| | |
|---|---|
| **Policy and Procedure No: RM 3.8** | **Revision No: 8** |
| **Division: Care Management** | |
| **Department: Risk Management** | |
| **Title: PHC-CA Potential Quality Issues** | |
| **Effective Date: 11/12/2010** | |
| **Supersedes Policy No: 95023, RM 3.0, RM 3.1, RM 3.2, RM 3.3, RM 3.4, RM 3.5, RM 3.6, RM 3.7** | |
| **Reviewed/Revised by: Tiffany Smith** | **Review/Revision Date: 12/11/2025** |
| **Approving Committee: Risk Management Committee** | **Date: 12/11/2025** |
| **Executive Oversight Committee Date: 12/16/2025** | |

**Purpose:**

To provide a systematic method for the identification, reporting, and processing of a Potential Quality Issue (PQI) to determine opportunities for improvement in the provision of care and services the Health Plan enrollees, and to direct appropriate actions for improvement based upon outcome, risk, frequency, and severity.

**Policy:**

PHC California (Health Plan) provides a systematic method for the identification, reporting, and processing of a PQI to determine opportunities for improvement in the provision of care and services to Health Plan enrollees and to direct appropriate actions for improvement based upon outcome, risk, frequency, and severity.

**Procedure:**

1. Identification of Potential Quality Issues

   Potential Quality Issues are identified through the systematic review of a variety of data sources, including but not limited to the following:

   a. Information gathered through concurrent, prospective, and retrospective utilization review

   b. Referrals by Health Plan staff

   c. Referrals by providers

      i. Referrals by Health Plan providers or provider staff

      ii. Referrals by non-Health Plan contracted providers or staff

   d. Facility site reviews

   e. Claims and encounter data

   f. Pharmacy utilization data

   g. Healthcare Effectiveness Data and Information Set (HEDIS) medical record abstraction process

h. Medical records audits

i. Phone log detail

j. Grievances

k. Impaired, or incapacitated, healthcare professionals identified in this process and referred to the Credentialing/Peer Review Committee, if warranted

l. Track and trend PQI data

2. The Scope of PQI Reporting Includes Services Provided by:

   a. Contracted and non-contracted providers, including subcontractors that provide inpatient and outpatient services

   b. Durable medical equipment (DME) and medical supplies providers

   c. Pharmacy providers

   d. Home health providers

   e. Ancillary service providers including, but not limited to, lab, pharmacy, radiology, Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT).

3. PQI Referral

   a. PQIs may be reported by any of the following:

      i. Health Plan staff member(s)

      ii. Member(s) of the community

      iii. Contracted or non-contracted provider(s)

      iv. Anonymous source

   b. A potential quality issue is reported using the PQI Referral Form (Appendix A Pages 13 and 14).

   c. PQI Referral Forms are located on SharePoint or can be requested from any Risk Management staff by sending an email to PQI@aidshealth.org

   d. The following information, at a minimum, is documented, and the form is promptly forwarded to PQI@aidshealth.org:

      i. The enrollee's name, date of birth, sex, and enrollee ID number

      ii. Admission/discharge dates for each admission and/or office visit dates, if applicable

iii. Physician/provider name(s) involved

iv. Facility where issue occurred

v. Date of the suspected/reported occurrence

vi. Date the PQI Referral Form was completed

vii. Name and department of the individual identifying the PQI

viii. Box marked on the referral form that most closely describes the issue

ix. Concise, factual, written description of the issue by the individual reporting the PQI.

4. Authorization Status Change

   a. If the PQI occurs in an acute care setting, the Utilization Management \ Department sends an email notification to:

      i. PQI email address to initiate the investigation

      ii. Claims to request the authorization status be amended to “Pended”

         a) This stops the claims payment until the PQI investigation is concluded and a decision is made.

         b) Findings are subject to recoupment.

