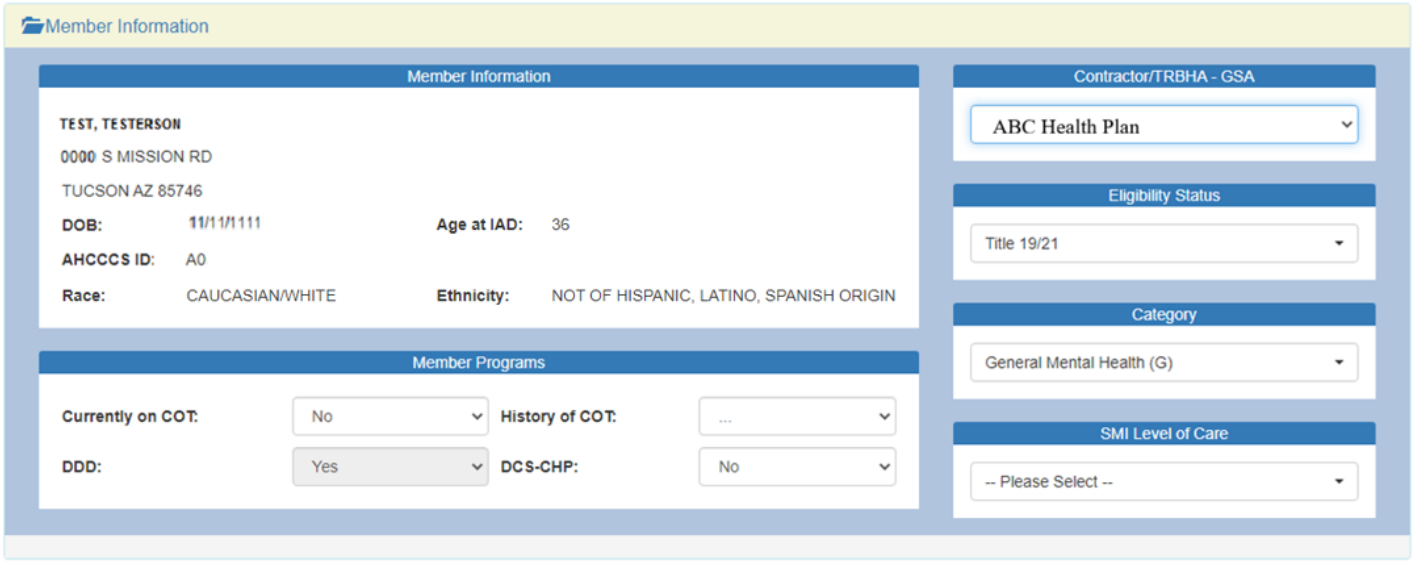
Figure 4.9



5. Member Information Panel

This panel contains information about Member (*Figure 5.0*)

Figure 5.0



Member Information is read-only and cannot be changed.

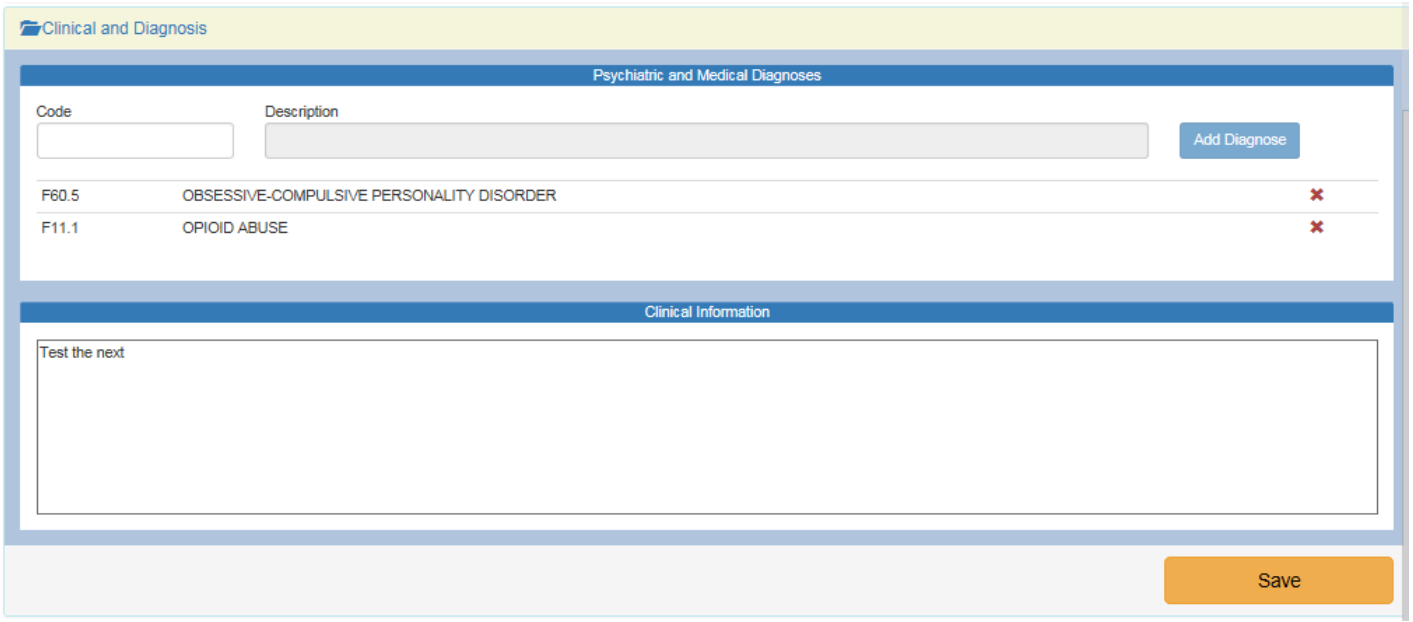
Changing selection of the dropdown lists (e.g. Contractor/TRBHA -GSA, Member Programs dropdown lists, etc.) will instantly update information for that Case.

For steps in reassigning the QOC to another health plan, please see section 19 linked here:

6. Clinical and Diagnosis Panel

This panel contains information about the member's diagnoses and clinical information.

Figure 2



Psychiatric and Medical Diagnoses section lists all diagnoses the member has at the time of the IAD. The Contractor should include all of the psychiatric and medical diagnoses if not already added.

This section allows adding new diagnoses by using ICD10 format only. Typing at least 3 characters in the Code field will open the dropdown list of diagnoses to choose from. When a diagnosis is chosen, a description field is populated. Clicking on the "Add Diagnose" button will confirm the addition action.

Clicking on the ✖ next to the diagnosis description, after the user confirms that the action is desired, the system will remove that diagnosis from the list (*Figure 6.0*).

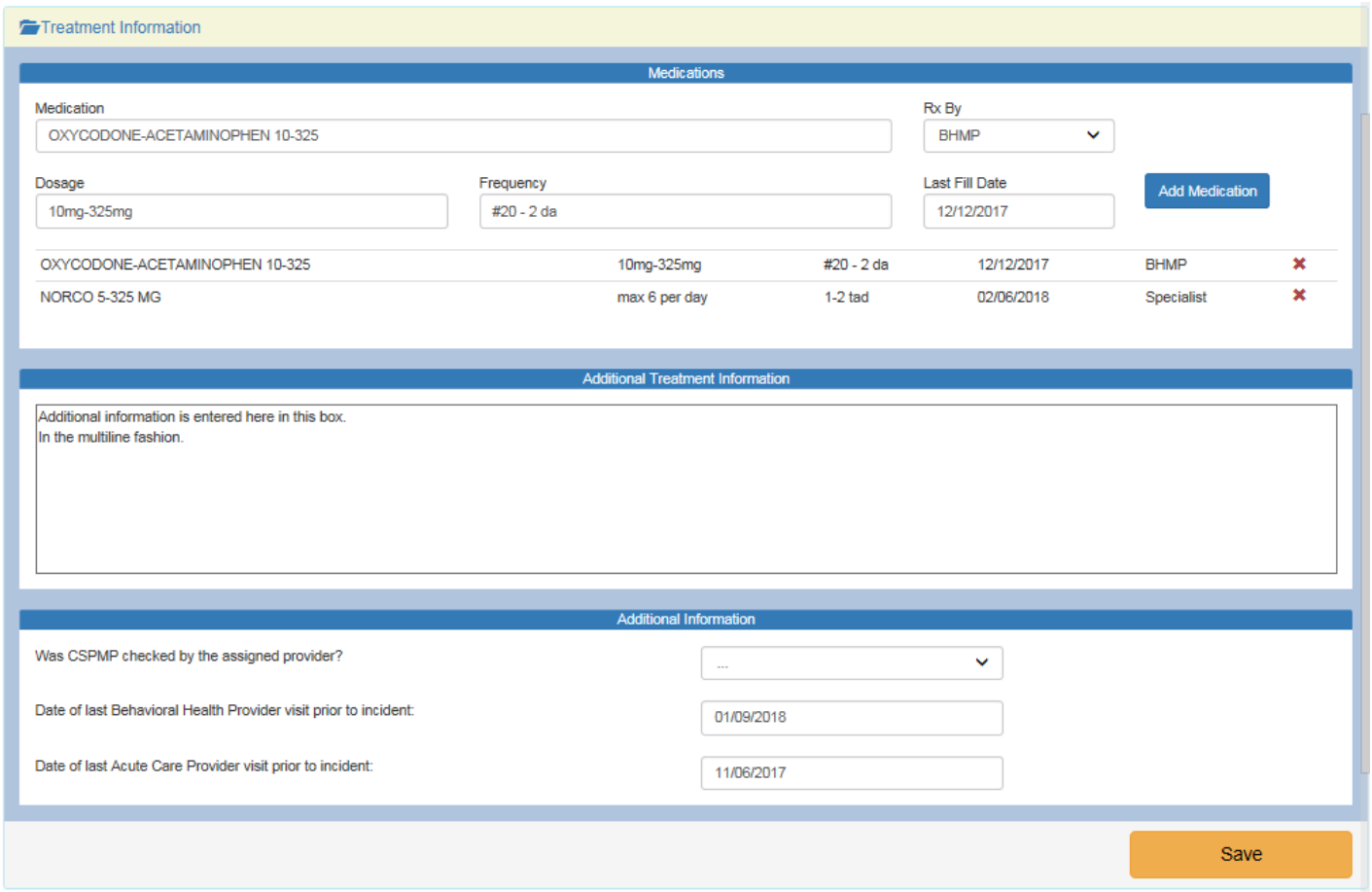
Data entered in the Clinical Information section is updated by pressing the "Save" button located in the footer section of the panel.

The Clinical Information section can be utilized to provide additional clinical information regarding the member and the member's clinical services. This is **not** where the case summary should be written. This section should focus on Clinical Information including diagnoses, medications, specialized treatments, etc. Any information regarding the timeline related to the investigation should be placed in the Timeline Panel. Information regarding the Investigation Details should be placed in the Investigation Findings of the Allegation Panel.

7. Treatment Information Panel

This panel contains information about the member's visits to the provider and treatment applied (*Figure 7.0*).

Figure 7.0



The Medications section lists all medications the member was prescribed at the time of the IAD and is pertinent to the QOC investigation. This section allows adding new medications. Typing at least 3 characters in the Medication field will open the dropdown list of medications for the user to choose from. All fields in this section are required. The addition of a medication is confirmed by clicking on the "Add Medication" button.

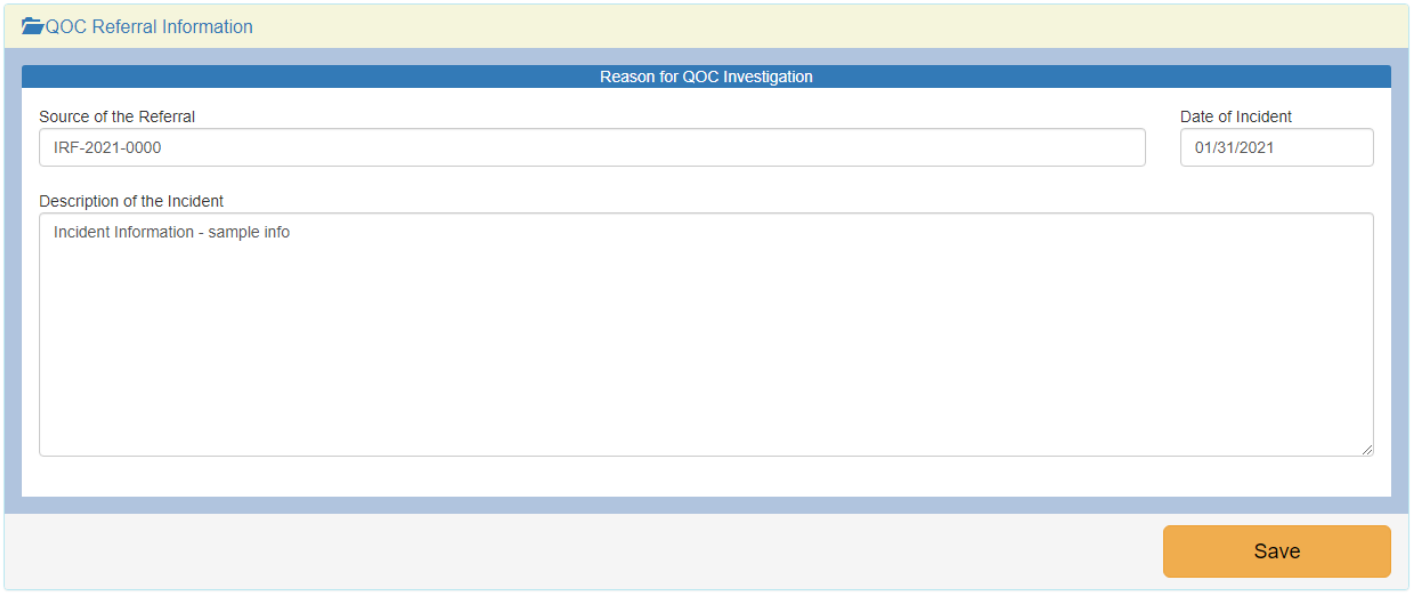
Clicking on the ✖ next to the medication record, after the user confirms that the action is desired, the system will remove that medication record from the list (*Figure 7.0)*.

