

# **Section 12**

## **Quality Enhancement**

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# Section 12

## Capital District Physicians' Health Plan, Inc. 2019 Quality Management Program Evaluation

### Introduction and Executive Summary

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#### Mission Statement

*"We provide quality health care at a reasonable cost for our subscribers and operate CDPHP as a model for the delivery, financing, and administration of health care services."*

#### Company Background

The affiliated companies collectively known as CDPHP® include Capital District Physicians' Health Plan, Inc., CDPHP Universal Benefits,® Inc., and Capital District Physicians' Healthcare Network, Inc.

CDPHP was founded by Capital District physicians in 1984 as a not-for-profit health maintenance organization (HMO) in Albany, NY. More than 30 years later, CDPHP has grown to be the leading health benefits provider in the region, with a full suite of commercial, self-funded, and government program offerings. CDPHP and its affiliates serve more than 400,000 members in 24 counties across New York.

The CDPHP family of products includes three business lines:

- **Capital District Physicians' Health Plan, Inc.** HMO, Healthy New York, Medicare Advantage (HMO), Medicaid, Essential Plan, Child Health Plus, and Marketplace HMO.
- **CDPHP Universal Benefits,® Inc.** Preferred provider organization (PPO) and high deductible PPO (HDPPPO) plans, exclusive provider organization (EPO) and high deductible EPO (HDEPO) plans, transitional plans (EPO and PPO), CDPHP Shared Health plans (EPO and PPO), CDPHP Embrace Health plans (EPO and PPO), Healthy Direction plans (EPO and PPO), Medicare Advantage (PPO), Medicare Advantage Medicare Supplemental insurance, and Marketplace EPO.
- **Capital District Physicians' Healthcare Network, Inc.** Administrative services only (ASO), self-insured plans, and funding accounts.

#### 2019 Awards and Recognition

For more than 30 years, CDPHP has taken great pride in its commitment to quality, and that continues to show as six of the company's health plans are among the top-rated in the nation according to NCQA's Health Insurance Plan Ratings 2019–2020.

##### NCQA's Private Health Insurance Plan National Ratings 2019–2020\*

- Capital District Physicians' Health Plan, Inc. – Commercial (HMO): 5 out of 5
- Capital District Physicians' Healthcare Network, Inc. – Commercial (HMO/POS): 5 out of 5
- Capital District Physicians' Healthcare Network, Inc. – Self-Funded (PPO): 4.5 out of 5
- CDPHP Universal Benefits, Inc. – Commercial (PPO): 4.5 out of 5

##### NCQA's Medicaid Health Insurance Plan National Ratings 2019–2020

- Capital District Physicians' Health Plan, Inc. (HMO): 4.5 out of 5

##### NCQA's Medicare Health Insurance Plan Ratings 2019–2020

- Capital District Physicians' Health Plan, Inc. (HMO): 4.5 out of 5

*\*Due to the COVID-19 pandemic, NCQA did not release 2020–2021 Health Plan Ratings for any product line. CDPHP maintains its 2019–2020 ratings.*

## Centers for Medicare & Medicaid Services (CMS)—2019–2020 Medicare Overall Stars Ratings

- CDPHP Medicare PPO earned a quality rating of 5 out of 5 Stars.
- CDPHP Medicare Advantage HMO earned a quality rating of 4.5 out of 5 Stars.

## Board of Directors

The CDPHP Board of Directors, as the governing body, maintains overall accountability and responsibility for the Quality Management Program. The Board delegates the responsibility and accountability for the day-to-day operation and administration of the program to the Quality Management Committee (QMC) and to the chief medical officer (CMO). The CMO, who reports to the chief executive officer (CEO), is responsible for the implementation and operation of the program and for ensuring responsible reporting and communication of plan progress and evaluation from the Quality Management Committee to the Board of Directors, and back to the Quality Management Committee.

The senior vice president of health care quality coordinates the overall development, review, and revisions of the program description and the review of the effectiveness of the Quality Management Program Evaluation in collaboration with the CMO and the Quality Management Committee.

A 15-member Board of Directors, including eight community physicians, governs CDPHP, along with community directors who play a vital role in policy setting and administration. In addition, community physicians share in the management of the plan through participation on the Nominating Committee, Physician Compensation Committee, Member Grievance Committee, Credentials Committee, Quality Management Committee (QMC), Utilization Management Committee (UMC), Behavioral Health Committee (BHC), Pharmacy and Therapeutics Committee (P&T), Joint Health Services Committee (JHSC), Clinical Quality Teams (ad hoc), and the Physician Grievance Committee.

