Health New England
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HNE Clinical Guidelines and Standards

Effective Date 1/1/2021 | Revised Date 1/1/2021

The HNE Clinical Care Assessment Committee (CCAC) and/or the Behavioral Health Assessment Committees (BHAC) are responsible for developing, disseminating and coordinating activities intended to define good medical practice and develop improved quality. Activities include establishing and maintaining a criterion-based system including standards and guidelines in relation to patient care and developing pre-treatment and pre-admission medical protocols.

Physician participation plays an important role in the development of clinical guidelines and standards. Participating physicians serve on the CCAC/BHAC and HNE welcomes and invites the comments of other participating physicians. If providers have comments, questions, or concerns about a clinical guideline or standard, they should contact the Health Services Supervisor at (413) 787-4000, extension 3457, or (800) 842-4464, extension 3457.

Unless new scientific evidence or revised national standards warrants review and update sooner, clinical guidelines and criteria are reviewed annually. Preventive health recommendations are reviewed annually.

All clinical guidelines, standards and criteria used for rendering decisions regarding the appropriateness of medical services are available to participating providers upon request by calling Health Services at (413) 787-4000, extension 3457, or (800)842-4464, extension 3457. In addition, clinical guidelines are available on the HNE website at http://healthnewengland.org/Providers/Resources and the physician information portal (https://www.hnedirect.com/login).

Appointment and After-Hours Standards

ACCESS STANDARDS

On average, 85% of members are able to access (type of appointment) within (stated time).

PRIMARY CARE PRACTITIONER

Appointment Type	Appointment Standard		Exception
	Non-Medical Home	Medical Home	Product-Specific Standards
Routine/Regular (includes Preventive)	Within 1 month of request		Medicaid: Within 45 days of request*
Non-Urgent Symptomatic	Within 7 business days of request	Same day of request	Medicaid: Within 10 days of request
Urgent	Within 24 hrs of request		Medicaid: Within 48 hrs of request
Emergency	Immediate or refer to emergency room		
After-Hours Care	24-hrs-a-day/7-days-a-week on-call system (answering service/ pager) for after-hours emergencies. PCP or covering MD returns call within 60 minutes		

- ***-Children in the Care or Custody of the Department of Child and Family Services (DCF):** A healthcare screening within seven calendar days after you or the DCF worker asks for it.
- A full medical exam within 30 calendar days after you or the DCF worker asks for it (unless a shorter time is required by Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services schedule.

HIGH-VOLUME SPECIALTY PRACTITIONERS

Appointment Type	Scheduled Appointment Timeframe	Exception Product-Specific Standards
Routine/Regular	Within thirty business days of request	
Non-Urgent Symptomatic	Within thirty business days of request	Medicaid: Within 30 days of request
Urgent	Same day of request	Medicaid: Within 48 hrs of request
Emergency	Immediate or refer to emergency room	
After-Hours Care	24-hrs-a-day/7-days-a-week on-call system (answering service/ pager) for after-hours emergencies. PCP or covering MD returns call within 60 minutes	

HIGH-IMPACT SPECIALTY PRACTITIONERS

Appointment Type	Scheduled Appointment Timeframe	Exception Product-Specific Standards
Routine/Regular	Within thirty business days of request	
Non-Urgent Symptomatic	Within thirty business days of request	Medicaid: Within 30 days of request
Urgent	Same day of request	Medicaid: Within 48 hrs of request
Emergency	Immediate or refer to emergency room	
After-Hours Care	24-hrs-a-day/7-days-a-week on-call system (answering service/ pager) for after-hours emergencies. PCP or covering MD returns call within 60 minutes	

BEHAVIORAL HEALTH PROVIDERS

Appointment Type	Scheduled Appointment Timeframe	Exception Product-Specific Standards
Routine/Regular	Within 10 business days of request	
Life Threatening Emergency Services	Requires immediate face-to-face medical care. The member or representative should call 911. Care should be provided within 6 hours. Member referred to the nearest hospital-based psychiatric emergency service crisis team for immediate treatment. Member with an established relationship, may call provider directly for urgent care. The urgent care request must be provided within 48 hours.	•Immediately….
Urgent	Requires immediate face-to-face medical care. The member or representative should call 911. Care should be provided within 6 hours. Member referred to the nearest hospital-based psychiatric emergency service crisis team for immediate treatment. Member with an established	•Medicaid: Within 48 hrs of request

	relationship, may call provider directly for urgent care. The urgent care request must be provided within 48 hours.	
Non-life Threatening	Requires immediate face-to-face medical care. The member or representative should call 911. Care should be provided within 6 hours. Member referred to the nearest hospital-based psychiatric emergency service crisis team for immediate treatment. Member with an established relationship, may call provider directly for urgent care. The urgent care request must be provided within 48 hours.	• Medicaid: Within 10 business days of your request
Follow-up After Hospitalization for Mental Illness	After discharge from a hospital stay, members are scheduled for the first follow-up visit within 7 days of discharge, and a second follow-up visit within 30 days of discharge.	
Follow-up Routine Care	Within 30 days from the routine care visit	
After-Hours Care	24-hrs-a-day/7 days-a-week on-call system must be in place for member emergencies after hours	

	Exception Product Specific Standard
Non 24-Hour Diversionary Services Discharges	• Medicaid: within 2 calendar days • Medicaid: Medication management within 14 calendar days • Medicaid: Other outpatient services within 7 calendar days Medicaid: Intensive Care Coordination (ICC) services within 24 hours of Referral, including self-Referral offering a face-to-face interview with the family