5. Medical Record Requests

   a. If the PQI occurs in a facility or provider office and the medical records were not submitted with the referral:

      i. Registered Nurse Clinical Risk Manager or designee requests Case Management to obtain medical records relevant to the PQI.

      ii. Registered Nurse Clinical Risk Manager or designee obtains clinicals from the member’s secure record in eQSuite, a proprietary web-based, HIPAA compliant system.

   b. If Case Management or Utilization Management is unable to obtain medical records, the Registered Nurse Clinical Risk Manager or designee submits a Request for Medical Record Form (Appendix C) via fax or certified mail/return receipt (as directed by the receiving provider and/or facility). Providers forward a copy of the Health Plan enrollee’s medical records to the Clinical Risk Manager within fifteen (15) calendar days from the date of the request.

   c. If the Health Plan has not received the requested medical records by calendar day fifteen (15), the Registered Nurse Clinical Risk Manager requests Provider Relations (PR) to

intervene and follow up with the provider. An extension of fifteen (15) days is applied at that time.

d. If the Health Plan does not receive a copy of the enrollee's medical records within thirty (30) days of the request, the Clinical Risk Manager forwards the concern to the Health Plan Medical Director for further assistance and/or direction. The Health Plan Medical Director may contact the provider personally to ensure they are aware of the request for information.

e. Further action may be necessary, including, but not limited to, termination from the provider network.

f. If a non-contracted provider refuses to comply with the timelines, the Clinical Risk Manager consults the Health Plan Medical Director about next steps.

6. PQI Review - Primary

a. Upon receipt of the PQI referral form, the Grievance and Appeal Team (GAT) enters the PQI in the PQI log. The GAT reviews the PQI and begins planning the process for resolution, including, but not limited to, contacting appropriate involved parties via email, fax, or phone to enable successful investigation of the issue.

b. The PQI referral is processed within seven (7) calendar days, unless the issue is urgent. The Risk Manager triages the referral on day one (1) for urgent issues. If the issue is urgent, the Risk Manager contacts the National Director, Quality and Health Plan Medical Director by phone with a follow-up secure email by close of business (COB).

c. PQIs are resolved within one-hundred and eighty (180) days. Processing the PQI referral includes requesting pertinent medical records.

i. If medical records are requested from multiple providers, the one-hundred and eighty (180) day time limit does not begin until all requested medical records are received.

ii. If, during the one-hundred and eighty (180) day review, it is discovered that additional records are required, an additional medical record request is completed, and the one-hundred and eighty (180) day timeframe resets.

iii. During case review, professionally recognized standards of care are taken into consideration. A PQI often represents a single event or occurrence. One report alone may not represent a quality issue; however, trending similar events may reveal a quality issue and dictate the re-opening of a case previously reviewed or closed.

d. All PQIs are rated by Severity Level as listed below:

| **Severity Rating Level Grid** | |
|---|---|
| ☐ SR 0 – No Quality of Care Issue | ☐ SR 3 – Serious Quality of Care with temporary patient impairment |
| ☐ SR 1 – Minor Quality of Care with benign consequences | ☐ SR 4 – Serious Quality of Care with permanent patient impairment |

| | |
|---|---|
| ☐ SR 2 – Moderate Quality of Care with modest clinical intervention required | ☐ SR 5 – Fatal substandard care |

e. If the PQI's initial review determines that no Quality of Care issues, the case is categorized as an SR 0, and the PQI is closed on the log. If the Clinical Risk Manager determines the enrollee needs immediate assistance beyond the scope of review, the appropriate information may be forwarded to other involved departments for action and follow up. If it is determined that the PQI is beyond an SR 0, the case is forwarded to the MD for secondary review.

7. PQI Review - Secondary

a. During secondary review, based on clinical expertise, the Health Plan Medical Director or designee may:

i. Assign a potential severity level of SR 0 and instruct the Clinical Risk Manager to close the case.

ii. Assign a potential severity level of SR 1, and instruct the Clinical Risk Manager to trend the PQI to the provider or facility.

iii. Assign a potential severity level of SR 2 or greater, and instruct the Clinical Risk Manager to send a letter to the provider(s) of concern requesting a response to the concerns of the case.

a) A response is required in thirty (30) days.

b) If the provider(s) response satisfies the Medical Director's concern(s), then the MD may lower the rating to SR 1, instruct the Clinical Risk Manager to trend the case to the provider or facility, and close the case or prepare the case for presentation to the CPRC.

iv. Request that the Clinical Risk Manager send the case to a consultant physician with the same specialty as the provider of concern.

a) For routine reviews, the specialist has thirty (30) days to return the case to the Clinical Risk Manager with a severity level rating and next steps.

b) If the review is expedited, the review is returned within seven (7) calendar days. The Clinical Risk Manager discusses the specialist's findings with the Health Plan Medical Director.