## Quality Management Program

CDPHP maintains a comprehensive, proactive quality management program that provides the structure, process, resources, and expertise necessary to systematically define, evaluate, monitor, and ensure that high-quality, cost-effective care and service are provided to CDPHP members. The program is a commitment to continuous quality improvement principles and requires participation of the CDPHP board of directors, CDPHP practitioners and providers, and CDPHP staff members. Practitioner and provider performance data may be used for quality improvement activities.

The CDPHP Quality Management Program includes a continuous, objective, and systematic process for monitoring and evaluating key indicators of care and service; identification of opportunities for improvement; development and implementation of interventions to address the identified opportunities; and re-measurement to demonstrate effectiveness of program interventions. All quality management program activities are evaluated and reported in the *CDPHP Annual Quality Management Program Evaluation for 2019*.

In this document, the CDPHP 2019 Quality Management Program activities (including those required by New York State for Medicaid–Select Plan and HARP) are summarized and evaluated, including the program’s major accomplishments and trending of data and results over time. The evaluation includes information regarding: program structure; quality management, performance measurement and related committees and their accomplishments; resources dedicated to the program; clinical guideline development; practitioner and provider credentialing/recredentialing; network adequacy; utilization management/resource coordination; member complaints and appeals; medical record review; HEDIS reporting; clinical and service quality initiatives; patient safety; member education, health promotion and population management. Also included is a description of completed and ongoing quality management activities, including trending of results to assess performance, analysis of results (including identification of barriers and mitigation plans), and overall evaluation/analysis of the effectiveness of the quality management program.

This process leads naturally to the development of recommendations for the upcoming year, which are then incorporated into the **2020 QM Program Description and 2020 QM Work Plan**. Through the annual Quality Management Program Evaluation, CDPHP is able to assess the strengths of the program and also to identify opportunities for improvement, enhancing our ability to improve care and service to members by incorporating the lessons learned from ongoing activities.

After reviewing and evaluating overall performance and program effectiveness in all aspects of the 2019 QI program, including its progress toward influencing network-wide safe clinical practices, adequacy of QI program resources, QI Committee structure and practitioner participation, and leadership involvement in the QI program, it has been determined by the Quality Management Committee and Board Of Directors that all planned activities in 2019 were completed and yearly objectives were met; thus the quality management program is effective and will not require any restructure in 2020.

As part of delegation oversight and coordination of delegated activities, in 2019, the JHSC required the following delegates to report to the committee: pharmacy vendor (Caremark), dental vendor (Delta Dental and DentaQuest), care management (Landmark), and physician and hospital online directories vendor (HealthSparq dba Clarus Health). In addition, program oversight of NYS health homes. The committee approved the written pre-delegation and delegation agreement documents, the quality management evaluations, programs, and work plans, and receives quarterly and annual reports containing results and action plans regarding delegated activities.

Members and/or their designees have the right to express their dissatisfaction with recent care or service provided by a CDPHP participating practitioner or facility. As part of our review, CDPHP will contact the provider/facility involved to request a response and associated records when applicable. The provider is allotted up to 7 days to provide the requested information so the review can be completed in a timely manner. Failure to provide the requested response/information is a direct violation of the provider's CDPHP contract. Following a thorough review by CDPHP's Medical Director, a written response will be sent to both the member and the provider.

## Clinical Service Quality Teams

Clinical service quality teams function on an ad hoc basis for the plan. Participating practitioners, representing the major medical, surgical, specialties, and behavioral healthcare practitioners are available to assist and support quality activities within the plan. These board-certified practitioners/providers may function independently, in multi-disciplinary clinical quality teams, or as a workgroup comprised of a particular specialty as needed. All other practitioner/provider types are called on as needed for quality management activities. Current teams include avoidance of antibiotics for acute bronchitis, ADHD, and use of medical imaging for low back pain.