The Additional Treatment Information section and the Additional Information section are updated by pressing the "Save" button located in the footer section of the panel.

8. QOC Referral Information Panel

This panel contains information about the reason for the Quality of Care investigation. The information in this section is transferred from the IAD or IRF side of the case from the QM Portal at the time of the escalation to a QOC (*Figure 8.0*).

Figure 8.0



All information is updated by pressing the "Save" button located in the footer section of the panel.

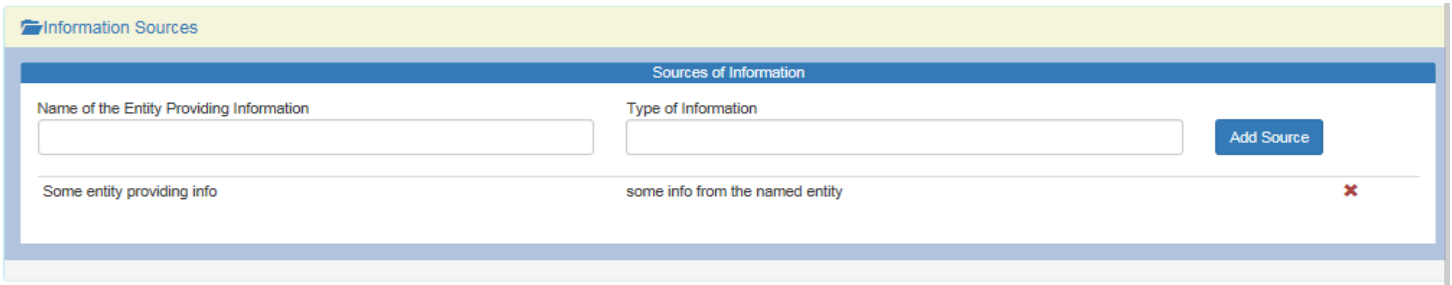
Note: For IRFs created by the Contractor/TRBHA, the Contractor must include the date of which they were notified/became aware of the incident, as the date of incident may not always coincide with the date of notification. If this information was not documented during the creation of the IRF and the case was transferred to a QOC, the Contractor must update the Description of the Incident section to include the date of which they were notified/became aware of the incident.

See AMPM Policy 960 and AMPM Policy 961 regarding IRF/IAD and QOC submission and notification timeframes.

9. Information Sources Panel

This panel lists all sources of information connected to the Case (*Figure 9.0*). This would include medical records, interviews with member(s) or witness(es), video recording(s), etc. **It is important for the Contractor to document the information source and include all appropriate and pertinent information associated with the investigation.**

Figure 9.0



This section allows the adding of new sources of information. **All fields in this section are required.** The addition of an entry is confirmed by clicking on the "Add Source" button.

Clicking on the ✖ next to the source of information record, after the user has confirmed that the action is desired, the system will remove that record from the list (*Figure 9.0*).

The QM Portal shall display a red informational pop-up message when one or both QOC Information Sources fields are blank (*Figure 9.1*). This red informational pop-up message is to ensure the user fills out the QOC Information Source fields completely.

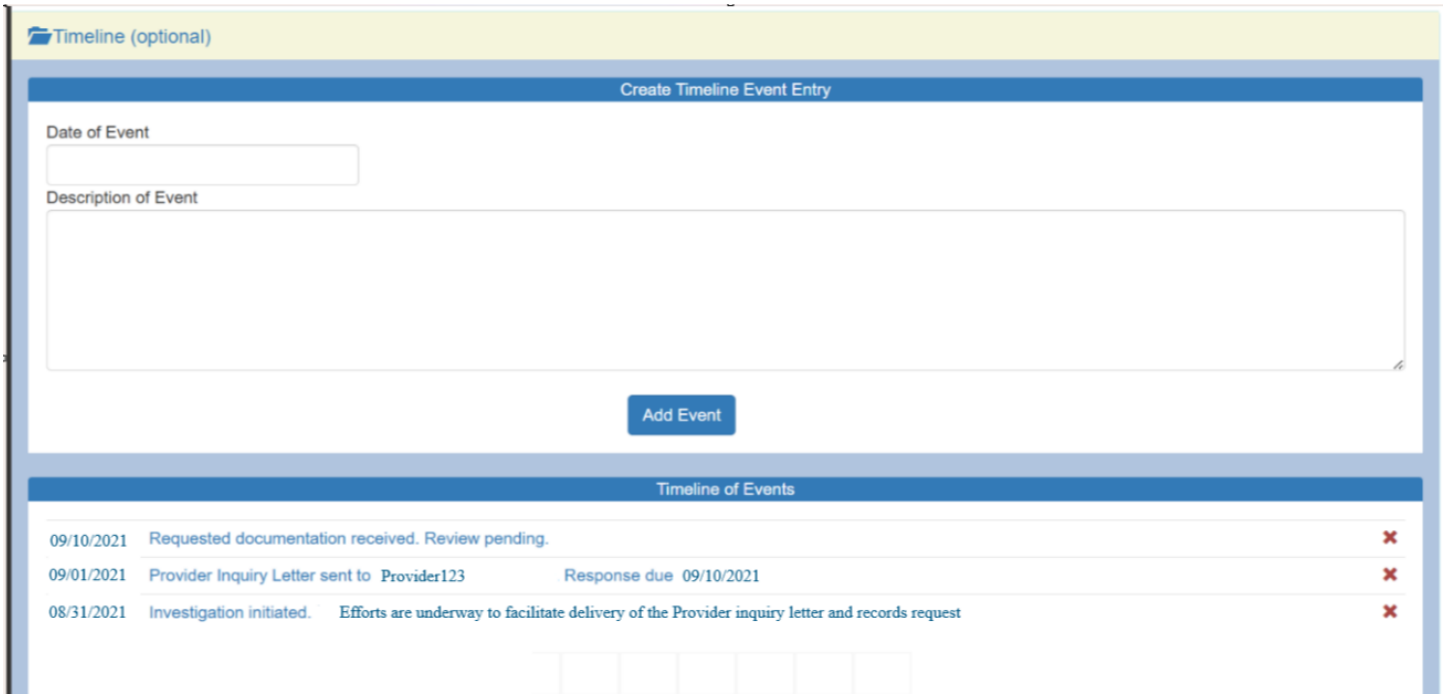
Figure 9.1

10. Timeline Panel

This panel lists all timeline events for the Case. This section is required and helps to track the status of the case during the investigation. This section of the QM Portal will be updated to reflect the actions of the investigator during the investigation. This will include adding events for when records are requested, member interviews are attempted or completed, outreach to provider, etc.

For AHCCCS CQM Coordinators, this provides a summary of the progress of the case when reviewing extension requests (*Figure 10.0* - example).

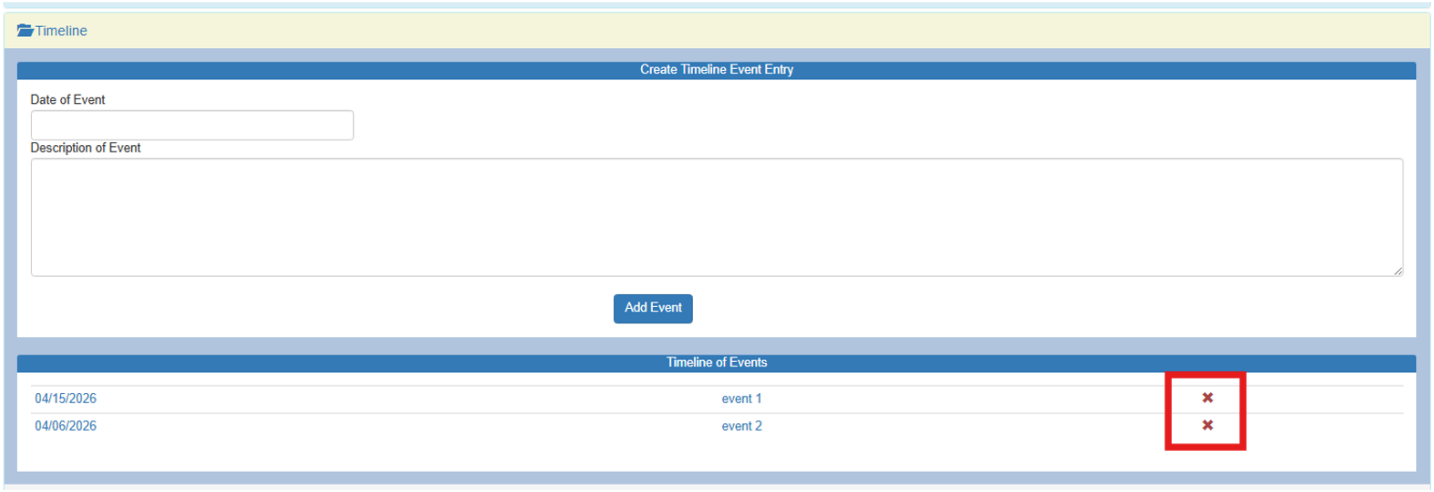
Figure 10.0



The section, Create Timeline Event Entry, allows adding new events. All fields in this section are required. The addition of an entry is confirmed by clicking on the "Add Event" button.

Clicking on the ✖ next to the timeline event record, after the user has confirmed that the action is desired, the system will remove that record from the list (*Figure 10.1*).

Figure 10.1



Clicking on either date or description of the event in the list of Timeline of Events, will open separate modal window with a prepopulated form to allow the user to update the selected event. Pressing the "Save" button will apply changes (*Figure 10.2*).

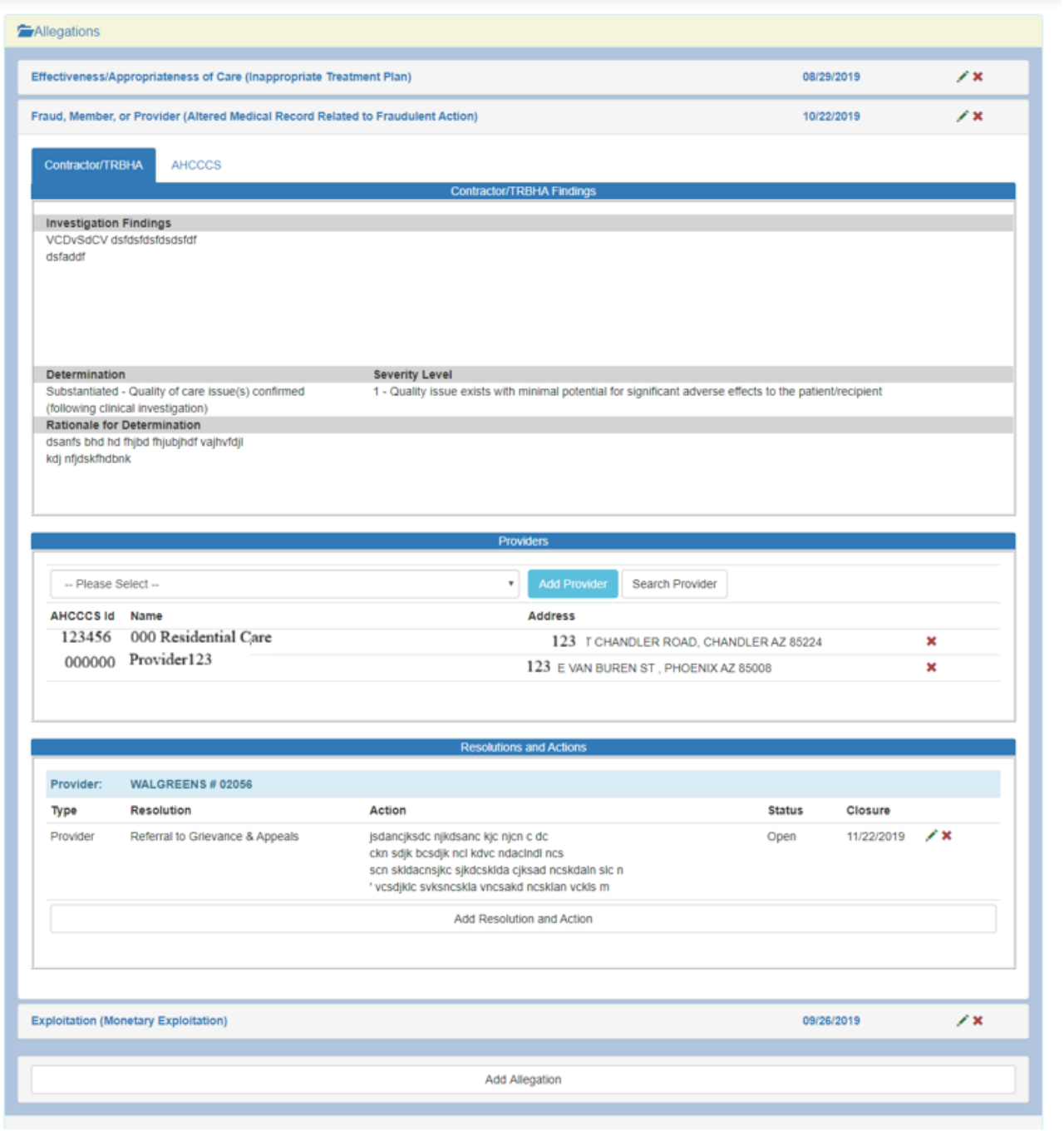
Figure 10.2

11. Allegations Panel

This panel lists all allegations as well as resolutions and actions connected to the Case (*Figure 11.0*).