v. Upon receiving responses from either the practitioner or consultant specialist, the Health Plan Medical Director rates the case.

a) For cases rated an SR 2 or higher, the Health Plan Medical Director instructs the Clinical Risk Manager to prepare the case for presentation to the C/PRC.

b) Cases rated SR 1 may or may not be referred to the C/PRC.

vi. For cases referred to the C/PRC, the CPRC determines the final severity level.

vii. Emergency action may be necessary. If the Health Plan Medical Director determines that a situation exists where immediate action is required to protect the life or well-being of a Health Plan enrollee or any person, or to reduce substantial and imminent likelihood of significant impairment of the life, health, or safety of any patient or prospective patient; the Health Plan Medical Director may summarily suspend or terminate the provider's credentialed status.

8. Opportunities for Discussion by the Provider(s) of Concern

    a. Where the provider(s) of concern has a potential SR 2 or higher, they are given an opportunity to discuss the case (in writing, by phone, or in person. The provider(s) of concern are given 30 calendar days to respond to the Health Plan's letter of concern, either in writing or by phone interview with the Health Plan Medical Director. At a minimum, the letter of concern addresses the following areas:

        i. Enrollee demographics

        ii. Brief statement explaining purpose of quality review activities

        iii. Brief summary of the background of the case

        iv. Potential severity level

        v. Confidentiality statement

        vi. Health Plan Medical Director's signature

    b. If the provider(s) of concern fails to provide additional information, the Health Plan Medical Director may choose to make a decision or refer the case to the CPRC without input. When the CPRC receives the PQI case for review, it may again request additional information from the practitioner or the provider facility.

    c. After the provider has had the opportunity to respond and upon review of the information, the Health Plan Medical Director may refer the case to the C/PRC or request a review by a provider within the same or a similar specialty or by an external review organization.

    d. Phone conversations between a peer reviewer and the Health Plan Medical Director have notes taken and entered into the peer review file, which are reflected back to the provider in a subsequent peer review letter to offer the opportunity to make corrections.

9. CPRC Review

    a. Information for PQI cases presented to the CPRC must include a summary of the case and material to the Health Plan Medical Director important for the committee's review. Any response from the provider and any review materials by an independent reviewer are available to the committee. The C/PRC may rate the case at any level. Case dispositions are as follows:

        i. SR 1 is trended to the provider's file.

        ii. SR 2 may be trended with a letter to the provider or may be treated in the same manner as an SR 3 or higher, as described below.

b. CPRC recommendations for cases determined to be SR3 may be as follows:

   i. Recommend that the provider develop a Corrective Action Plan (CAP). A notice is given to the provider within seven (7) calendar days of the recommendation of such action. Grounds for recommending a CAP include, but are not limited to:

   ii. Failure to provide professional services of acceptable quality as determined by the CPRC;

   iii. Failure to follow the Health Plan's utilization review policies;

   iv. Failure to follow the Health Plan's risk management policies;

   v. Failure to treat enrollee for whom the provider is responsible;

   vi. Failure to adhere to the provider contract or the Health Plan's policies;

   vii. Acts or omissions constituting unprofessional or unethical conduct;

   viii. Acts constituting disruptive behavior, inability to work collaboratively with others;

   ix. Sexual misconduct with an enrollee, or harassment/discrimination complaints;

   x. Failure to report adverse action by another peer review body or a hospital.

c. If a corrective action plan (CAP) is initiated, it is included in the PQI case file. A CAP includes the goals, objectives, deliverables, time frames, persons responsible, follow up and evaluation as recommended by the CPRC.

   i. The time frame for providers to respond to a CAP is thirty (30) days.

   ii. The provider(s) of concern may be sent a reminder notice between days 15-25.

   iii. If the Health Plan does not receive the CAP by day thirty (30), the Clinical Risk Manager will follow up with the Provider.

   iv. A fifteen (15) day extension may be granted for reasonable concerns.

   v. If by day forty-five (45), the CAP has not been received, the case is then forwarded to the Health Plan Medical Director for further determination, including review by the CPRC for review of privileges.

d. Upon completion, the Clinical Risk Manager reviews the CAP and reports the results to the CPRC.

e. The CAP may include, but is not limited to:

   i. Required attendance at continuing education program(s) applicable to the issue identified and selected by the entity requiring the CAP.

ii. Required training / re-training and/or certification / re-certification for performance of those procedures that require specific training and professional certification.