The practitioners/providers actively assist the QMC and other quality-related committees in:

- Developing and revising preventive and clinical practice guidelines and protocols
- Reviewing and recommending medical policies and procedures for benefit coverage by assessing medical technologies, medical intervention, or drugs in terms of effectiveness, efficacy, safety, and outcome
- Providing expert opinions on specific specialty issues or cases
- Performing peer review and consulting functions
- Integrating quality activities with performance management, physician engagement, case management, disease management, and population health and wellness departments
- Providing applicable information relating to the resolution of member complaints

## Practitioner and Provider Network

### Practitioners

Practitioners	Number (12/01/18)	Number (12/01/19)	Number (12/01/20)
Primary Care Physicians	3,693	3,989	4,180
Specialists including OB	6,680	8,229	12,792
Adjunct Practitioners	2,190	2,517	2,951
Enhanced Primary Care (EPC) Practitioners*	804	846	852

\*EPC Practitioner numbers are included in the Primary Care Physician counts

### Providers

Providers	Number (12/01/18)	Number (12/01/19)	Number (12/01/20)
Hospitals	71	73	75
Skilled Nursing Facilities	116	113	123
Home Health Agencies	64	64	58
Outpatient Surgery Centers	29	33	34
Other, including DME, Lab, Radiology, and Pharmacy	1,431	562	5,505

### Behavioral Health Providers/Practitioners

Practitioners	Number (12/01/18)	Number (12/01/19)	Number (12/01/20)
Behavioral Health	2,390	2,496	3,119

CDPHP has a 26-county service area. During 2019, the overall strategic goal was to align with providers in progressive population management payment models that promote and incentivize pay for value, cost efficiencies, patient satisfaction, and quality care, while maximizing operational effectiveness and lower medical cost trend.

EPC is the CDPHP patient-centered medical home (PCMH) model. The model essentially abandons fee-for-service (FFS) and instead pays for the value derived from the PCP's influence on all care, advancing the principles of the Quadruple Aim on cost or efficiency, quality or effectiveness, and experience of care, and thus providing prospective risk-adjusted comprehensive payment for comprehensive care. In 2019, our EPC program included 190 network practice sites and over 900 network clinicians caring for nearly 250,000 members across all product lines.

The EPC payment model is structured to encourage providers (through compensation incentives) to spend more time with the patients in most need of care, rather than focusing on the number of visits, which has economic incentive under the traditional FFS payment model. CDPHP engages the EPC sites with physician engagement specialists and population health engagement specialists who work with the providers on quality and cost of care metrics for CDPHP members.

The CDPHP strategy to support primary care is continuing in 2020 with practice transformation assistance services. CDPHP is a Transformation Agent for the NYS PCMH/ NYS Advanced Primary Care initiative and has engaged more than 45 practices in the program. CDPHP will also continue to work with practices to assist in the achievement of CPC+ requirements and milestones.

## **The Future of CDPHP: Building Our Health Value Strategy**

CDPHP continues to work with employers, members, providers, as well as CDPHP employees, to ensure the provision of quality health care at reasonable costs and operate CDPHP as a model for the delivery, financing, and administration of health care services. CDPHP is an innovator in health care transformation and payment reform and remains committed to offering more choice and flexibility to employer groups, ultimately providing health care solutions and value through all stages of our members' lives. CDPHP will continue to introduce and promote innovations in care and population management, leading the move to value-based payment as the true partner with our physician network and providing expertise and resources to aid in their move to new payment methodologies. CDPHP has emerged as a leader for practice transformation and training care management resources by offering unique approaches to population health. CDPHP seeks to form partnerships with organizations that can bring value in the shared goals of the Triple Aim.

## **Health Value**

The CDPHP board of directors and management team are committed to making CDPHP one of the leading not-for-profit health plans in the country, known for a commitment to quality, payment and care innovation, and customer service. This corporate strategy reflects a commitment to working with members, providers, regulators, and the larger community to enhance the value of the services that members receive and to move to payment methodologies that encourage and reward that value.

Basic tenets of health value are:

- Goals are aligned with the Triple Aim of improved health, improved member experience, and control of cost increases.
- Quality must be maintained or enhanced and cannot be compromised for cost.
- Quality includes the six areas defined by the Institute of Medicine: safe, effective, patient-centered, timely, efficient, and equitable.
- Overall, the value of the services will be enhanced through better continuity and coordination of care and increased compliance with evidence-based guidelines to provide better outcomes.
- Identification of populations with similar health care needs and organizing resources to address those needs effectively and efficiently.
- Payment reform is focused on value over volume, with comprehensive payment for comprehensive care.

**The key strategies** employed toward the goal of being one of the leading not-for-profit health plans in the country, known for our commitment to quality, payment and care innovation, and customer service, are:

- Develop a deep understanding of our customers.
- Be valued partners with our physicians.
- Maintain our market-leading position in the Capital Region across all product lines.
- Improve the health and economic well-being of our community.
- Be profitable by controlling medical and pharmacy costs.
- Utilize data to segment member population and drive data insights.
- Build morale internally and trust externally.