All allegations are displayed as an array of sub-panels which hold specific information for that allegation. Those sub-panels are expandable and collapsible in an “accordion” manner.

Figure 11.0

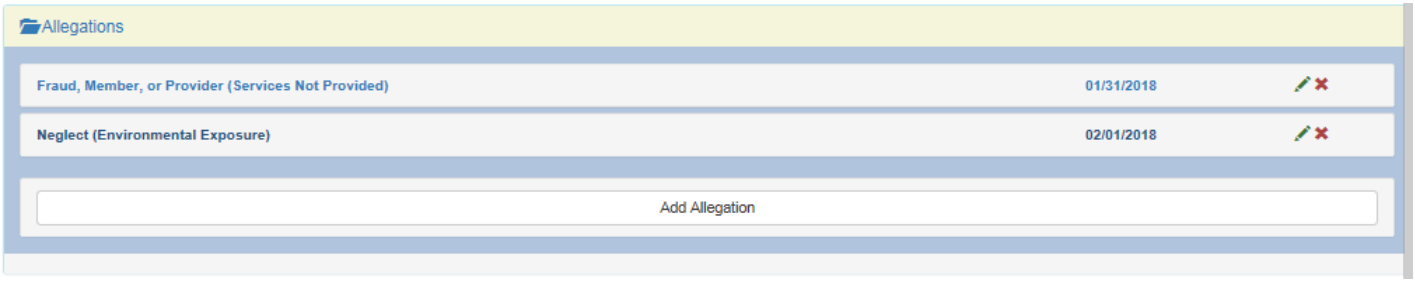


The header section of the subpanel information about the allegation is displayed in the format of "Category (Sub Category)" and the date the allegation was added. The two icons on the far-right side of the sub-panel represent clickable links with the following actions:

- Edit allegation information
- Remove allegation information

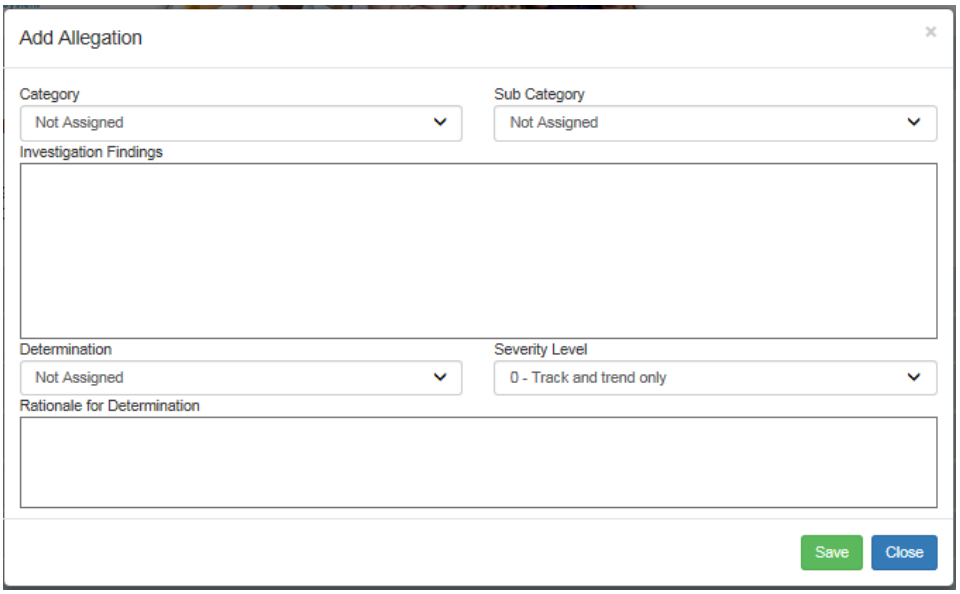
Clicking on the ✖ icon, after the user has confirmed that the action is desired, the system will remove the allegation from the case (*Figure 11.1*).

Figure 11.1



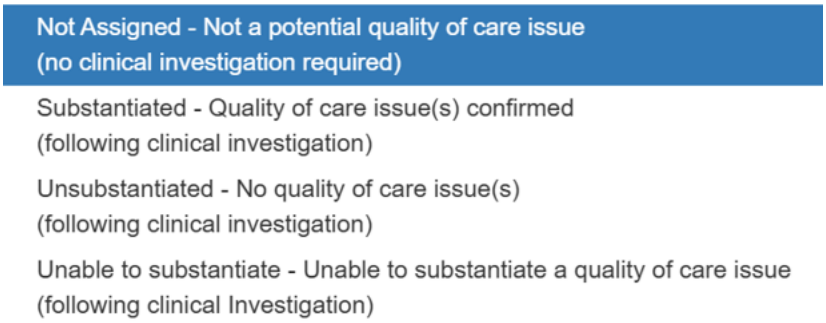
Adding an allegation information is enabled by clicking on the button "Add Allegation" located on the bottom section of the Allegations main panel. This action will open a separate modal window with a form to allow the addition of new allegation information. Information addition is restricted to the logged-in user business entity. Contractor/TRBHA, State Agency, or AHCCCS users will be able to add only parts of the allegation information that belongs to them (*Figure 11.2*).

Figure 11.2



Determination and Severity Leveling
Clicking on the drop down for determination will reveal: (*Figure 11.3*)

Figure 11.3



Not Assigned – Not a potential quality of care issue (no clinical investigation required)
Substantiated – Quality of care issue(s) confirmed (following clinical investigation)
Unsubstantiated – No quality of care issue(s) (following clinical investigation)
Unable to substantiate – Unable to substantiate a quality of care issue (following clinical investigation)

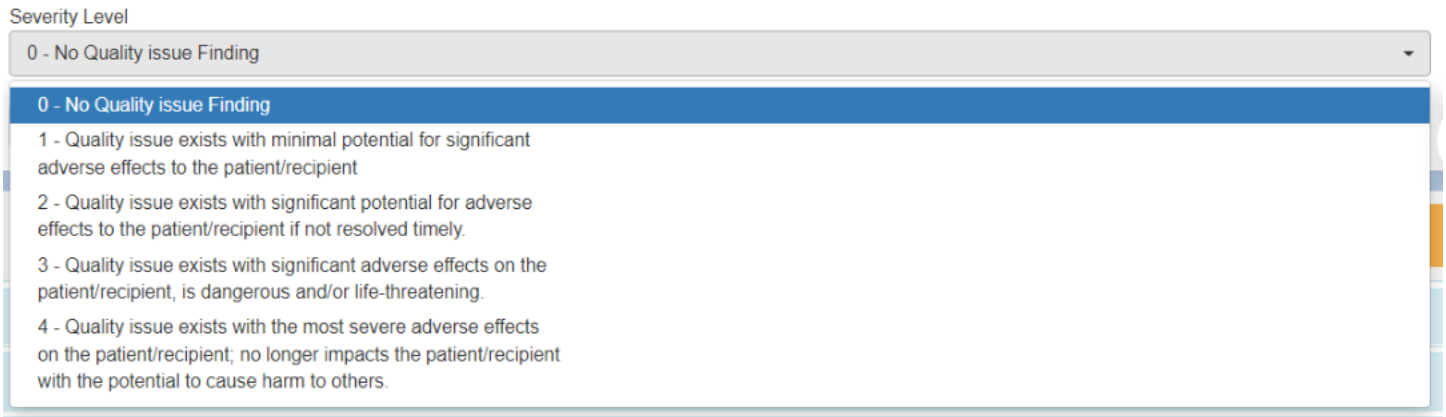
Unable to substantiate – Unable to substantiate a quality of care issue (following clinical investigation):

The determination of unable to substantiate is utilized when available evidence was not sufficient to determine whether an allegation occurred or not, including due to inconclusive evidence or a “he said/she said” scenario after all evidence is reviewed

Additionally, Unable to Substantiate would be considered a higher determination than Unsubstantiated
For example, if a case has two allegations and the first allegation is Unsubstantiated level 0 and the second allegation is Unable to Substantiate level 0, the overall determination and leveling of the case is Unable to Substantiate, level 0.

Clicking on the drop down for Severity Level will reveal: (*Figure 11.4*)

Figure 11.4



Level 0 – No Quality Issue Finding
Level 1- Quality Issues Exist with Minimal Potential for Significant Adverse Effects to the Patient/Recipient
Level 2 - Quality issue exists with significant potential for adverse effects to the patient/recipient if not resolved timely.
Level 3 - Quality issue exists with significant adverse effects on the patient/recipient, is dangerous and/or life-threatening.
Level 4 - Quality issue exists with the most severe adverse effects on the patient/recipient; no longer impacts the patient/recipient with the potential to cause harm to others.

Severity Level 0 – No Quality Issue Finding:
This leveling applies to unable to substantiate or unsubstantiated only.
For death allegations, if the provider's actions did NOT contribute to the member's death, then it will be leveled as a 0.

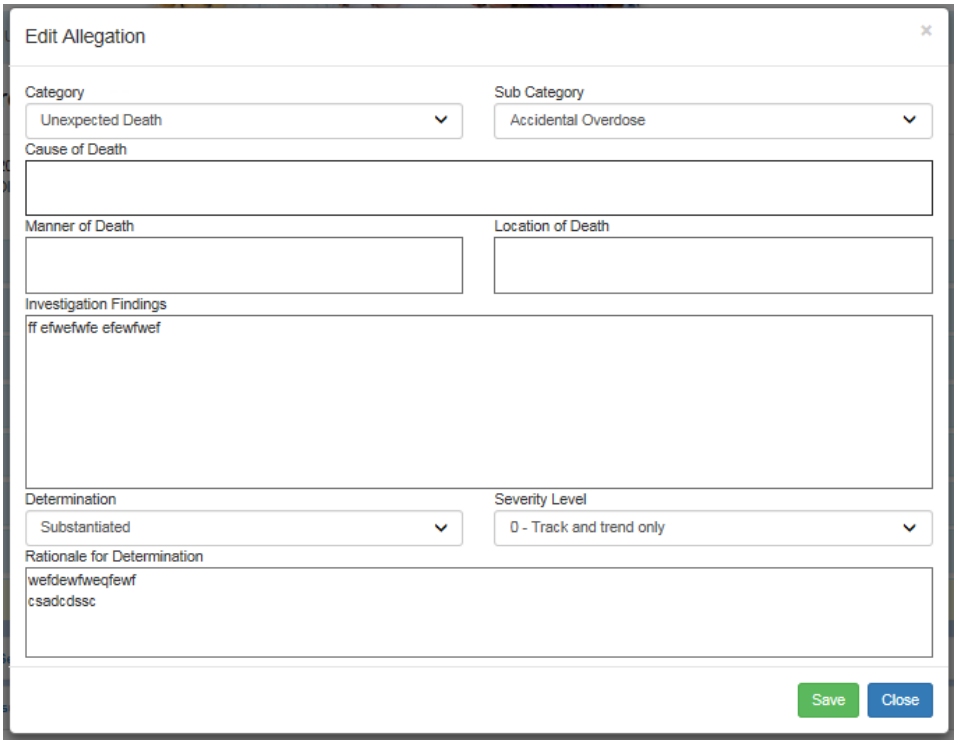
Severity Level 1-4:
These levels will **only** apply to substantiated cases.
The levels increase in severity and in definition. Special attention should be made to the key phrasing in each definition, such as minimal potential or most severe adverse effects.
For death allegations, if the provider's actions are directly related to the member's death, this should only be leveled as a Level 4 due to the extreme effects on the member.

Unexpected Death Allegation:

If the Allegation Category, "Unexpected Death", is chosen, the form will present these additional fields: "Cause of Death", "Manner of Death", and "Location of Death". Pressing the "Save" button will apply changes.

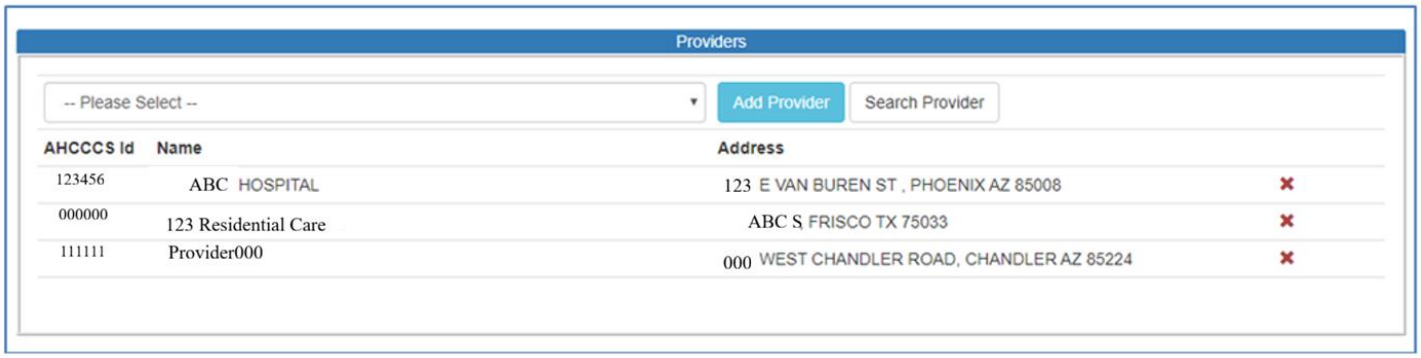
Clicking on the icon will open a separate modal window with a prepopulated form to allow updating selected allegation information. Information update is restricted to the logged-in user business entity. Contractor/TRBHA, State Agency, or AHCCCS users can update only parts of the information that belongs to them. Pressing the "Save" button will apply changes (*Figure 11.5*)

Figure 11.5



Adding Provider to the Allegation:
Resolution Reports need to have a provider associated with the specific allegations before the report is submitted to AHCCCS. This is done using the Providers section form of the allegation. This section consists of a dropdown list of all providers associated with the case (main provider and additional facilities) and a button named, “Add Provider”, which associates a provider from the dropdown list with the specific allegation (*Figure 11.6*).