iii. Continuing concurrent trend analysis of the adverse quality issues identified in the provider's practice patterns.

iv. Monitoring of provider of concern's medical record documentation by physicians selected by the CPRC for a prescribed length of time.

v. In-service training for providers and/or their staff.

vi. Correction of the system defect by the provider or facility, if the finding is a system problem.

f. Other recommendations for consideration by the CPRC may include, but are not limited to:

i. Provider contract changes, including modification, restriction or termination of participation privileges with the Health Plan.

ii. Summary suspension, which is the immediate suspension of credentialed status based on the need to take immediate action to protect the life or well-being of a Health Plan enrollee or any person to reduce substantial and imminent likelihood of significant impairment of the life, health, and/or safety of any enrollee or prospective member

iii. Recommendation of counseling for behavior modification

iv. Focused review of the provider's cases including, but not limited to:

a) Second opinion for invasive procedures

b) Retrospective or prospective medical claims reviews

c) Preceptorship with a physician of the same specialty

d) Required physician review of each request for pre-certification

v. Institution of a monitoring process through proctoring by another qualified, specialty matched provider

vi. Recommendation for the suspension, restriction, or termination of the provider with the Health Plan.

g. The provider has the right to request a Fair Hearing for adverse actions reducing the provider's privileges as outlined in the Health Plan policy "*Fair Hearing Process for Adverse Actions."* Any actions by the Health Plan that reduce or terminate a provider's privileges that are accepted or upheld by a Fair Hearing must be reported as described in the Health Plan "Reporting to Medical Board of California (MBOC), National Practitioner Data Bank (NPDB), and the Healthcare Integrity and Protection Data Bank (HIPDB).

h. All CPRC recommendations and necessary attachments are forwarded to the MD for coordination of any recommended action.

i. If a PQI has multiple providers involved in care who are separately evaluated by a clinical reviewer or the CPRC, determination of severity ratings is not final until all involved providers have been assigned final severity ratings. If any data needed to make a final determination for any provider is pending, the other providers' determinations remain pending, and notifications are not made until all final determinations are complete.

j. For contracted providers that are not individuals (e.g., hospitals, skilled nursing facilities, community clinics), when deemed necessary, the case is referred, in writing, to the MD of the facility involved.

    i. The referral requests acknowledgement that the issue was reviewed and assurance that action has been taken to prevent similar system issues in the future.

    ii. System issues are tracked, trended, and reviewed at the time of re-contracting the facility. If the MD or C/PRC determines the system issue at a facility places members at risk of adverse health outcomes, they may recommend the contract with this facility be suspended or terminated.

10. PQI Completion

    Each confirmed PQI is assigned a final severity level with action code by the MD or C/PRC to denote the determined effect of the problem and action taken as a result of review. If a PQI originated as a grievance, a summary of the PQI investigation's outcome and the rating are sent to the Grievances & Appeals (G&A) Department.

11. PQI Retention

    All PQI cases are stored in a secure server location, and only select personnel have access to these files. The Chief of Care Management, National Quality Director, Quality Managers, CPRC, and the Health Plan Medical Director may access the files. Each file includes the PQI report form, all correspondence, pertinent copies of medical records, reports, and other documents associated with the review and disposition of the PQI case.

12. Provider File Review and Recommendations

    The Health Plan Medical Director and/or the CPRC review the provider's quality file at the time the provider is to be recredentialed.

    If a recommendation is made to revoke, suspend, or restrict the privileges of a provider, or to terminate the provider's agreement with the Health Plan, the following individuals and committees are notified:

    a. Chief of Care Management

    b. Provider Relations

    c. Director of Care Coordination

    d. Member Services

e. Executive Oversight Committee of the Board of Directors (EOC) and Quality Improvement and Health Equity Committee (QIHEC), at their next regularly scheduled meeting

f. The CEO of the medical group that employs the provider, if applicable, and/or the Health Plan Medical Director of the clinic where the provider is employed

g. Any required regulatory agencies

13. Record Retention

The Clinical Risk Manager or designee ensures the medical records received for PQI cases are downloaded / scanned into Health Plan's system along with all pertinent supporting documentation.

a. A scanned document constitutes a "hard" copy.

b. The scanned file is maintained electronically for a period of at least ten (10) years.

c. All original documentation (e.g., certified letters, responses to letters, policies and procedures) is kept in house, along with the scanned file, for a minimum of three (3) years and off-site for a minimum of ten (10) additional years.

