CLINICAL QUALITY MANAGEMENT PROGRAM (CQMP)

1.0. CQMP PLAN

The contractor shall operate a CQMP which results in demonstrable quality improvement of the health care provided beneficiaries and of the process and services delivered by the contractor. Structural and functional components included in the quality management plan are:

CQMP Annual Plan Format - At a minimum the CQMP Annual Plan shall include:

- Table of Contents
- Executive Summary
- Quality Improvement Plan
  - Planned Quality Improvement Initiatives
  - Planned Research and/or Clinical Quality Studies
  - Planned Patient Safety/Quality Issue Program
- CQMP Interface With Office of the Regional Director
- National Quality Monitoring Contractor (NQMC) Interface

2.0. CQMP STRUCTURAL AND FUNCTIONAL REQUIREMENTS

The contractor shall participate in monthly, or less frequently if directed by the Regional Director, region level quality management committees. The contractor shall develop and implement written policies and procedures to identify potential quality issues, identify steps to resolve identified problems, provide interventions to resolve problems, and provide ongoing monitoring of all components of the contractor's operations and the care and treatment of TRICARE beneficiaries. At a minimum, the contractor shall assess every medical record reviewed for any purpose and any care managed/observed/monitored on an ongoing basis for potential quality indicators (PQIs) in accordance with the following:

The contractor shall identify, track, trend, and report interventions to resolve the following PQIs and QIs:

EVENT	ADDITIONAL SPECIFICATIONS	NO ACTUAL QI	PATIENT SAFETY AND/OR QUALITY ISSUE (QI)			SENTINEL EVENT
			SEVERITY LEVEL 1	SEVERITY LEVEL 2	SEVERITY LEVEL 3	SEVERITY LEVEL 4
Medical, Surgical, Inpatient, Outpatient, Skilled Nursing, Mental Health Facility, Office Visit						
1. SURGICAL EVENTS						
A. Surgery performed on the wrong body part	*Defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient.* *Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent.* *Surgery includes endoscopies and other invasive procedures.*					
B. Surgery performed on the wrong patient	*Defined as any surgery on a patient that is not consistent with the documented informed consent for that patient.* *Surgery includes endoscopies and other invasive procedures.*					
C. Wrong surgical procedure performed on a patient	*Defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient.* *Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent.* *Surgery includes endoscopies and other invasive procedures.*					
D. Retention of a foreign object in a patient after surgery or other procedure	*Excludes objects intentionally implanted as part of a planned intervention and objects present prior to surgery that were intentionally retained.*					

EVENT	ADDITIONAL SPECIFICATIONS	NO ACTUAL QI	PATIENT SAFETY AND/OR QUALITY ISSUE (QI)			SENTINEL EVENT
			SEVERITY LEVEL 1	SEVERITY LEVEL 2	SEVERITY LEVEL 3	SEVERITY LEVEL 4
E. Intraoperative or immediately post-operative death in an ASA Class I patient	*Includes all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.* *Immediately post-operative means within 24 hours after induction of anesthesia (if surgery not completed), surgery, or other invasive procedure was completed.*					
2. PRODUCT OR DEVICE EVENTS ***A. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the health care facility***	*Includes generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination and/or product.*					
B. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended	*Includes, but is not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators.*					
C. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a health care facility	*Excludes deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.*					
3. PATIENT PROTECTION EVENTS ***A. Infant discharge to the wrong person***						
B. Patient death or serious disability associated with patient elopement (disappearance) for more than four hours	*Excludes events involving competent adults.*					
C. Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a health care facility	*Defined as events that result from patient actions after admission to a health care facility.* *Excludes deaths resulting from self-inflicted injuries that were the reason for admission to the health care facility*					