Figure 11.6



The Search Provider button will open a new modal window to allow users to search for and add providers that are currently not affiliated with the case. Selecting a provider from the list will both affiliate that provider with the allegation and with the case itself adding it to the Other Agencies list. Clicking on the ✖ icon, after the user has confirmed that the action is desired, the system will remove that provider affiliation from the allegation.

Resolutions and Actions:
This section is required for any allegation that is substantiated, regardless of leveling, prior to submission to AHCCCS. This includes any resolutions and actions for the case including CAP(s) for the provider, technical assistance, required trainings, etc. The Contractor must submit evidence of any documentation (e.g. In-service attendance sheets, new policies and/or procedures, etc.) received from the provider associated with its completed CAP(s), this includes any Contractor CAP documentation, such as letter of concern, technical assistance, etc. This evidence of CAP documentation will be uploaded to the QM Portal under the Attachment section. The Expected Closure Date entered in the Resolutions and Actions section will be the date the resolution and/or action will be closed.

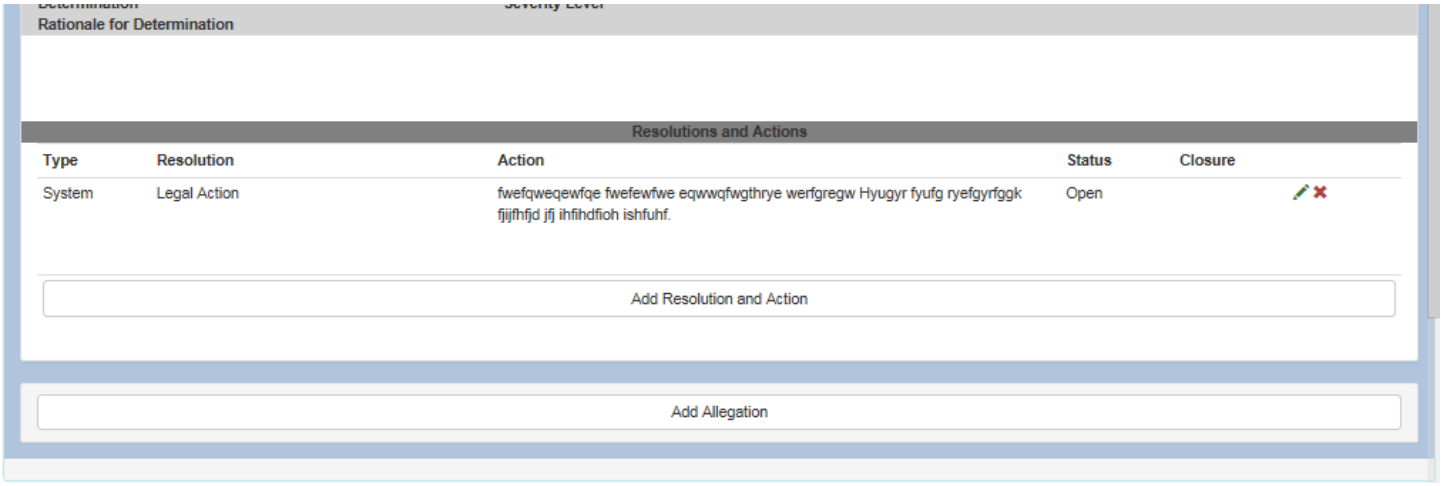
See below Appendix B of this document for a list of Resolutions and Actions in the QM Portal.

Resolutions and Actions section of the Allegation sub-panel is in the form of a list, with two icons on the far right side representing clickable links with following actions:

- Edit resolutions and actions information
- Remove resolutions and actions information

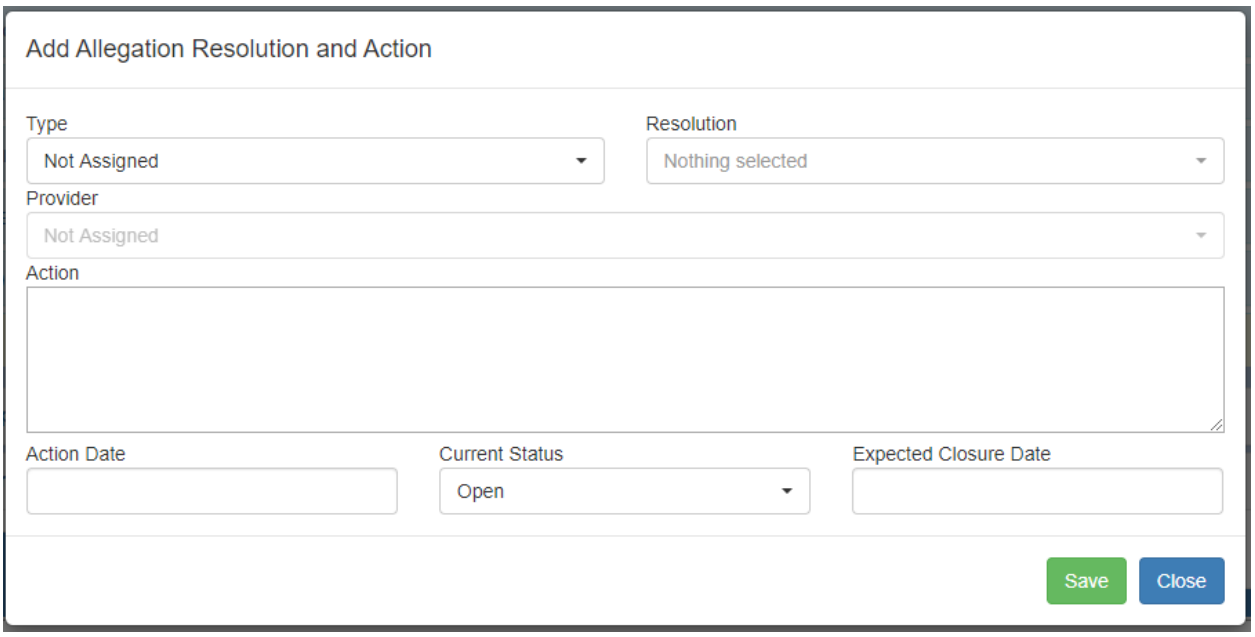
Clicking on the ✖ icon, after the user has confirmed that the action is desired, the system will remove that action and resolution from the allegation (*Figure 11.7*)

Figure 11.7



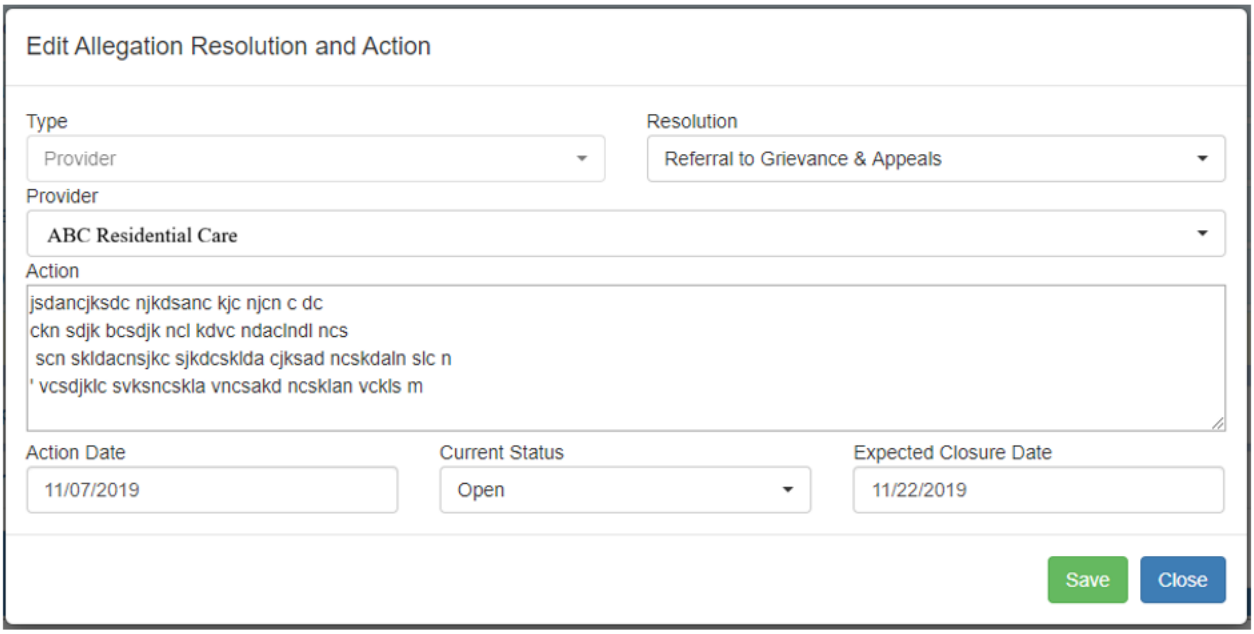
The button, “Add Resolutions and Action”, located on the bottom of the section will open a separate modal window with a form to allow the addition of a new resolution and action for the allegation (*Figure 11.8).* Information addition is *not* restricted to the logged-in user business entity. Pressing the “Save” button will apply changes.

Figure 11.8



Clicking on the icon will open a separate modal window with a prepopulated form to allow the user to update a selected action and resolution record. Information update is *not* restricted to the logged-in user business entity. Pressing the "Save" button will apply changes (*Figure 11.9*).

Figure 11.9



12. Case Summary Panel

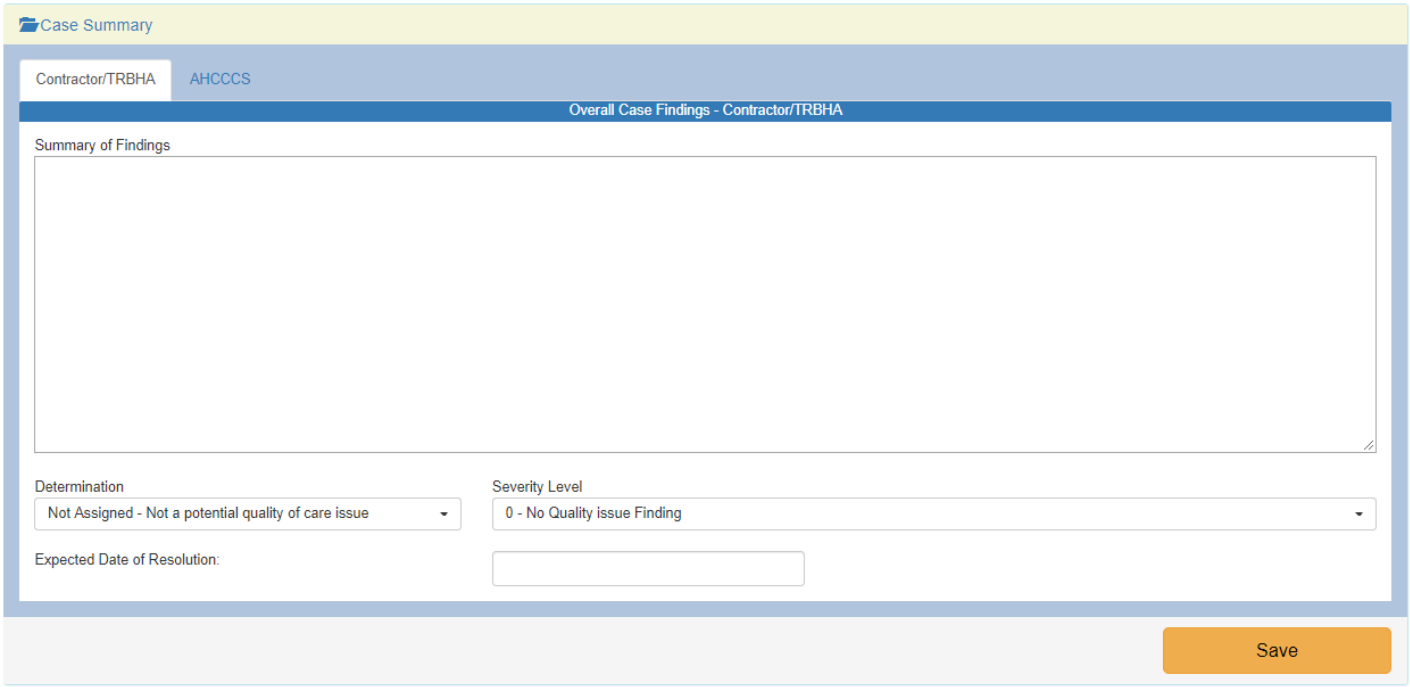
This panel holds information about overall Case findings (*Figure 12.0*). This section should be filled out with all relevant case summary/information. This summary/information should include a summary of allegations, substantiation determination, severity leveling, CAP (if needed), identified tracking and trending concerns, and overall case finding/determination and closing severity.

The determination and severity leveling should match the information provided in the allegation tab.

The Expected Date of Resolution is the date of the latest Expected Closure Date of the case, which can be located under the Resolutions and Actions section. For example, one substantiated allegation may have an Expected Closure Date of November 23rd, and another allegation with an Expected Closure Date of December 2nd. The date that should be entered in the Expected Date of Resolution should be December 2nd. Entry of a date in this section should be utilized only when there are substantiated allegations.