## **Appendix 1—2019 Quality Work Plan and Progress Toward Goals**

# Practitioner Standards for Medical Records Review—2024

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Performance Goal: 90%

1. Is the patient's name, date of birth and the date of service on each page of the chart? \_\_Y \_\_N

2. Is there a completed problem list? \_\_Y \_\_N

*Indicated on a separate list; should be updated to include all significant illnesses and medical conditions. For EMR this can be listed within the note.*

3. Are allergies (or the absence of) prominently displayed? \_\_Y \_\_N

*Presence or absence of allergies must be prominently displayed with reactions noted for each allergy identified. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.*

4. If allergies are indicated, are adverse reactions documented as well? \_\_Y \_\_N \_\_NA—if patient had no allergies

*Presence or absence of allergies must be prominently displayed with reactions noted for each allergy identified. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.*

5. Is there a medication list? \_\_Y \_\_N

*There needs to be a current list of medications that the patient is taking. This list can be located on a separate sheet or within each visit note.*

6. Does the record contain an appropriate medical history and a physical? \_\_Y \_\_N

*Past medical history is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.*

7. Is working diagnosis consistent with findings? \_\_Y \_\_N

*The history and physical exam document the appropriate subjective and objective information for the presenting complaints. A written diagnosis is recorded as related to the findings of the completed physical exam.*

8. Are plans of action/treatment consistent with diagnosis? \_\_Y \_\_N

*Any course of treatment or plan of action must directly correlate to the written diagnosis, or for necessary preventive health or chronic illnesses.*

9. Is the plan of care documented? \_\_Y \_\_N

*Care plan is identified in the chart.*

10. Is there evidence of documentation of care delivered in other settings (e.g. inpatient stays, emergency room visits, and ambulatory surgery)? \_\_Y \_\_N \_\_NA—if the patient had no services in these locations

*Documentation is evident in the record to support coordination of care between the practitioner and the health care facility.*

*There should be documentation by the physician in subsequent progress notes and/or a copy of the actual incident report evident in the chart.*

11. Is there evidence of continuity and coordination of care between primary and specialty physicians—Is there documentation of the reason for the referral? \_\_Y \_\_N \_\_NA—if the patient was not referred

*There should be a reason for the referral in the chart. There should be a copy of the consult report in the record regarding the progress or condition of the patient, and/or documentation within the physician's notes of efforts to obtain such information. A recorded discussion with the specialist is sufficient documentation. Answer NA if the member was not seen by the specialist yet.*

*\*CDPHP requires that OB/GYN practitioners provide the primary care physician with written correspondence of all care rendered.*

12. Is it documented that cancer screening was discussed or completed? \_\_Y \_\_N \_\_NA

a. Documented breast cancer screening \_\_Y \_\_N \_\_NA

b. Documented cervical cancer screening \_\_Y \_\_N \_\_NA

c. Documented colorectal screening \_\_Y \_\_N \_\_NA

*Documentation of appropriate screenings for each cancer screening: Mammogram, Pap smear, and/or HPV screening, colonoscopy or other appropriate screenings for colorectal cancer screenings, or exclusion criteria documented as to why screening was not completed.*

13. Are the provider's signature and credentials on each chart entry? \_\_Y \_\_N

- Signature must be legible, or over a typed name including credentials.
- Electronic signatures must indicate "approved by," "signed by," or "electronically signed by."
- Rubber-stamp signatures are NOT acceptable.

14. Were required or recommended immunizations discussed and/or documented for the patient? \_\_Y \_\_N \_\_NA

*Appropriate immunizations documented in the record according to age requirements.*

15. Screened for depression? (applicable for 12 years and older) \_\_Y \_\_N \_\_NA

16. Standardized tool used? \_\_Y \_\_N \_\_NA

*Was depression screening done of the patient, PHQ2 or PHQ9 tool or any other depression screening tool use?*

Resource: NCQA/CMS

DS:MedRec2001, Revised 2010, Reviewed 2014, Revised 2016, Reviewed 2024

Revised February 2025

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# Medical Record Documentation: Basics and Beyond

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CDPHP often reviews member medical records, as needed, to transact health plan business, as well as to comply with regulatory agencies such as NCQA and CMS. We generally find that our network providers' documentation practices adequately fulfill basic standards of care, but, occasionally we do identify opportunities for improvement in documentation.