14. Confidentiality

Peer review records and proceedings, as well as records obtained for the CPRC process, are protected by California Evidence Code §1157 and are not subject to discovery when confidentiality has been maintained.

a. To maintain confidentiality Clinical Risk Manager retains peer review records and does not release them to anyone for purposes other than peer review.

b. Records are maintained in a locked file cabinet with access restricted to the Health Plan Medical Director, Chief of Care Management, the Clinical Risk Manager, the National Quality Director and CPRC.

c. While records are being reviewed, or during transport to CPRC meetings, a Risk Management staff person accompanies them at all times.

i. If records are referred to an outside reviewer or organization, an exception is made.

ii. If a subpoena is served to the Health Plan regarding a peer review case, the Provider Relations Representative may act as the "certifier of the medical records" being requested.

**Definitions:**

1. Corrective Actions: means specific identifiable activities or undertakings of Contractor which address Contract deficiencies or noncompliance.

2. Corrective Action Plan (CAP): A plan approved by CPRC to help ensure that a related quality issue does not occur in the future. The CAP has clearly stated goals and time frames for completion.

3. Potential Quality Issue (PQI): A suspected deviation from expected provider performance, clinical care, or outcome of care, which requires further investigation to determine whether an actual quality issue or opportunity for improvement exists. Not all PQIs represent quality of care issues.

4. Provider: Any individual or entity engaged in the delivery of health care services, licensed or certified by the State to engage in that activity in that State if such licensure or certification is required by State law or regulation.

5. Quality Improvement and Health Equity Committee (QIHEC): means a committee facilitated by Health Plan's medical director, or the medical director's designee, in collaboration with the Health Equity officer that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions.

6. Quality Issue: A confirmed deviation from expected provider performance, clinical care, or outcome of care, which has been determined through the PQI process to be inconsistent with professionally recognized standards of care.

7. Quality of Care: means the degree to which health services for Members increase the likelihood of desired health outcomes and are consistent with current professional standards of care and knowledge

8. Severity Score: Refer to Exhibit B: Case Leveling Grid.

**Monitoring:**

1. The Clinical Risk Manager or designee provides a review and analysis of the frequency of PQIs and severity of outcomes to the Quality Improvement and Health Equity Committee (QIHEC) no less than quarterly.

2. The Risk Management Committee reviews and approves this policy and procedure at least annually.

**Attachments:**

1. Appendix A - Referral Form

2. Appendix B - Investigation Case Form

3. Appendix C - Medical Record Request Form

**References:**

1. Policy No.: 4H - Fair Hearing Process for Adverse Decisions

2. Policy No.: QI-014 – Reporting to Medical Board of California (MBOC), National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB)

3. California Evidence Code § 1157

4. NCQA Standards CR6 – Ongoing Monitoring

## PQI Referral Form Reference Table

| | | |
|---|---|---|
| **Access/Availability**<br>• Complications due to a delay /denial of service by provider or plan<br>• Excessive wait time in the PCP or Specialist's office ( routine or after hours) | **Admit within 3 days of ER Services** | **Assessment/Treatment/Diagnosis**<br>• Inadequate assessment, diagnosis or treatment-adult<br>• Inadequate assessment- diagnosis or treatment-child |
| **Communications/Conduct**<br>• PCP/Specialist does not return phone calls<br>• Rudeness by provider or office staff<br>• Threatened lawsuit by member against PCP / PHC/ancillary<br>• Threatened media event by member<br>• Culturally inappropriate remarks by PCP/ specialist or staff<br>• Allegations of sexual misconduct<br>• Allegations of discrimination<br>• Unprofessional conduct<br>• Staff speaking a language ,other than English, while in the performance of their duties, at a PCP /specialist or ancillary office | **Continuity of Care**<br>• Adverse outcome due to delay in referral to specialist<br>• Delay in ordering tests/forwarding radiology /lab forms to ancillary providers | **Mental Health**<br>• Failure to communicate patients medications to PCP<br>• Failure to communicate patients medications to mental health provider<br>• Inadequate referral of a suicidal or homicidal patient |
| **Pharmacy/UM Authorizations**<br>• Overprescribing of narcotics<br>• Inadequate or lack of a physical assessment on patients prior to prescribing narcotics<br>• Abruptly terminating members narcotics without a plan for the weaning process<br>• Refusal to follow PHC formulary<br>• Delay in completion of a TAR for medications<br>• causing a delay in member's treatment regimen | **Readmission/UM**<br>• Readmission <15 days from discharge<br>• Adverse outcome due to premature discharge | **Safety**<br>• Fall in SNF or acute care<br>• Report by member that conditions of facility are unsafe-dirty etc. |
| **Surgical Services**<br>• Post-op diagnosis differs from pre-op<br>• Surgical complication<br>• Unplanned return to surgery or repeat invasive procedure<br>• Blood loss during surgery requiring transfusion<br>• Admission following outpatient procedure<br>• Unexpected maternal transfer to a higher level of care<br>• Delivery complication | **Other:** | **Unexpected Death**<br><br>**Unsure** |