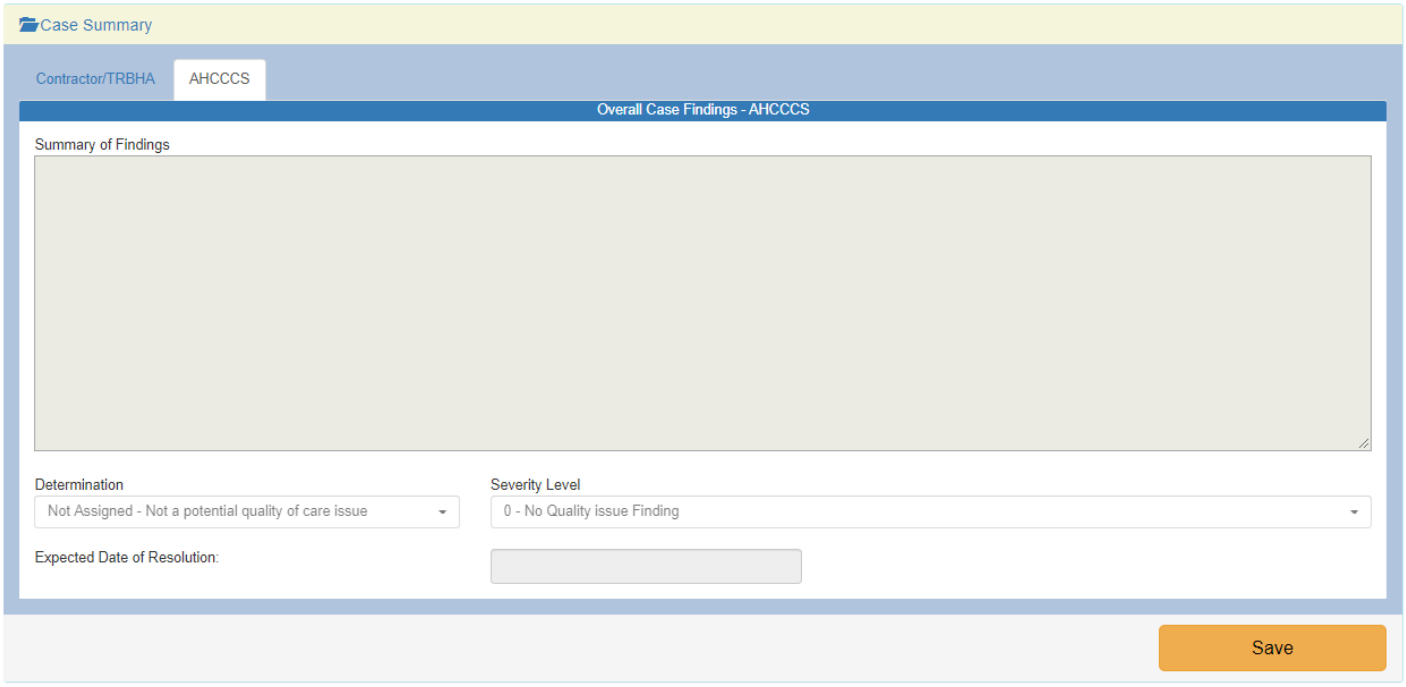
Note: This section is not where the clinical information should be written. Please refer to the Clinical Information Section of the Clinical and Diagnosis Panel to document clinical information regarding the member and the member's clinical services, such as diagnoses, medications, specialized treatments, etc. Any information regarding the timeline related to the investigation should be placed in the Timeline Panel. Information regarding the Investigation Details should be placed in the Investigation Findings of the Allegation Panel.

Figure 12.0



The Case Summary panel contains two or three tabs, depending on affiliated member designations, one for each of the business entities: Contractor/TRBHA, State Agency (DES / DCS), and AHCCCS. Initially, a visible tab will be one that corresponds with the logged-in user business entity. Click on the tab header to view other entity's overall Case findings. Viewing these entries are read-only. See *Figure 12.1* for an example of the AHCCCS tab.

Figure 12.1



Information updates are also restricted to the logged-in user business entity. Contractor/TRBHA, State Agency, or AHCCCS will only be able to update the panel which holds the information that belongs to them.

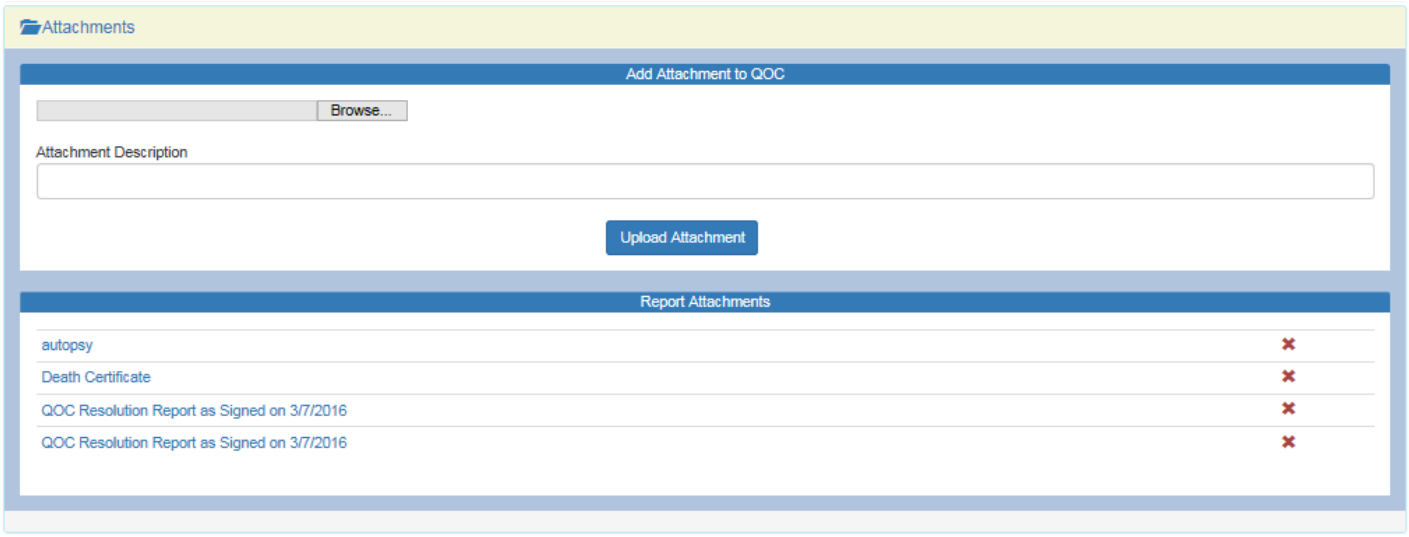
All information is updated by pressing the “Save” button located in the footer section of the panel.

13. Attachments Panel

This panel's purpose is to list all attachments for the Case (*Figure 13.0).* This includes 7-day initial findings, Attachment C, transcripts from interviews, provider response letters, etc.

Note: Per AMPM Policy 960, the Contractor shall ensure the redacted Attachment C is uploaded to the Attachments panel of the QM Portal and notify AHCCCS via the QM Portal within one business day of completion of the visit.

Figure 13.0



The Add Attachment to QOC section allows uploading files and attaching it to the Case. The maximum file size allowed for the upload is 12 MB. If the file size exceeds this value, an error notification will be displayed. There are no limits for file types that can be uploaded. But the system will refuse to upload files that are considered unsecure, such as HTML files or script files.

By using the "Browse" button, the user can choose a file for upload from the user's local file system. Attachment Description is a single line text box, and it is required field. The Upload action is confirmed by clicking on the "Upload Attachment" button.

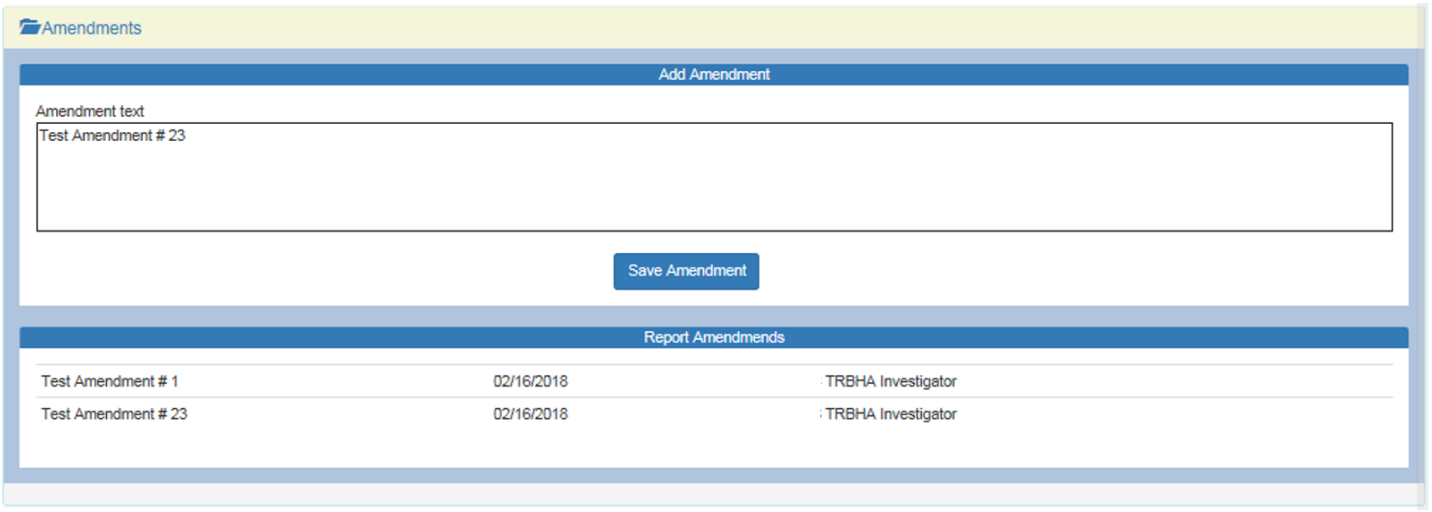
Clicking on the ✖ next to the attachment, after the user has confirmed that the action is desired, the system will remove that attachment from the list.

By clicking on the attachment description in the list of Report Attachments, the system will download the selected attachment and offer the user the option to open or save the downloaded file.

14. Amendments Panel

This panel lists all amendments to the Case. If the case is altered after the Resolution Report is signed, the amendment section should be completed to note the changes that were made. The Amendments panel can also be used as a way to add information to the case after the case is in the status of Resolution Report Sent to AHCCCS or AHCCCS Closure Completed, including answering questions from AHCCCS CQM. The amendments section does print as part of the final resolution report.

Figure 14.0



The section, Add Amendment, allows adding new amendments and contains one field Amendment Text. The user can confirm the addition action by clicking on the “Save Amendment” button.

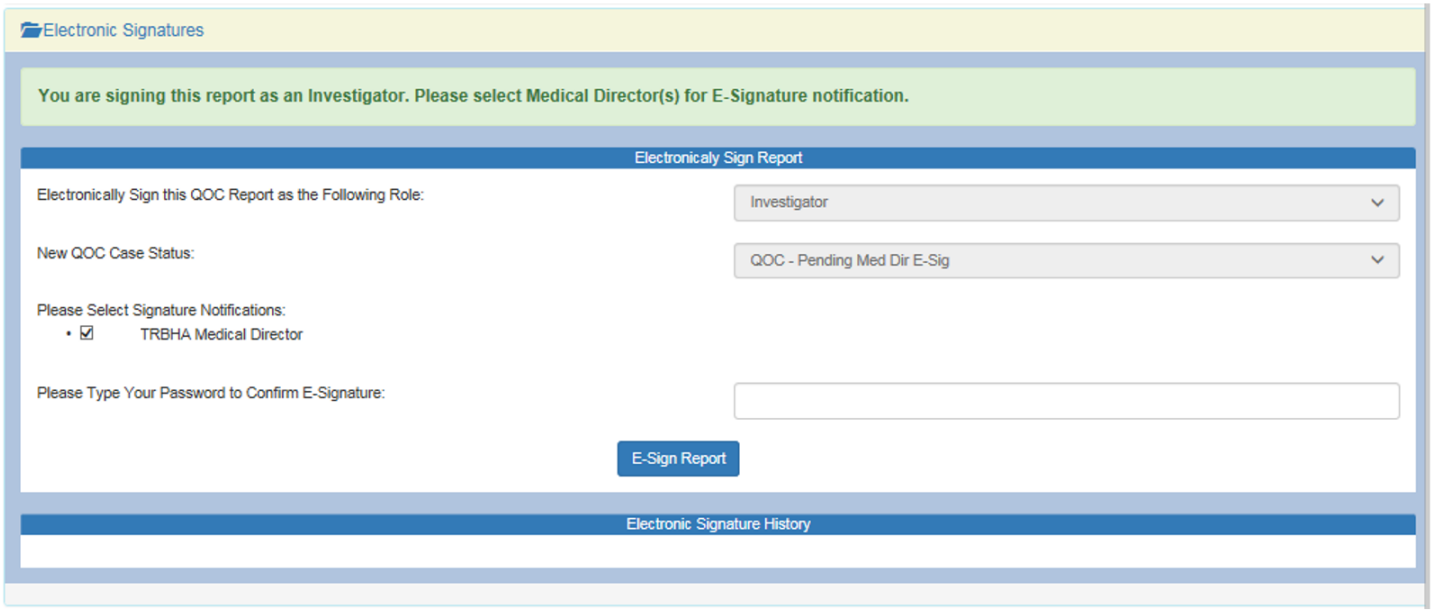
Once added, the amendment cannot be removed from the case!

In addition to the amendment text, the Report Amendments section contains the list of information about the date and username who added the amendment.

15. Electronic Signatures Panel

This panel's purpose is to list all signatories and allow users to sign the Quality of Care Report.

Figure 15.0



Content of this panel depends on logged-in user business entity, status of the QOC Case signatures and user roles in the Contractor/TRBHA business entity. For AHCCCS users, the only list of signatories will be visible, while the Contractor/TRBHA user will be able to sign the QOC Case Report.