Please be aware of the following documentation guidelines from CMS:

- The provider's *signature and credentials* must be on each chart entry, with the *patient name and date of service on each page* of the medical record.
- Signatures must be legible, or written above a typed name, *including credentials*.
- Electronic signatures must indicate "approved by", "signed by" or "electronically signed by."
- Rubber stamp signatures are NOT acceptable; stamped signatures are only permitted in the case of an author with a physical disability who can provide proof to a CMS contractor of an inability to sign due to a disability.
- When an error is made in the handwritten record, the provider must cross out the incorrect information with a single line, *initial and date the correction*, then write in the correct information. (i.e., ~~with a single line~~)
- For accurate and complete diagnosis coding, always use the current version of ICD-10-CM and follow standard coding guidelines.

Thank you for your cooperation in meeting and exceeding the basics of good medical record documentation.

For more information about the CMS regulations, visit the Medicare Learning Network at <http://go.cms.gov/MLNProducts> to access the following resources:

DHHS/CMS publication ICN 905364, October, 2013

DHHS/CMS publication ICN 909160, November, 2015

Optum Risk Adjustment Documentation, Coding & Quality Toolkit, September, 2013



# Capital District Physicians' Health Plan, Inc. Appointment Access—PCPs and OB/GYN

**Exhibit A.1**

Initial Survey: \_\_\_\_\_

Date of Study: \_\_\_\_\_

Repeat Survey: \_\_\_\_\_

Time of Study: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Reviewer Name: \_\_\_\_\_

Group Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

*Please ask to examine the practitioner's appointment book with a member of his or her staff to determine the next available appointment for the following types of service: Use the scripted patient care scenarios to describe the situations.*

Appointment Type	Appointment: Date & Time	Standard	Standard met?	
			Yes	No
Urgent Care		Within 24 hours		
Non-urgent "sick" visit		Within 48-72 hours, as clinically indicated		
Emergency Care		Immediately		
Routine Primary Care; Preventive Care Appointments		Within 48 hours		
<b>FOR PRACTITIONERS RENDERING OBSTETRICAL CARE:</b>				
Initial prenatal visit		Within: 3 weeks during 1st trimester, 2 weeks during 2nd trimester, 1 week during 3rd trimester		
Non-urgent "sick" visit		Within 48 hours		
<b>FOR PRACTITIONERS RENDERING FAMILY PLANNING SERVICES:</b>				
Initial Family Planning		Within 2 weeks		
<b>FOR PRACTITIONERS TREATING NEWBORNS:</b>				
Initial Newborns		Within 2 weeks of hospital discharge		

Open/Closed Practice	Yes	No	Comments
Is the physician accepting new patients?			
Are medical records required for scheduling office visits?			

STD Reporting	Yes	No	Comments
Does the practice do mandatory STD reporting?			

Specialty Restrictions	Yes	No	Comments
OB/GYN—limited to GYN?			
OTHER: Are there any restrictions to the provider specialty?			

*Special Notes:* Note here extenuating circumstances affecting appointment availability (e.g., vacations, illness, practice below optimal staffing, etc.).

If practitioner is not accepting new patients or does not meet appointment standards, can this be met by the group or other practitioners in the office? (i.e., practitioner cannot see new patients in 4 weeks; however, nurse practitioner can):



## Practice Site Evaluation and Medical Record Documentation

Initial Survey: ..... \_\_\_\_\_  
 Urgent Care Facility: ..... \_\_\_\_\_  
 Repeat Survey: ..... \_\_\_\_\_  
 Member Complaint: ..... \_\_\_\_\_

**Site Survey Score: Must Pass each Site Observation Section; if not met, then a corrective action plan will be implemented for the area scored less than passing and a re-evaluation survey conducted.**

Reviewer: \_\_\_\_\_

Date: \_\_\_\_\_

It is recommended that a copy of the office letterhead or business card be obtained to ensure that all current office information is obtained.