Medical Record Standards and Reviews

The following medical record standards have been adopted by the CCAC and BHAC:

Criteria	**Benchmark**
1. Each page in the record contains the patient's name or ID number.	95%
2. Personal biographical data include the address, employer, home and work telephone numbers, and marital status.	95%
3. All entries in the medical record contain author identification. Author identification may be hand written, stamped, or electronic.	95%
4. All entries are dated.	95%
5. The record is legible by someone other than the writer. A second surveyor examines any record judged to be illegible by one physician surveyor.	95%
6. Significant illnesses and medical conditions are indicated on the problem list,	95%
7. Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.	100%
8. Past medical history (for patients seen three or more times) 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,	95%
9. For patients 14 years and older, there is appropriate notation concerning the use of cigarettes, alcohol, and substances (for patients seen three or more times, query substance abuse history.)	95%

10. The history and physical exam records appropriate subjective and objective information pertinent to the patient's presenting complaints.	95%
11. Laboratory and other studies are ordered as appropriate.	100%
12. Working diagnoses are consistent with findings.	100%
13. Treatment plans are consistent with diagnoses.	100%
14. Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return in noted in weeks, months, or as needed,	95%
15. Unresolved problems from previous office visits are addressed in subsequent visits,	100%
16. Review for under- and over-utilization of consultants,	95%
17. If a consultation is requested, is there a note from the consultant in the record?	95%
18. Consultation, lab, and imaging reports filed in the chart are initialed by primary care practitioner to signify review. If the reports are presented electronically, or by some other method, there is also representation of practitioner review,	100%
19. Consultation, abnormal lab, and imaging study results have an explicit notation in the record of follow-up plans.	100%
20. There is no evidence that the patient is placed at inappropriate risk by diagnostic or therapeutic procedure.	100%
21. An immunization record for children is up to date, or an appropriate history has been made in the medical record for adults.	95%
22. There is evidence that preventive screening and services are offered in accordance with the organization's practice guidelines.	100%
23. Advance Directive documented in a prominent area in the medical record.	92%
24. Medication list is present in the medical record.	95%

Medical records are assessed against the 24 standards listed above. A provider will be deemed fully compliant when the compliance score is equal to or greater than 90 percent for the medical records reviewed.

If after the review, a Provider does not meet compliance requirements, the office is presented with a report outlining any deficiencies and a corrective action plan for improvement. A follow-up appointment is scheduled to review medical records again within six months.

Office Site Standards

The office practice environment is assessed in the following categories:

- Physical accessibility
- Physical appearance
- Medical record keeping practices
- Safety measures
- Appointment availability
- Adequacy of waiting and exam rooms and patient privacy

Physical Accessibility and Appearance

- Clean, well lit
- Poses no safety hazards
- Building and office should have accommodations for the disabled.
- Building ramp or elevator should be present if office is not on the first floor.
- If no accommodations for the disabled, then office must have arrangements in place to accommodate disabled patients.

Adequacy of Waiting Room and Examining Room Space

- Waiting / reception areas neat and clean. These areas appear to be cleaned regularly and are free of excessive clutter.
- There should be an adequate number of examination rooms to accommodate patient volume.
  Standard: Two (2) examination / treatment rooms per MD in office per day.
- Adequate number of seats to accommodate patient volume. Standard: Three (3) chairs per physician.

Safety Measures:

- Fire exits are clearly labeled, and free of any obstacles.
- Emergency evacuation response plan is posted or staff can describe the plan.
- Office has evidence of personal protective equipment, tuberculocidal surface disinfectant.

Medical Record Standards and Reviews

Medical record reviews may be conducted during practice site evaluations or initiated as a result of quality concerns, and during HEDIS medical record reviews.

When appropriate, the auditing of medical record keeping practices of participating providers will be assessed against the following categories:

- Confidentiality of medical records
- Medical record documentation standards
- Organization of medical records
- Availability of medical records
- Quality of medical record keeping

Confidentiality of all medical record information will be protected in accordance with state and federal regulations and HNE's guidelines.

Medical record documentation will include:

- History and Physicals
- Allergies and Adverse Reactions
- Problem list
- Medication list
- Documentation of clinical findings and evaluation for each visit
- Preventative services / risk screening
- Documentation of Advance Directives in a prominent part of the medical record
- Documentation in regards to whether or not a member has executed an advance directive

Medical records must be organized and stored in a manner for easy retrieval and in a secure environment which allows access by authorized personnel only.

A summary report, indicating compliance with HNE standards, identified deficiencies, and a suggested action plan will be communicated to the provider.

Providing Care in a Culturally Competent Manner

Here are some useful references for developing cultural competence and links to training materials for your consideration. The training materials include ideas and assistance about how to provide care in a culturally competent manner. Providers can access educational materials through the following websites:

Physician Toolkit and Curriculum:
http://minorityhealth.hhs.gov/assets/pdf/checked/toolkit.pdf

Physicians's Practical Guide:
https://cccm.thinkculturalhealth.hhs.gov

Provider's Guide to Quality and Culture:
http://erc.msh.org/mainpaige.cfm?file=1.0htm&module=provider&language=English

HRSA Cultural Competence Resources for Health Care Providers:
http://www.hrsa.gov/CulturalCompetence/research.html