If the QOC Case is not yet signed by any of the Contractor/TRBHA users, the user with the role of "Investigator" will be required to sign first. After, the user with the "Medical Director Dsg" role will be required to sign. The user must ensure that Medical Director is a Medical Director within the organization. If the Contractor/TRBHA business entity employs a "Third Level Review" role, then the user who has that role is required to sign before the QOC Case Report is sent to the AHCCCS QM department. If the Contractor/TRBHA does not employ a "Third Level Review" role, the Report is sent after the second level ("Medical Director Dsg") signature.

If the Contractor/TRBHA does employ a "Third Level Review" role, the "Third Level Review" role cannot be the same user/person signing as the second level "Medical Director Dsg" role.

The top portion of the panel (in green) will display messages according to the above-mentioned rule. All users that are required to sign off on the QOC Case Report must complete the electronic signature within the QOC assigned due date as delineated in AMPM Policy 960 QOC timeframes. If additional time is required to complete the electronic signature, the Contractor/TRBHA QM will need to request an extension from AHCCCS.

The Electronically Sign Report section fields: Role and Case Status are always disabled and will change according to the above explained rule. The Signature Notifications check box list will allow for the notification of all users, that may be necessary, to be informed after the QOC Case report was signed.

The QOC Case Report is signed by the user using their password used to log-in to the QM Portal. After verification, the system will make all necessary changes to the Case, send an email correspondence to the selected users, and create and attach the Case Report in Microsoft Word format. The Attached Report will be named "QOC Resolution Report as Signed on MM/DD/YYYY"

16. QOC Status and Assignments

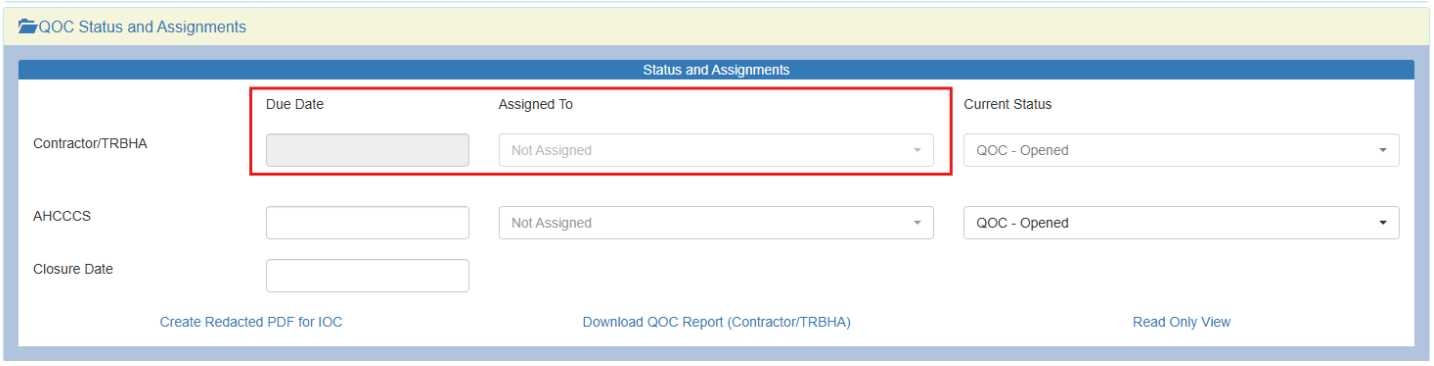
This panel's purpose is to show/change Case status, users assigned to the Case and the due date (*Figure 16.0*).

It is important for this section to remain updated as a source of information for the Contractor/TRBHA and AHCCCS QM. AHCCCS QM Coordinators use this section to verify the expected due date and the current assigned investigator. If there is a change to this information, including due to an AHCCCS approved extension request, it should be updated **immediately.**

AMPM Policy 960 states, "The Contractor shall ensure the case is updated within the AHCCCS QM Portal to reflect changes during the investigation as additional details and allegations are discovered and added."

The Status and Assignments section contains a form with one set of fields for each user business type: Contractor/TRBHA, State Agency (DES / DCS), and AHCCCS. Each business type can only update their set of fields.

Figure 16.0



IMPORTANT: The Due Date and the Assigned To fields are required fields per AMPM Policy 960.

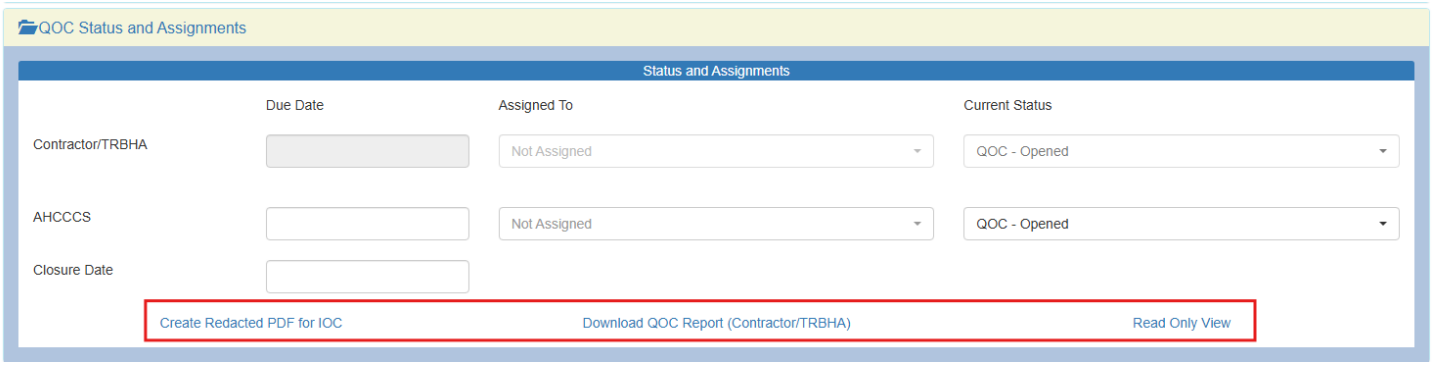
AMPM Policy 960 is clear regarding the notification timelines and due date timelines for investigations. The date documented in the Due Date field of the QM Portal shall follow the timeframes outlined in this policy.

When extension requests are approved by AHCCCS QM, the QM Coordinator will include a reminder in the QM Portal Communication, to update the Due Date to reflect the extension approved date. **It is important to wait for AHCCCS QM approval prior to updating this area. Current AMPM Policy 960: "The Contractor shall not update the AHCCCS QM Portal due date until approval has been received from AHCCCS QM."**

QOC Status and Assignments Panel Links (*Figure 16.1):*
Three links on the bottom of the section are used to:

- Create Redacted PDF for IOC link, loads page for uploading documents prepared for Independent Oversight Committees (IOC). Contractors need to review the report to verify redactions prior to submission to the IOC
- Download QOC Report (Contractor/TRBHA) link, will create and download the QOC Report in Microsoft Word format. Users will be presented with a choice to open or save the downloaded document.
- Read Only View link, loads the page and shows a read-only version of the QOC Report.

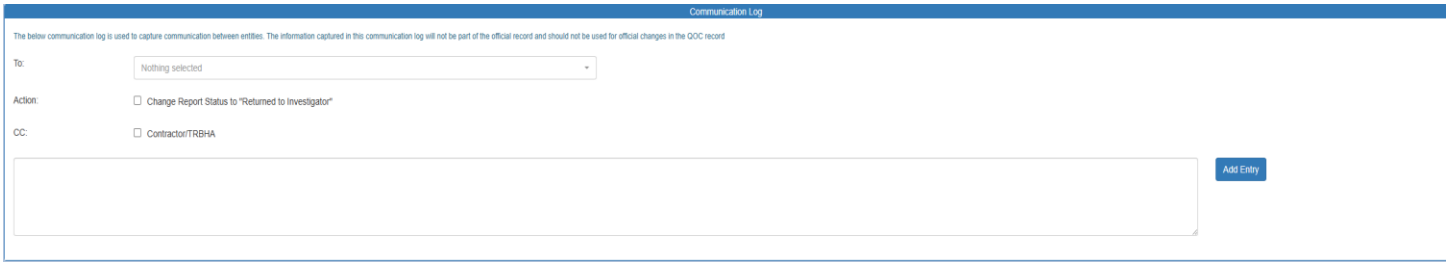
Figure 16.1



17. QOC Communication Log

This panel's purpose is to manage internal communications between entities that concern that Case (*Figure 17.0*). The action field check box is used to change a Case status to "Returned to Investigator". If the box is left unchecked at the time of clicking the "Add Entry" button, the case status will not reflect, "Returned to Investigator", and the case will not be returned to the investigator.

Figure 17.0



The QOC Communication Log allows authorized users to enter and review internal communications between entities associated with the case. Optionally, communication can be sent to the Contractor/TRBHA in the CC section of the entry. An audit log is displayed after each communication is entered.

Clicking on the "Add Entry" system will send the email message to selected parties and set the Case status (if the action check box is checked).

The list of all communications is at the bottom of the Communication Log panel. Click on the Details link (*Figure 17.1*) button in the list to open a new window with the details about the communication (*Figure 17.2*).

Figure 17.1

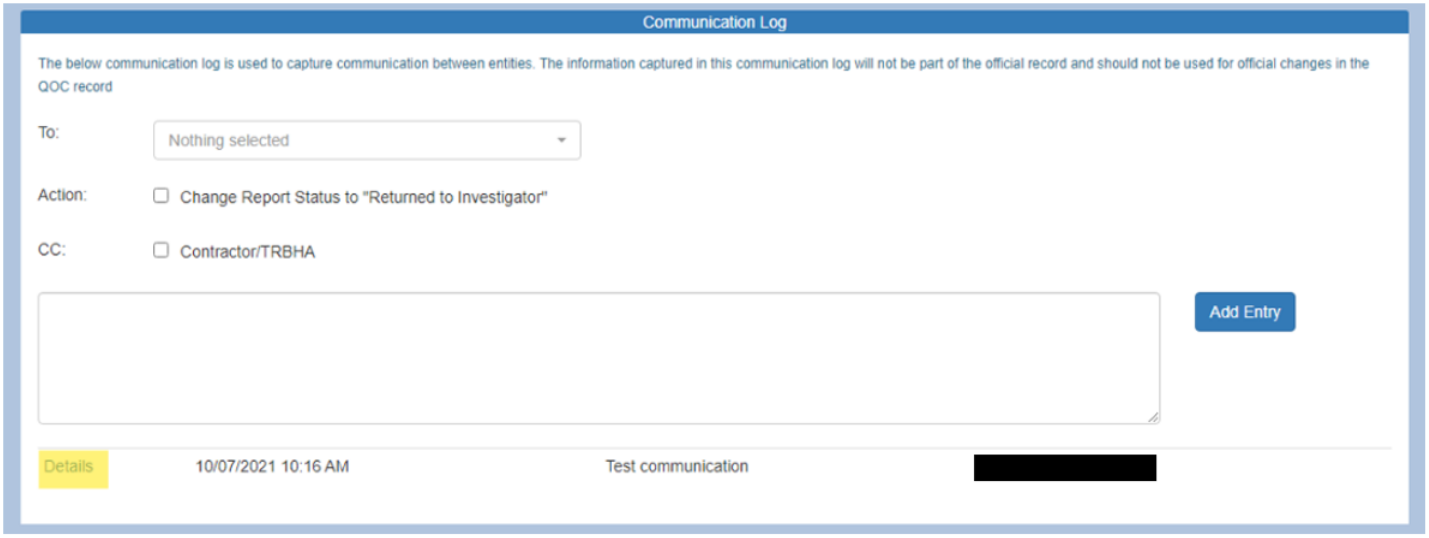
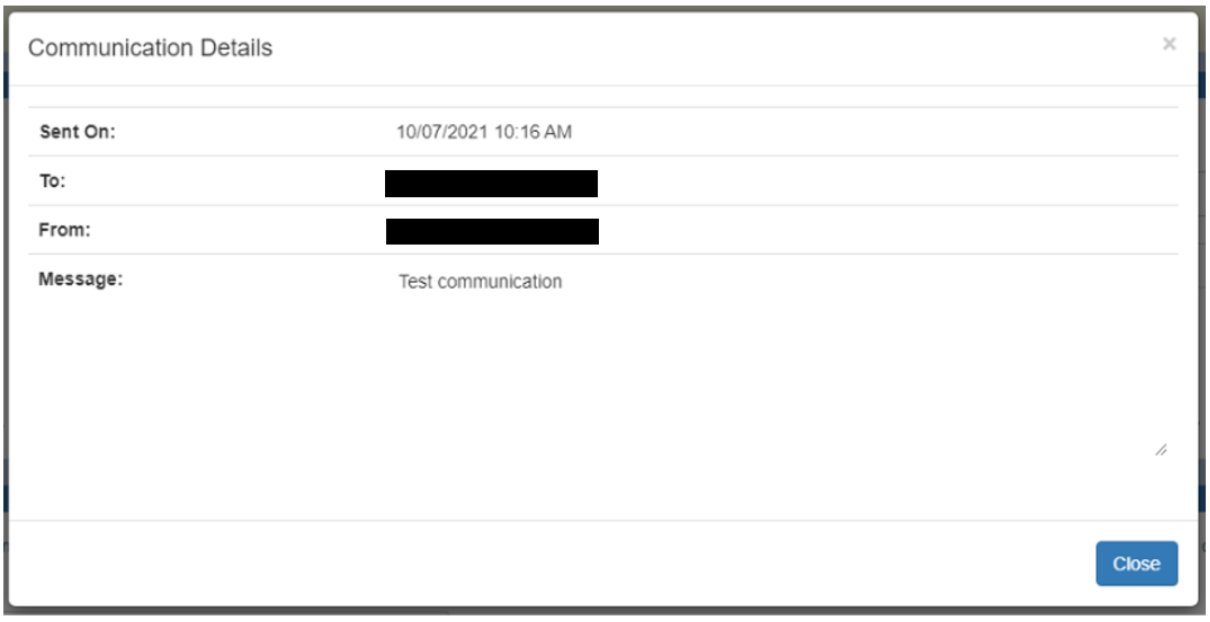


Figure 17.2



18. QOC - Report - and Read Only View

This is a separate page used to display read only information about the Case. This happens when the status of the Case is set to one of the following:

- QOC - Administrative Close
- Resolution Report Sent to AHCCCS
- Resolution Report Sent to State Agency
- AHCCCS Closure Complete

Figure 18.0

A whole, on-screen, read-only report will be visible by opening the “QOC Resolution Report” panel
Other visible panels on this page have the same functionality as on the QOC page and were explained in detail earlier in this document.