Provider: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Site Observation	Criteria Assessed	Score to	No	N/A	Comments
1. Handicapped parking identify	• Available near entrance with pedestrian ramps at sidewalks and/or drop-offs	5	0		Score (10/10) to pass __ Passed
	• Access ramp available	5	0		__ Not met; Action plan required
2. Office is handicapped accessible	• Elevator, ramp, or lift-chair for non-first floor office	5	0		Score (25/30) to pass __ Passed
	• Accessible entrance provides direct access to the main floor, lobby, or elevator	5	0		__ Not met; Action plan required
	• Bathroom railings/grab bars	5	0		
	• Doorways, pathways and aisles 36" to accommodate W/C	5	0		
	• Low carpeting securely attached along the edges or tile floor	5	0		
3. Needles, sharps and bio-hazardous materials	• Accessible seating spaces in the waiting area	5	0		
	• All sharp and bio-hazardous materials are stored in proper containers	5	0		Score (5/5) to pass __ Passed __ Not met; Action plan required

Site Observation	Criteria Assessed	Score to	No	N/A	Comments
4. Prescription drugs storage	<ul style="list-style-type: none"> <li>• Prescription and controlled drugs are stored in an area of restricted access and locked as appropriate.</li> <li>• Prescription pads are not left where easily accessible.</li> </ul>	5 5	0 0		Score (10/10) to pass __ Passed __ Not met; Action plan required
5. Refrigerators	<ul style="list-style-type: none"> <li>• Equipped with a thermometer.</li> <li>• Separate refrigerators for medications and specimens, each with a thermometer.</li> </ul>	5 5	0 0		Score (10/10) to pass __ Passed __ Not met; Action plan required
6. Waiting room	<ul style="list-style-type: none"> <li>• Neat and clean.</li> <li>• Average of two seats per practitioner in office</li> </ul>	5 5	0 0		Score (10/10) to pass __ Passed __ Not met; Action plan required
7. Exam/treatment rooms	<ul style="list-style-type: none"> <li>• Neat and clean.</li> <li>• Average of two exam rooms for each practitioner.</li> <li>• Rooms offer auditory and visual privacy for patient.</li> <li>• Hand washing facilities are available.</li> <li>• Dressing rooms and treatment rooms are accessible to handicapped members.</li> </ul>	5 5 5 5 5	0 0 0 0 0		Score (25/25) to pass __ Passed __ Not met; Action plan required
<b>Medical Record Keeping Audit</b>					
8. Records are maintained in a confidential manne .	<ul style="list-style-type: none"> <li>• Assess the practice of protecting PHI and handling of confidential membe information.</li> </ul>	5	0		Score (5/5) to pass __ Passed __ Not met; Action plan required
9. There is a standard format for medical record keeping.	a. Format and content of medical record meet regulatory requirements. b. All documented office visits have a provider signature and credentials.	2.5 2.5	0		Score (5/5) to pass __ Passed __ Not met; Action plan required
<b>Corrective Action Plan (if needed)</b>					
<b>Corrective Action Plan:</b> List Site Observation(s) Failed: 1. _____ 2. _____ 3. _____ 4. _____ Explain reason rationale for not meeting the criteria:	<b>Reviewer documents the Practitioner Office Summary of proposed Corrective Action Plan:</b>  Date of Action Plan: _____ Date scheduled for re-evaluation: _____				__ Not required, received passing score in all Sections __ Action Plan requested __ Action Plan accepted __ Action Plan not acceptable, further action needed __ Action Plan to be re-evaluated __ Passed the re-evaluation survey

Original 12/01  
 Reviewed 7/8, 2/10, 7/10, 7/11, 7/12, 7/13, 8/15  
 Revised 7/09, 2/10, 7/10, 7/14, 8/15

# Advance Care Planning

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CDPHP, in agreement with the New York State Department of Health (NYS DOH), strongly recommends that our practitioners discuss and encourage advance care planning, i.e., a discussion of advance directives and/or Medical Orders for Life-Sustaining Treatment (MOLST), if applicable, with all of our adult members.

Advance directives can assure members that their wishes are followed if they themselves are unable to provide that information directly. A member can choose a family member or close friend to make health care decisions for him/her if that member is otherwise incapacitated. Wishes about organ and tissue donation can be made clear. Members can document their wishes by completing a Health Care Proxy Form. A copy of the form and supporting information can be found on the NYS DOH website, [www.health.state.ny.us](http://www.health.state.ny.us).

MOLST allows the member, when seriously ill or near end of life, to document with their treating physician actionable medical orders for life-sustaining treatment, including resuscitation, intubation, administration of fluids/nutrition, antibiotics, and other time-limited trial treatments of care instructions. NYS DOH approved the MOLST form as a portable nonhospital DNR and DNI order that covers the patient throughout the healthcare continuum (i.e., in outpatient and inpatient settings). MOLST can be used for patient/surrogate consent to a DNR or other life-sustaining treatment order. MOLST is reviewed periodically with patient/surrogate and physician or whenever member's need for life-sustaining treatment changes. To obtain a NYS DOH-approved MOLST form and to follow MOLST Instructions and Checklists for ethical framework and legal requirements, consult this website [http://www.health.ny.gov/professionals/patients/patient\\_rights/molst/](http://www.health.ny.gov/professionals/patients/patient_rights/molst/).