## APPENDIX A

### POTENTIAL QUALITY ISSUE REFERRAL

**To maintain confidentiality of this referral, please do not copy completed form.**

Please complete and submit the form via secure email to PQI@aidshealth.org

| **MEMBER / CLIENT INFORMATION** | | | |
|---|---|---|---|
| **Business Line:**<br>☐PHP ☐PHC ☐PHP/PHC ☒C.H.A.I.N. (referrals only) ☐Ryan White ☐TPP: Enter Text Here ☐Uninsured<br><br>Reportable critical incident ☐Yes ☐ No<br><br>**PHC California Only:**<br>LTSS User ☐Yes ☐ No<br>CBAS User ☐Yes ☐ No<br>Previous Grievance Filed ☐ Yes ☐ No (If applicable) | | | |
| **Last Name:**<br>Click here to enter text. | **First Name and MI:**<br>Click here to enter text. | **Member ID:**<br>Click here to enter text. | **Date of Birth:**<br>Click here. |
| **Address:**<br>Click here to enter text. | **City:**<br>Click here to enter text. | **State:**<br>Click here. | **Zip:**<br>Click here. |
| **Daytime Phone Number:** Click here to enter text. | | **Alternate Phone Number:** Click here to enter text. | |
| **Sex:** ☐ M ☐ F<br>**Transgender:** ☐ MtF ☐ FtM | **Race/Ethnicity:**<br>Click here to enter. | **Language:**<br>Click here to enter. | |

| **PROVIDER / FACILITY / VENDOR INVOLVED** | |
|---|---|
| **Place of Service (HCC, provider office, facility, etc.):**<br>Click here to enter text. | **Providers/Staff Involved in Incident:**<br>Click here to enter text. |
| **Provider /Staff / Facility Address:**<br>Click or tap here to enter text. | **Provider /Staff / Facility Phone Number:**<br>Click or tap here to enter text. |
| **Type of Facility**: ☐ Inpatient ☐ Outpatient ☐ Emergency Department ☐ PCP ☐ Specialist ☐ Other: | |
| **Date(s) of possible PQI**: Click or tap here to enter text. | **Admission Date:** Click or tap here to enter text. |
| **PQI Referral Source:**<br>Enter name here.<br>Enter department here. | **Form completed by (if not by referral source):**<br>Click or tap here to enter text.<br>Enter department here. |

## POTENTIAL QUALITY ISSUE REFERRAL

| REASON FOR REFERRAL TO QI DEPARMENT<br>QUALITY OF CARE INDICATORS (CHECK ALL THAT APPLY) | |
|---|---|
| ☐ Delay in diagnosis or medical treatment | ☐ Unexpected trauma or other safety issue identified during health care treatment |
| ☐ Death unexplained by diagnosis | ☐ A lower level of service used when a higher intensity should have been used |
| ☐ Medication error | ☐ Unscheduled readmission for the same diagnosis within 15 days |
| ☐ Surgical or clinical procedural error | ☐ Unscheduled admission following outpatient surgery for a related diagnosis or condition |
| ☐ Lack of required medical record documentation | ☐ Unscheduled return to surgery during the same admission period for the same condition |
| ☐ Facility acquired decubitus ulcer | ☐ Potential quality of care issue involving an ancillary vendor |
| ☐ Facility acquired infection | ☐ Other, please specify:<br>Click or tap here to enter text. |