19. QOC Reassignment

When a Health Plan user attempts to reassign a QOC case by changing the Health Plan dropdown selection to a different health plan (*Figure 19.0*), the system shall display the following alert message: ALERT: The health plan assignment cannot be changed. Please send a QM Portal communication to AHCCCS QM to request an administrative closure to update the health plan assignment and include a rationale for this requested change (*Figure 19.1*).

The health plan will be required to submit an administrative closure request to the AHCCCS QM Coordinator assigned to the case or, if no AHCCCS QM Coordinator is assigned, then the AHCCCS QM Coordinator assigned as lead to the health plan. The communication should also include the AHCCCS QM Manager and QM Supervisor.

Figure 19.0

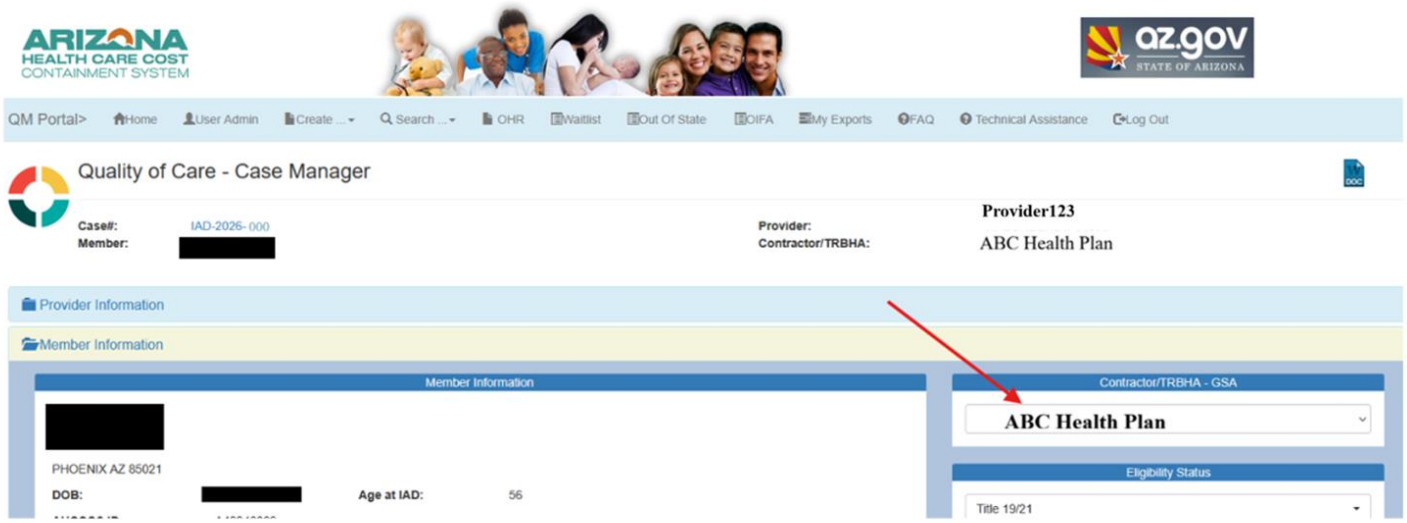
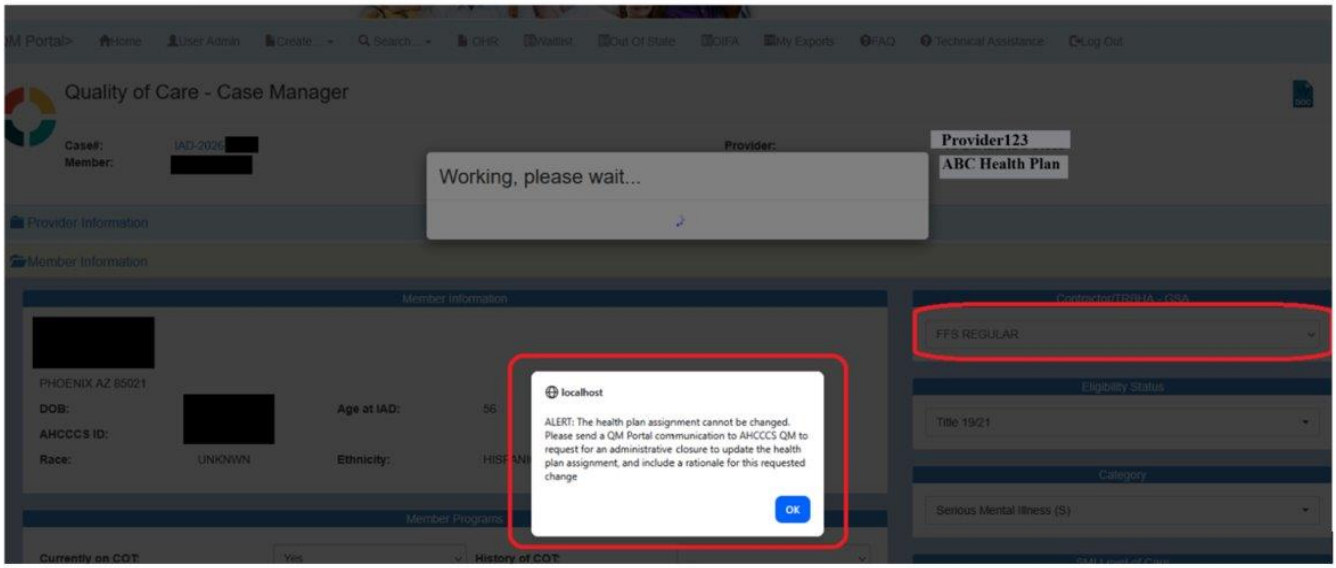


Figure 19.1



- AHCCCS will review the administrative closure request and rationale and will in turn make the following updates to the case in the QM Portal:
  - If the administrative closure is not approved, then a QM Portal communication will be sent to the health plan that the request was not approved and why. The case will remain with the health plan to continue investigation.
  - If the administrative closure is approved, AHCCCS QM will send a QM Portal communication to the health plan approving the request. AHCCCS QM will then update the health plan assignment to the new health plan

resulting in the following changes to the case in the QM Portal. By updating the Health Plan assignment the system will:

- Update the existing Case ID by appending an "-R" to the end of the case number (*Figure 19.2* and 19.3).
- Close the original case with the status, "QOC – Administrative Close" (*Figure 19.2*).
- Create a new case using the same number as the original case and assign it to the newly selected Health Plan (*Figure 19.3*).

Figure 19.2

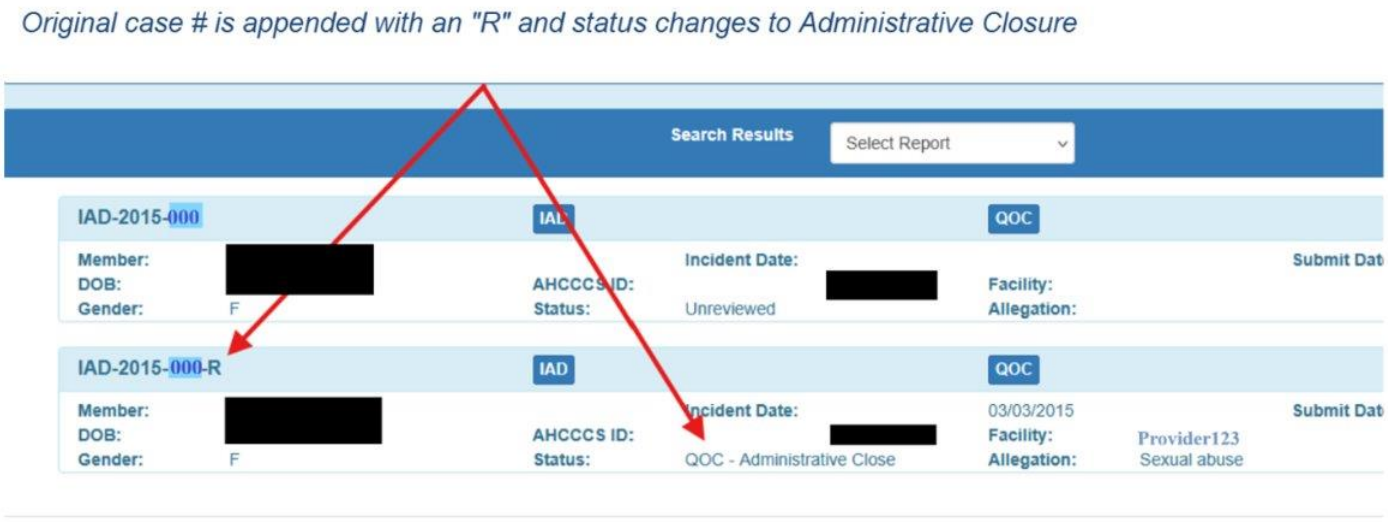
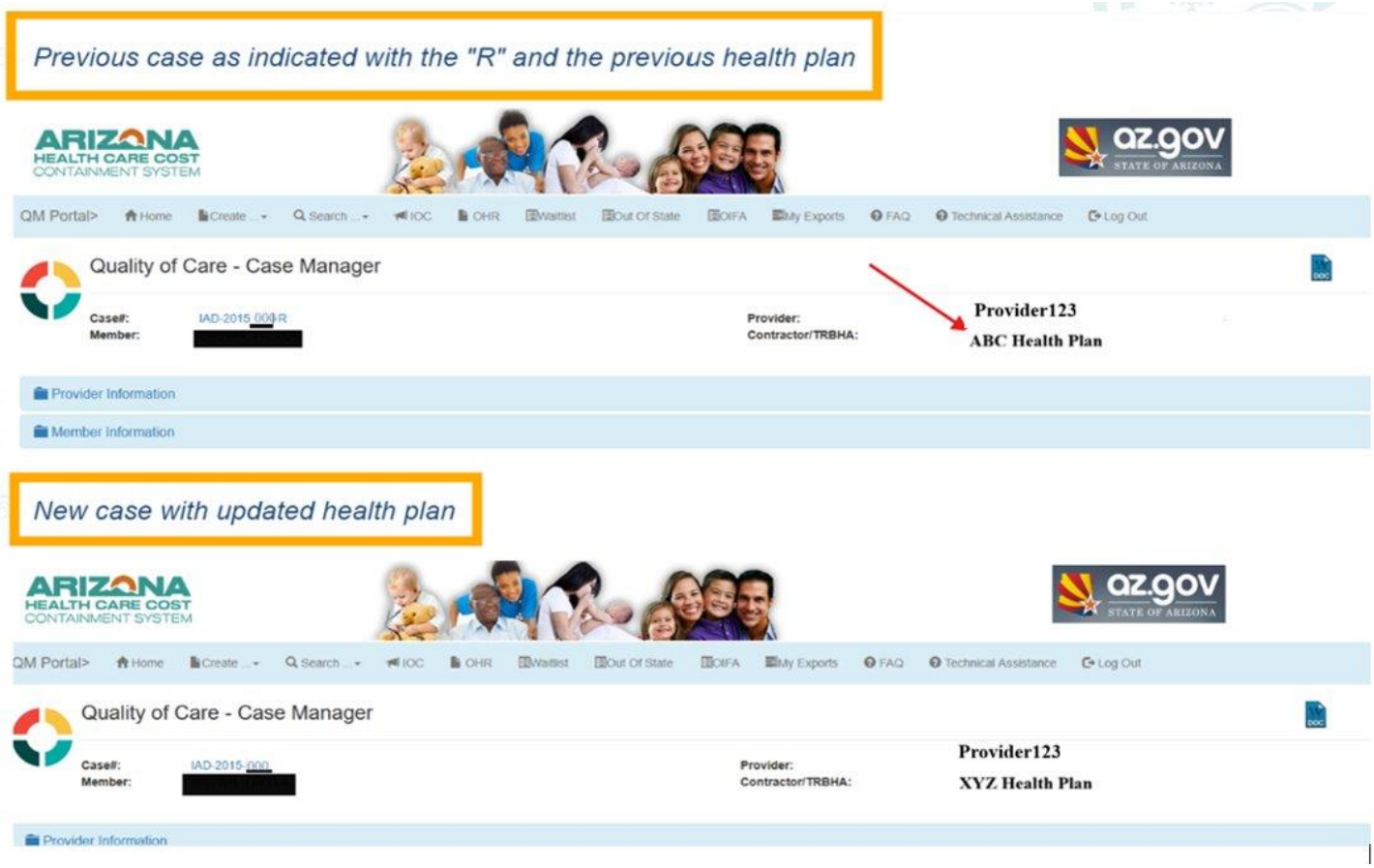


Figure 19.3



Data Handling for Recreated Cases:

- The newly created case shall include all data originally submitted by the Provider.
- Health Plan data shall begin from the Contractor/TRBHA Status Review page of the QM Portal wizard.
- Contractor/TRBHA Status Review information from the original Health Plan shall not be included.
- The new case shall be submitted to the new Health Plan with a status of Unreviewed, trigger all established notifications, and follow the standard QOC workflow.