Practitioners should document discussions with members about the Health Care Proxy Form and MOLST in the member medical records. Relevant information should be documented in a prominent location in the medical record with a copy of the completed form also filed in the medical record.

See section 17 for information on advance directives.

## Other Forms Available

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### Health Maintenance Forms and NYS Department of Health Forms

- Diabetes Mellitus Flow Sheet
  - <https://www.health.ny.gov/publications/0924.pdf>
- DOH Sterilization Consent Form (LDSS-3134)
  - [https://www.health.ny.gov/health\\_care/medicaid/publications/docs/ldss/ldss-3134.pdf](https://www.health.ny.gov/health_care/medicaid/publications/docs/ldss/ldss-3134.pdf)
- DOH Acknowledgement of Hysterectomy Information Form (LDSS-3113)
  - [https://www.health.ny.gov/health\\_care/medicaid/publications/docs/ldss/ldss-3113.pdf](https://www.health.ny.gov/health_care/medicaid/publications/docs/ldss/ldss-3113.pdf)
- Health Care Proxy

### Preventive Care Forms and Standards for Medical Record Documentation

- Adolescent Physical Exam Form
- Adolescent Preventive Care Flow Sheet: 11–18 Years of Age
- ADHD Screening Tool
- OB/GYN-Prenatal Risk Assessment Form and Definitions
- OB/GYN-Post Partum Progress Note
- OB/GYN-Annual GYN Exam form
- OB/GYN Report to Primary Care Physician
- Pediatric Exam 2–6 yrs
- Pediatric Exam 7–10 yrs

The above forms are available under “Provider Health Guides” in the Provider section of the CDPHP website at [www.cdphp.com](http://www.cdphp.com). You may also request a paper copy of any of the forms listed by calling the CDPHP provider services department at 1 (800) 926-7526.

Each form is developed from nationally accepted practice guidelines which are reviewed and updated by the CDPHP Quality Management Committee.

# CDPHP Practitioner Practice Guidelines

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CDPHP practice guidelines are adapted from nationally accepted guidelines. They are reviewed and updated every two years—or sooner as needed—by the CDPHP quality management committee.

A list of existing guidelines appears below. Please view them in their entirety in the secure provider portal of [www.cdphp.com](http://www.cdphp.com). For a paper copy of any of the guidelines, you may contact the CDPHP provider services department at (518) 641-3500.

## Health Management Guidelines

- ADHD Guidelines for the PCP 2023
- ADHD Guidelines 2023
- Asthma Guidelines 2023
- Atypical Antipsychotic Medications Guidelines 2023
- Bipolar Guidelines 2023
- CHF Guidelines 2024
- Clinical Evidence for Chronic Conditions Prevention 2023
- COPD Guidelines 2023
- Depression Guidelines 2023
- Depression Guidelines for PCP 2023
- Diabetes Guidelines 2023
- Diabetes—Pre-Diabetes Treatment Algorithm 2023
- HIV NYS Testing Guidelines March 2023
- Hypertension JNC 8 2023
- Hypertension Guideline Algorithm JNC 8 2023
- Hypertension Guidelines JNC 8 2023
- Immunization and Pregnancy Guidelines 2023
- Influenza Guidelines 2023
- Obesity Guidelines Child and Adolescent 2023
- Perinatal 2023
- Pneumonia Guidelines 2024
- PTSD Guidelines 2023
- Schizophrenia Guidelines 2023
- STI Screenings and Vaccinations 2023

## Preventive Health Guidelines

- Children Preventive 2023
- Preventive Health Guidelines Adolescents 2023
- Preventive Health Guidelines Adult Men 2023
- Preventive Health Guidelines Women 2023

# Administering Adolescent Immunizations: Seizing All Available Opportunities

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To achieve optimal vaccine administration rates, it is imperative that you take advantage of the time your pre-teen patients are in the exam room. As a reminder, children between the ages of 11 and 12 should receive the Tdap, HPV and meningococcal vaccines. Here are some strategies for success:

- Immunizations for adolescents have changed in recent years and provider offices need to assess at each office visit which may have been missed.
- New vaccines specifically target adolescents such as HPV. Start education about HPV early!
- Consider using “standing orders” for vaccinations such as HPV. Go to [www.immunize.org/standingorders](http://www.immunize.org/standingorders) for the most current versions of sample standing orders.
- Work with your county health department to educate/train office staff on immunization requirements
- Schedule office appointments to coincide with required time frames for immunization administration
- Use your EMR system for pre-visit planning and set reminder flags
- Communicate to parents the importance of having their children immunized to protect themselves and others in their family, schools, and community.
- Report all immunizations through NYSIIS – doing so will ensure that members do not show up on your gap list.
- Be sure that your medical record includes immunization history from all sources (e.g., hospital, local health department, previous provider, etc.).

## Health Equity: Member Race, Language, Culture and Linguistics

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Education, language, culture, access to resources, and age are all factors that affect a person’s health literacy skills. CDPHP recognizes the need to engage in skill building with our members (as health care consumers), as well as the health care professionals in our network, across all lines of business. CDPHP is committed to supporting its provider network with helpful resources and tools to promote health literacy awareness and greater cultural and linguistic competency. The following list represents our strategies, evidence-based tools, and available resources for the provider/practitioner community:

- CDPHP encourages the use of the *Self-Assessment Checklist for Personnel Providing Primary Care Services*, a tool developed by the National Center for Cultural Competence at Georgetown University that can be found at: <http://nccc.georgetown.edu/documents/Checklist%20PHC.pdf>.
- Continue to identify practice-specific needs around cultural and linguistic competency and provide additional evidence-based resources and support as needed.
- CDPHP case management staff receive training on trauma-informed care to promote awareness of the prevalence of trauma histories in low-income households, the impact of trauma history on health care costs and utilization patterns, and to provide strategies to mitigate the effects of trauma in the context of service delivery.
- Identify and address provider/practitioner training needs around trauma-informed care and the impact of adverse childhood experiences on health outcomes. This includes sponsorship and promotion of a local symposium on trauma-informed care for the health care industry each spring.
- CDPHP maintains a cross-departmental workgroup to assess the unique health literacy needs of Medicare, commercial (HMO and PPO, including marketplace products), and Medicaid populations, with guidance from resources and toolkits available from the Department of Health and Human Services, which can be found at: <http://health.gov/communication/literacy/quickguide/>.
- Encourage provider/practitioner community to use *Provider Tools to Care for Diverse Populations*, which contains resources to assess health literacy and help communicate across language barriers, as well as an employee language skill self-assessment tool. This resource can be found at: [http://www.iceforhealth.org/library/documents/ICE\\_C&L\\_Provider\\_Toolkit\\_7.10.pdf](http://www.iceforhealth.org/library/documents/ICE_C&L_Provider_Toolkit_7.10.pdf).
- Promote use of the National Patient Safety Foundation’s *Words to Watch Fact Sheet*, which identifies problematic terms and phrasing for patients with low health literacy and provides suggestions for rephrasing. This tool can be found here: [http://c.ymcdn.com/sites/www.npsf.org/resource/collection/9220B314-9666-40DA-89DA-9F46357530F1/AskMe3\\_WordsToWatch\\_English1.pdf](http://c.ymcdn.com/sites/www.npsf.org/resource/collection/9220B314-9666-40DA-89DA-9F46357530F1/AskMe3_WordsToWatch_English1.pdf).
- To address health disparities and promote greater health equity, CDPHP continues to use community health workers to expand outreach capabilities to the Medicaid population in Albany and Rensselaer counties, with the goal of linking members with important preventive health services.

- CDPHP continues to leverage partnerships with local hospitals and work with First Tier, Downstream, and Related Entities (FDRs) and other delegate entities across all lines of business to ensure greater health equity and ongoing assessment of the health equity needs of our membership.
- CDPHP medical and behavioral health case management teams stay abreast of relevant community resources through regularly scheduled in-services to provide culturally responsive resources to members.
- Expand access to community-based case management by embedding nurse case managers in EPC practices and community-based sites with high Medicaid traffic.
- Continue to monitor diversity of membership across all lines of business and identify any emerging needs or trends related to cultural and linguistic diversity.
- Continue to analyze and learn from member responses to this CAHPS survey question: *With the choices your health plan gave you, how much of a problem, if any, was it to get a personal doctor who met your special cultural and/or language needs?*
- Explore additional community partnerships that will enhance our ability to be culturally and linguistically responsive to the needs of our membership.