| QUALITY OF SERVICE INDICATORS (CHECK ALL THAT APPLY) | |
|---|---|
| ☐ Access to care/appointment availability | ☐ Inadequate healthcare facility /office maintenance |
| ☐ Confidentiality & privacy rights or responsibility | ☐ Staff/ Provider behavior |
| ☐ Continuity of Care | ☐ Staff/ Provider turnover |
| ☐ Delay in authorization processing time | ☐ Quality of service issue involving an ancillary vendor |
| ☐ Delay in referral processing time | ☐ Other, please specify:<br>Click or tap here to enter text. |

| BRIEF SUMMARY OF EVENTS (INCLUDE DATES OF SERVICE) |
|---|
| Click or tap here to enter text. |

| *For QI Department Use Only* | |
|---|---|
| ***Intake Agent:*** *Click here to enter text.* | ***Medical Records Included?*** *☐ Yes ☐ No* |
| ***Case Coordinator:*** *Click here to enter text.* | ***Receipt Date:*** *Enter date here* |

## APPENDIX B

— CONFIDENTIAL —

### Potential Quality Issue Investigation Case Form

**Instructions: Section in WHITE to be completed by initial intake agent within QI department (Does not have to be an RN).**

| **Case Closure Information:** *To be completed by investigating RN.* | | |
|---|---|---|
| | *Final QOC Severity Level:* | ☒ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| | *Final Category:* | Click here to enter text. |
| | *Closure Date:* | Click here to enter a date. |

| | |
|---|---|
| Reportable critical incident | ☐ Yes ☐ No |
| **PHC California Only** | |
| LTSS User | ☐ Yes ☐ No |
| Previous Grievance Filed | ☐ Yes ☐ No |

**Member Information**

| | | | |
|---|---|---|---|
| Business Line:<br>☐ PHP ☐ PHC ☐ PHP/PHC<br>☐ C.H.A.I.N. (referrals only)<br>☐ Ryan White<br>☐ TPP / Other Carrier:<br>☐ Uninsured/AHF HCC | PQI Referral Source:<br>Enter name here.<br>Enter department here. | Intake Agent:<br>Enter name here. | |
| Last Name:<br>Click here to enter text. | First Name and MI:<br>Click here to enter text. | Member ID:<br>Click here to enter text. | |
| Address:<br>Click here to enter text. | City:<br>Click here to enter text. | State:<br>Click here. | Zip:<br>Click here. |
| Daytime Phone Number:<br>Click here to enter text. | Alternate Phone Number:<br>Click here to enter text. | | Date of Birth:<br>Click here. |
| Sex: ☐ M ☐ F<br>Transgender: ☐ MtF ☐ FtM | Race/Ethnicity:<br>Click here to enter. | Language:<br>Click here to enter. | Assigned QI Team:<br>☐ CA ☐ FL |
| Providers/Staff Involved in Incident:<br>Click here to enter text. | Provider/Staff's Phone Number(s):<br>Click here to enter text. | **Health Care Center/Place of Service:**<br>Click here to enter text. | |

**Summary of Potential Quality Issue (This is the perception based on referral information.)**

Click here to enter text.

**Case Activities performed by Initial Intake**

| Date | Activity | Outcome |
|---|---|---|
| Click or tap to enter a date. | Click here to enter text. | Click here to enter text. |
| Click or tap to enter a date. | Click here to enter text. | Click here to enter text. |
| Click or tap to enter a date. | Click here to enter text. | Click here to enter text. |

*To the extent that the information contained in this document relates to a quality of care issue or peer review matter, this document is a privileged communication under applicable State statutes. As such, this document will be maintained as confidential and will not be the subject of discovery.*

— CONFIDENTIAL —

Page 1 of 5

## Potential Quality Issue Investigation Case Form

| QI - Medical Records Reviewed | | | |
|---|---|---|---|
| **List the medical records reviewed.** | | | |
| 1 | Click here to enter text. | 2 | Click here to enter text. |
| 3 | Click here to enter text. | 4 | Click here to enter text. |
| 5 | Click here to enter text. | 6 | Click here to enter text. |
| 7 | Click here to enter text. | 8 | Click here to enter text. |

| QI – Case Note / Resolution Summary |
|---|
| Click here to enter text. |

| Over 30-Day Explanation |
|---|
| Click here to enter text. |

*To the extent that the information contained in this document relates to a quality of care issue or peer review matter, this document is a privileged communication under applicable State statutes. As such, this document will be maintained as confidential and will not be the subject of discovery.*

