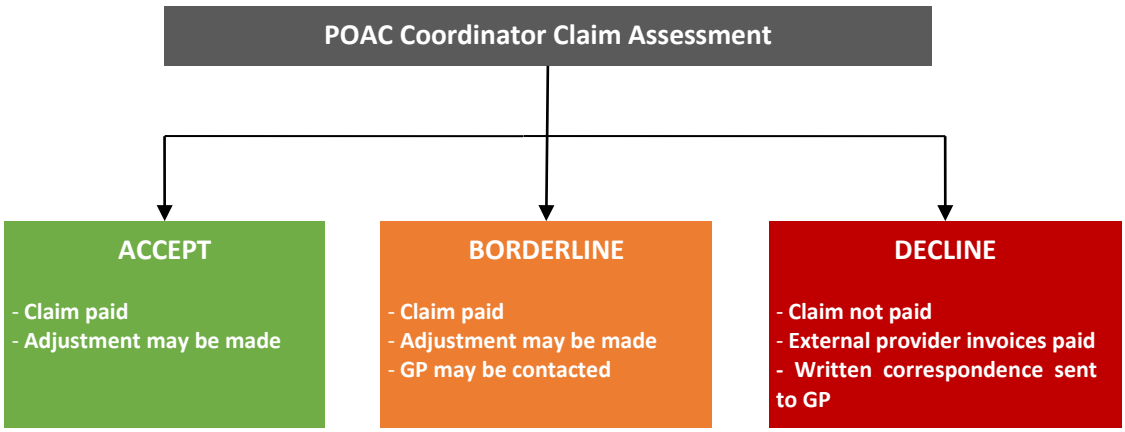
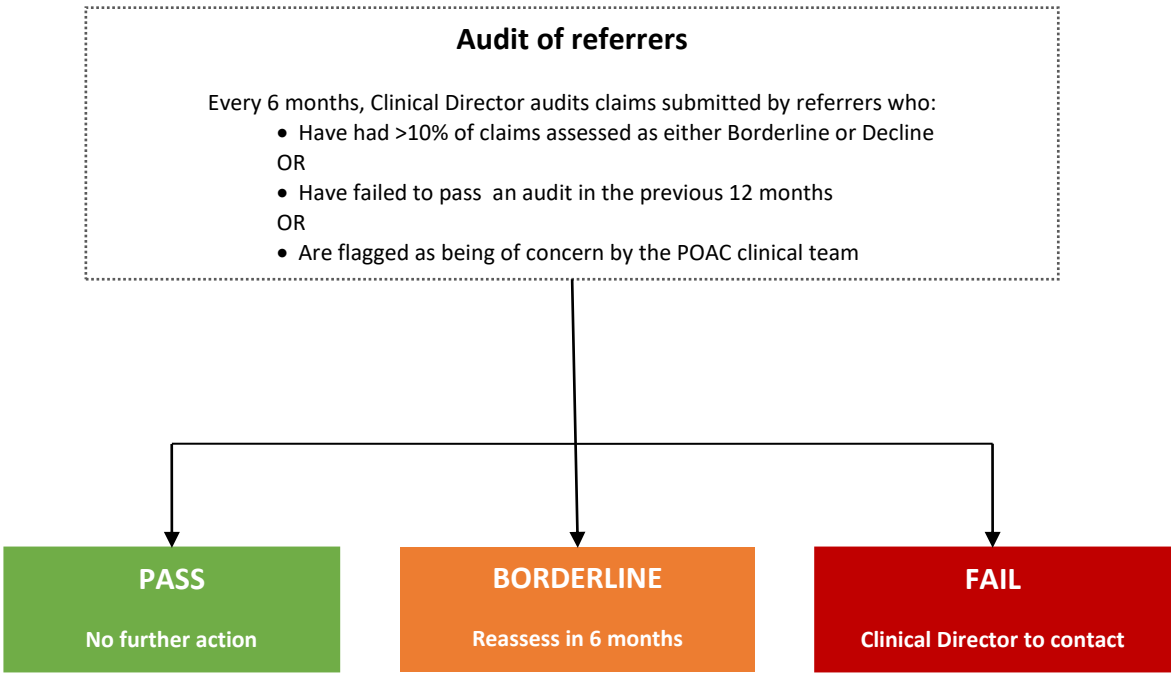
POAC Clinical Governance Processes

POAC Claim Review Process

Claim Based



Referrer Based



POAC Clinical Governance Processes

POAC Clinical Review Process Guidance

Initial Claim Assessments

Accepted:

POAC team members may 'Accept' claims that clearly adhere to POAC principles and any guidelines, clinical policies or the Auckland Regional HealthPathways. Claim may be adjusted if is claimed incorrectly, is clearly inconsistent with the stated work undertaken, or is outside of an existing POAC claiming fee schedule.

Borderline:

A claim may be assessed as Borderline where it does not fit with best practice or POAC principles or policies. Communication to referrer and education may be required. Claim is paid on this occasion. Claim may be adjusted, as per above.

Declined:

The Nurse Advisor, Service Manager or Clinical Director may decline a claim clearly outside of POAC policy/guidelines and/or potentially unsafe practice or risk of significant adverse outcome. Claims may also be declined where an alternative funding stream is more appropriate (e.g. ACC, maternity). Claims submitted by external providers may on occasion be approved for payment. Any claim submitted by the referring clinician will not be paid and will be informed in writing. The referrer will be provided with opportunity to dispute any declined claim.

Nurse Advisor Claim Assessments

The POAC Nurse Advisor will:

- Assess claims that have been referred by the POAC team members
- Refer to the Clinical Director claims about which there remains uncertainty
- Undertake random audit of cases to review appropriateness of assessments.
- Six monthly review of audit activity

Claims assessed by the Nurse Advisor or Clinical Director as Borderline will be paid, and consideration given to communication with the referrer, either by phone or in writing. The decision whether to communicate is based on the nature of the concern over the claim. As a general rule, where the cause for concern relates to patient safety or clinical quality of care, contact will be made.

Declined claims should always trigger a written communication with the referrer, notifying of the assessment outcome and offering a right of reply.

POAC Clinical Governance Processes

Review of a Claim Assessment decision will be undertaken on the basis of a written response being received from the referrer.

Clinical Director Referrer Assessments

When a referrer fails to pass an audit, or is repeatedly assessed as Borderline, the Clinical Director and/or Nurse Advisor should make direct contact in order to discuss concerns and develop a remediation plan. This may include:

- Direct conversation with clinician (phone call/visit)
- Discussion/liaison with PHO or Urgent Care Clinical Director

A further audit should be undertaken 6 months later. Actions available to manage referrers who repeatedly fail to pass claim audits may include:

- Referral to PHO or Urgent Care Clinical Director
- Controlled access to POAC funding such as requiring Clinical Director or Nurse Advisor approval
- Suspension of access to POAC funding

If the POAC Clinical Team identifies that referral to the New Zealand Medical Council may be appropriate, the Clinical Director will discuss with the appropriate PHO, Urgent Care and/or DHB clinical leader.

POAC Clinical Reporting

Quarterly reporting to POAC Clinical Governance Group, Metro Auckland Clinical Governance Forum and Clinical Assessments Limited Board on:

- Number and percent of GP referred borderline and declined claims by PHO
- Number of referrers being actively monitored
- Number of referrers with action taken, including the reason for action and nature of the action taken
- Number and results of Serious Adverse Events investigated
- Risks identified

POAC Clinical Governance Group

The POAC Clinical Director will assemble a Clinical Governance Group (refer Terms of Reference)