QM Portal Search Page Enhancements:

- Health Plan Users - When searching by Case ID, the QM Portal Search Page shall return results for both "-R" and non - "R" cases (*Figure 19.4*).
- The QM Portal Search Page shall also include a "Include -R" checkbox next to the Case No. field, allowing health plan users to choose whether to include reassigned ("-R") cases in their search results (*Figure 19.5*).

- When the "Include -R" box is checked next to the case number in the Case No. field:
  - This will produce search results that have cases with both R designations and non-R designations.
- When the "Include -R" box is unchecked:
  - The QM Portal will produce a search only for the case number entered in the Case No. field. It will not include any cases designated with an "-R."

- The "Include -R" checkbox is associated only with the Case No. field. When no case number is entered into this field and a broad search is completed using date ranges, regardless if the ("Include -R") box is checked or not, the search results will produce cases with and without R-designations.

Figure 19.4

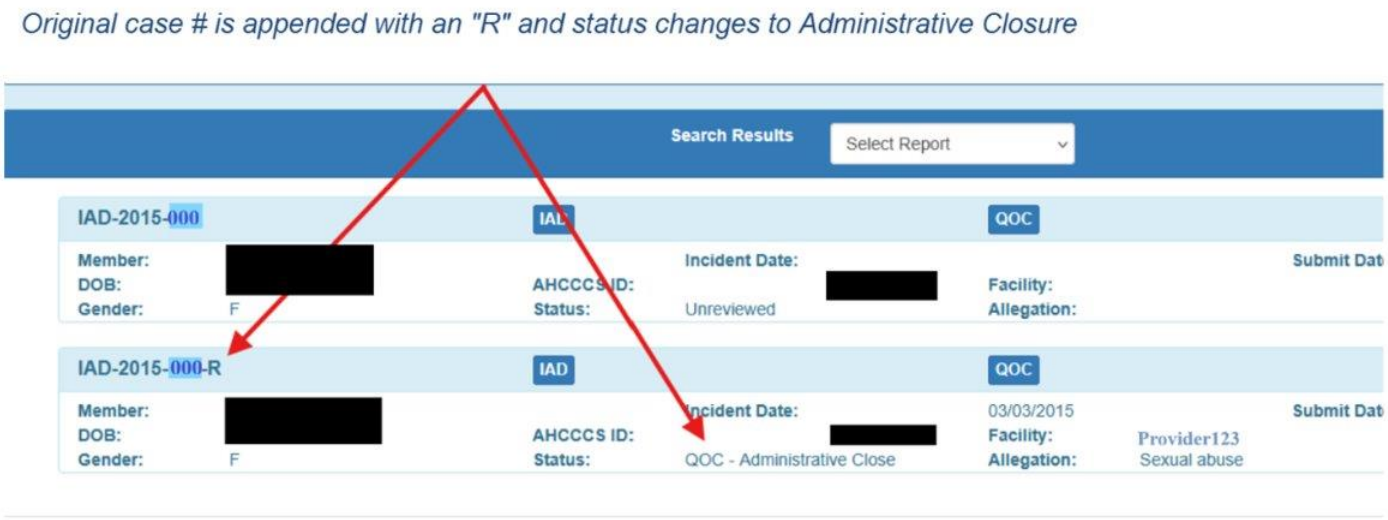
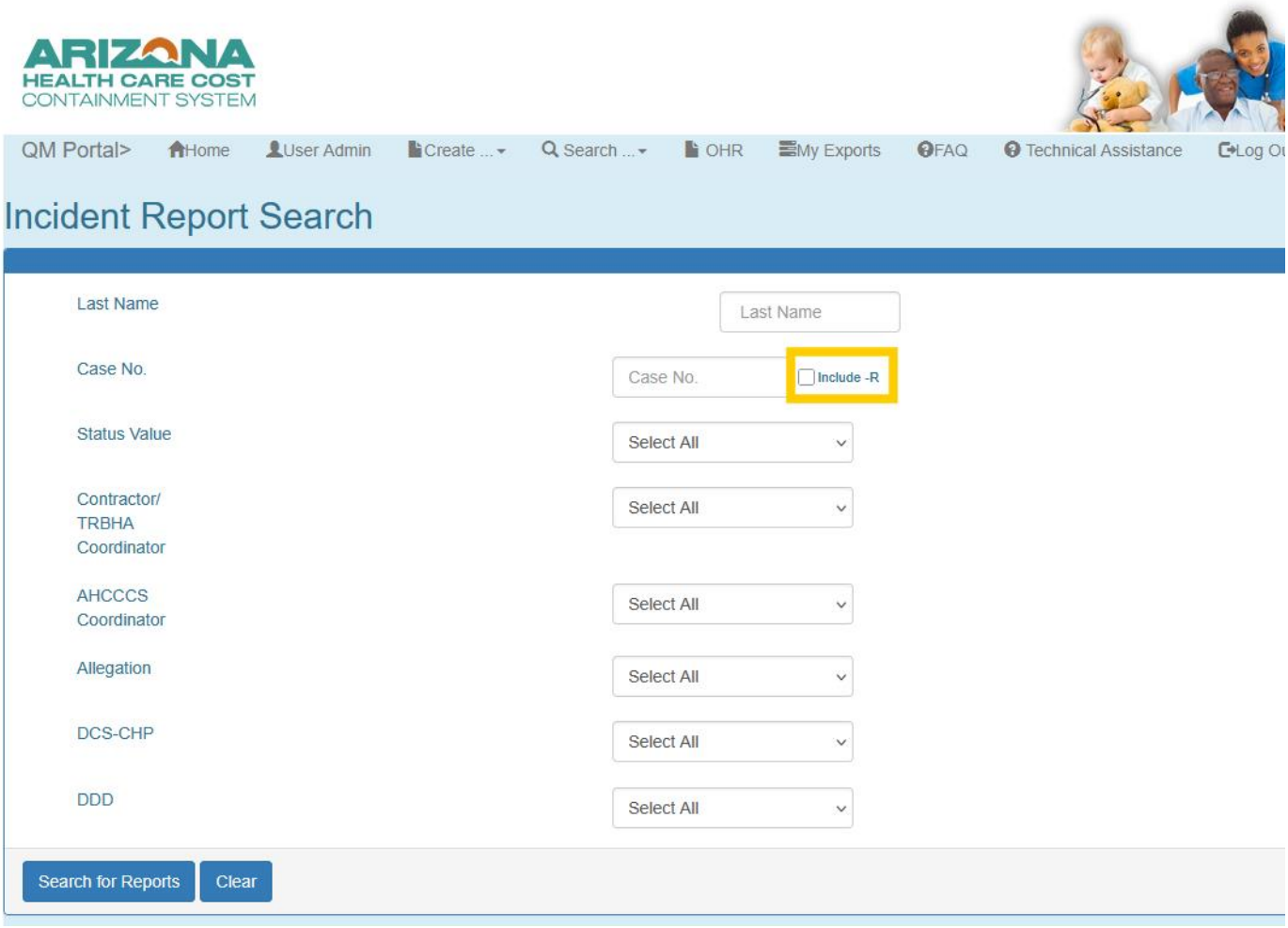


Figure 19.5


ARIZONA
HEALTH CARE COST
CONTAINMENT SYSTEM
QM Portal>
Home
User Admin
Create ...
Search ...
OHR
My Exports
FAQ
Technical Assistance
Incident Report Search
Last Name
Last Name
Case No.
Case No.
Include -R
Status Value
Select All
Contractor/
TRBHA
Coordinator
Select All
AHCCCS
Coordinator
Select All
Allegation
Select All
DCS-CHP
Select All
DDD
Select All
Search for Reports
Clear

Appendix A – Incident Categories and Subcategories

ALLEGATION_CATEGORY_DESCR	ALLEGATION_SUBCATEG_DESCR
Availability, Accessibility, Adequacy	Delay in treatment, service, or referral
	Inadequate access to care and or services
	Inadequate access to medical records
	Organ Transplant Issues
	Transportation Issues
ABUSE	Emotional abuse on a member
	Physical abuse on a member
	Physical assault (i.e., battery) on a member
	Sexual abuse/assault on a member
	Sexual Abuse/assault on a member within or on the grounds of a healthcare setting
	Verbal abuse on a member
	Exploitation of a member
	Neglect of physical, medical, or behavioral needs of a member
Death - Member	Death - Suicide
	Death - Substance Use Disorder - ETOH
	Death - Substance Use Disorder - METHAMPHETAMINE
	Death - Substance Use Disorder - HEROIN
	Death - Substance Use Disorder -PRESCRIPTION OPIOID
	Death - Substance Use Disorder - POLY PHARMACY
	Death - Substance Use Disorder - OTHER
	Death - Unexpected
	Death - Other
	Member death associated with a missing person
	Member suicide Due to Opioid or Multi-Drug Toxicity
	Member death associated with a Medication Error
	Member death associated with a fall while being cared for in a healthcare setting
	Member death associated with the use of seclusion and/or restraints
	Death of a member resulting from a physical assault
Effectiveness/Appropriateness of Care	Inadequate or Inappropriate Discharge Planning
	Inadequate or Inappropriate Discharge Planning with a Readmission for Same Condition
	Lack of Continuity of Care
	Lack of Coordination of Care
	Delay in Diagnosis or Missed Diagnosis
	Inadequate Documentation; Example, ASAM Not Completed
	Ineffective or Inappropriate Case Management
	Lack of engagement/re-engagement of member
	Treatment Below Medical Standards/Ineffective Treatment

	Ineffective or Inadequate Service Plan and/or Treatment Plan
	Ineffective or Inappropriate Management of Substance Use Disorder (SUD)
	Ineffective or Inappropriate Management of Opioid Use Disorder - OVERDOSE
	Ineffective or Inappropriate Management of Opioid Use Disorder - MEDD greater than 90
	Ineffective or Inappropriate Management of Opioid Use Disorder - Co-Occurring use of MUSCLE RELAXANT
	Ineffective or Inappropriate Management of Opioid Use Disorder - Co-Occurring use of BENZODIAZEPINE
	Ineffective or Inappropriate Management of Opioid Use Disorder - Co-Occurring use of LONG ACTING OP
FRAUD	Fraudulent actions - billing, documentation, services, licensure
	Fraudulent Utilization: Over utilization of covered services
	Fraudulent Utilization: Inappropriate utilization of covered services
OPPC-HCAC	Any Stage 1, Stage 2 pressure ulcers acquired after admission/presentation to a healthcare setting
	Avoidable Healthcare Associated Infection (HAI)
	Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a health care institution
	Avoidable Injury/Trauma: Fractures, Dislocations, Intracranial Injuries, Crushing Injuries, Burns, O
	Avoidable Complication & Other (Surgical Site Infections, Deep Vein Thrombosis, Pulmonary Embolism,
	Wrong Surgical or Other Invasive Procedure Performed on a Patient, Performed On The Wrong Body Part,
Member Rights/Respect and Caring	Inappropriate Use of Physical, Mechanical, Personal, Chemical Restraint, or Seclusion
	Cultural Competency Issue(s)
	Disrespectful/unprofessional conduct by provider
	HIPAA Breach
	Member dissatisfaction with treatment plan or care provided
Safety/Risk Management	Failure to Report a Change in Condition
	Failure to follow up or communicate laboratory, pathology, or radiology test results
	Missing person from secured setting (e.g., Dementia or memory care locked unit)
	Missing person from a licensed Facility
	Missing person not associated with a residential setting
	Unsafe environment
	Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist,
	Attempted suicide
	Suicide attempt resulting in medical attention
	Self-harm, attempted and/or completed
	Avoidable Injury or Complication
	Discharge or release of a patient/resident of any age, who is unable to make decisions

	Failure /Delay or Inadequate Regulatory Agency Reporting
	Inadequate Staffing
	Inappropriate Use of Medical Equipment
	Medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong
	Medication Error occurring at a licensed residential Provider site i
	Pharmacological Management Issues
	Treatment rendered outside clinician scope of practice
	Injury occurring on the premises or during a registered Provider sponsored activity that requires me
	Injury resulting from the use of a personal, chemical, physical, mechanical restraint, or seclusion
	Serious injury associated with member disappearance (missing person)
	Attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare
	Serious injury associated with a Medication Error
	Serious injury associated with a fall while being cared for in a healthcare setting
	Serious injury associated with the use of seclusion and/or restraints
	Serious injury of a member resulting from a physical assault that occurs during the provision of ser
	Homicide committed by or allegedly committed by a member
	Alleged or Suspected Criminal Activity
	Police/Fire/EMS called to a licensed facility
Other	Other

Appendix B – Allegation Resolution and Action Categories

ALLEGATION_CATEGORY_DESCR	ALLEGATION_SUBCATEG_DESCR
System	Advocacy
	Education
	Policy/Procedural Change
	Sanctions/Recoupment
	Regulatory/Agency Reporting
	Other
	Referral to Network Management
	Referral to Medical Management
	Referral to Performance Management
	Referral to Legal
	Referral to OIG
	Referral to Other Support Service

	Regulatory Board Meeting
	Other Peer Review Recommendations
Member	Advocacy
	Given Assistance to File a Grievance and/pr Appeal
	Other
	Referral to Customer Service
	Referral to Medical Management
	Referral to Grievance and Appeals
	Referral to Case/Care Management
	Referral to Clinical Resolution Unit
	Referral to Legal
	Referral to OIG
	Referral to Oher Support Service
Provider	Letter of Education
	Policy/Procedure Change
	Termination
	Suspension
	Regulatory/Agency Reporting
	Regulatory/Board Reporting
	Sanction
	Other Peer Review/Recommendations
	Education Staff
	Education Provider or Facility
	Referral to Network Management
	Referral to Medical Management
	Referral to Grievance and Appeals
	Referral to Clinical Resolution Unit
	Referral to Performance Improvement
	Referral to Legal
	Referral to OIG
	Referral to Other Support Service