## Potential Quality Issue Investigation Case Form

| Medical Directors Clinical Review | |
|---|---|
| **MD Review / Investigation with Recommendation** | |
| Click here to enter text. | |
| Medical Directors Name: Click here to enter text. | Date: Click to enter date. |

| Specialty Review and/or Peer Review | |
|---|---|
| Click here to enter text. | |
| Reviewer Name: Click here to enter text. | Date: Click to enter date. |

*(Please check the appropriate level)*

| Medical Directors Determination– Final Severity Level Identified | |
|---|---|
| ☐ SR 0 – No Quality of Care Issue. | ☐ SR 3 – Serious Quality of Care with temporary patient impairment |
| ☐ SR 1 – Minor Quality of Care with benign consequences | ☐ SR 4 – Serious Quality of Care with permanent patient impairment |
| ☐ SR 2 – Moderate Quality of Care with modest clinical intervention required | ☐ SR 5 – Fatal substandard care |

*(Corrective action is required if the final severity rating is between Level 3 and 5)*

| Corrective Action | |
|---|---|
| ☐ Counsel or educate via written or verbal communication | Complete by:<br>Responsible Party: Click here to enter text. |
| ☐ Written response to issues identified, such as a corrective action plan with responsible person(s) and completion dates | Complete by:<br>Responsible Party: Click here to enter text. |
| ☐ Required continuing education | Complete by:<br>Responsible Party: Click here to enter text. |
| ☐ Off-cycle review of the practitioner's credentialing file | Complete by:<br>Responsible Party: Click here to enter text. |
| ☐ Focused peer review monitoring | Complete by:<br>Responsible Party: Click here to enter text. |
| ☐ Referral to Legal department | Complete by:<br>Responsible Party: Click here to enter text. |
| ☐ Termination | Complete by:<br>Responsible Party: Click here to enter text. |
| ☐ Other reasonable action<br>Specify: | Complete by:<br>Responsible Party: Click here to enter text. |

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## Potential Quality Issue Investigation Case Form

| **Notification of Trending to Provider Relations:** |
| --- |
| *In cases where issues or complaints concerning Providers, Healthcare Staff, and Healthcare Facilities have been identified and can be corrected through education, the Provider Relations Department will be notified for assistance in resolving the complaint/issue.*<br><br>**Brief Explanation of Trending Issues:** Click here to enter text.<br><br>**Provider(s) Involved:** Click here to enter text.<br><br>**Recommendation:** Click here to enter text.<br><br>**Notification Date:** Click or tap to enter a date. |

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## APPENDIX C

Click or tap to enter a date.

Click or tap here to enter Provider/Facility Name.
Click or tap here to enter Provider/Facility Address.
Click or tap here to enter Provider/Facility Address Line 2.
Click or tap here to enter City, State, Zip Code.

Attn: Medical Records

FROM: Risk Management/Quality Improvement Department

RE: **ENROLLEE NAME**

Request for Records

| | |
|---|---|
| **MEMBER'S NAME** | Click here to enter. |
| **MEMBER'S BIRTHDATE** | Click here to enter. |
| **MEMBER'S SS#** | Click here to enter. |
| **DATE (S) OF SERVICE** | Click here to enter. |

For the purposes of conducting utilization management and/or quality improvement activities, PHC is requesting medical records for the above-named member for the dates of service listed. PHC manages health plan benefits for Medi-Cal Managed Care enrollees. Please submit the following information within 5 business days of receipt of this request:

| | | | |
|---|---|---|---|
| | **ENTIRE MEDICAL RECORD** | | Vital Signs Record |
| | Medical History/Physical Examination | | Psychological Tests |
| | Physician Orders | | Drug Screens |
| | Specialist consultation (s) | | Laboratory Tests |
| | Progress Notes | | Occupational Therapy |
| | Admission Nursing Assessment | | Physical Therapy |
| | Nurses Notes | | Face Sheet |
| | Medication Record | | Discharge Summary |
| | Treatment Plan | | Imaging Results |
| | Psychiatric History or Evaluation | | Case Management |
| | Other: | | |

**Please mail/fax records to:**

PHC California
P.O. Box 46160
Los Angeles, CA 90046
ATTN: Tiffany Smith, RN
Phone : (954) -522-3132 Ext 53222 Fax : (888) -972-7976
Thank you for your assistance.