EVENT	ADDITIONAL SPECIFICATIONS	NO ACTUAL QI	PATIENT SAFETY AND/OR QUALITY ISSUE (QI)			SENTINEL EVENT
			SEVERITY LEVEL 1	SEVERITY LEVEL 2	SEVERITY LEVEL 3	SEVERITY LEVEL 4
4. CARE MANAGEMENT EVENTS						
A. Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)	Excludes reasonable differences in clinical judgement on drug selection and dose					
B. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products						
C. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility	Includes events that occur within 42 days post-delivery. Excludes deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy or cardiomyopathy.					
D. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a health care facility						
E. Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinimia in neonates	Hyperbilirubinimia is defined as bilirubin levels > 30 mg/dl. Neonates refers to the first 28 days of life.					
F. Stage 3 or 4 pressure ulcers acquired after admission to a health care facility	Excludes progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.					
G. Patient death or serious disability associated due to spinal manipulative therapy						
5. ENVIRONMENTAL EVENTS						
A. Patient death or serious disability associated with an electric shock while being cared for in a health care facility	Excludes events involving planned treatments such as electric countershock.					

EVENT	ADDITIONAL SPECIFICATIONS	NO ACTUAL QI	PATIENT SAFETY AND/OR QUALITY ISSUE (QI)			SENTINEL EVENT
			SEVERITY LEVEL 1	SEVERITY LEVEL 2	SEVERITY LEVEL 3	SEVERITY LEVEL 4
B. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances						
C. Patient death or serious disability associated with a burn incurred from any source while being cared for in a health care facility						
D. Patient death associated with a fall while being cared for in a health care facility						
E. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health care facility						
6. CRIMINAL EVENTS *A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider*						
B. Abduction of a patient of any age						
C. Sexual assault on a patient within or on the grounds of a health care facility						
D. Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care facility						

3.0. PATIENT SAFETY OR QUALITY ISSUE IDENTIFICATION

The contractor shall apply medical judgment and follow the TRICARE criteria for the identification, evaluation and reporting of all PQIs and confirmed QIs.

3.1. Quality Interventions

The contractor shall implement appropriate quality interventions to reduce the number of quality issues and improve patient safety. When the contractor confirms a quality issue, the determination shall include assignment of an appropriate severity level, and describe the actions taken to resolve the quality problem (if appropriate).

4.0. DEFINITIONS

Potential Quality Indicator (PQI) - a clinical or system variance warranting further review and investigation for determination of the presence of an Actual Quality Issue.

No QI - Following investigation there is NO quality issue finding.

Quality Issue - a verified deviation from acceptable standard of practice or standard of care as a result of some process, individual, or institutional component of the health care system.

- **Severity Level 1 -** Quality issue is present with minimal potential for significant adverse effects on the patient.
- **Severity Level 2 -** Quality issue is present with the potential for significant adverse effects on the patient.
- **Severity Level 3 -** Quality issue is present with significant adverse effects on the patient.
- **Severity Level 4 -** Quality issue with the most severe adverse effect and warrants exhaustive review.
- **Sentinel Event -** the most severe, verified deviation from acceptable standard of practice or standard of care as a result of some process, individual, or institutional component of the health care system. A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

5.0. IMPROVING THE QUALITY OF HEALTH CARE BY REDUCING MEDICAL ERRORS AND INCREASING PATIENT SAFETY

- The contractor shall report annual patient safety initiatives.
- Report on ways the patient safety program will be strengthened.
- Demonstrate effective implementation of patient safety improvement programs.

6.0. CLINICAL QUALITY MANAGEMENT ANNUAL REPORT

The contractor shall submit to the Regional Director and TMA, no later than 90 calendar days following the end of each *fiscal year*, a report of the CQMP activities; problems identified and resolved; ongoing problems and corrective action plans; improvements in the care provided to beneficiaries and the contractor's operations. The report shall be formatted as follows:

- Table of Contents
- Executive Summary
- Quality Improvement Plan Review
  - Outcomes of Quality Improvement Initiatives
  - Outcomes of Research and/or Clinical Quality Studies
  - Summary of Patient Safety/Quality Issue Findings
- Summary of National Quality Monitoring Contractor (NQMC) Interface with CQMP
- Summary of CQMP Interface with the Regional Director