

Quality Policy: Potential Quality Issues (PQI)

Revision Date: August 2009, January 2010, May 2011, February 2012, August 2012, Feb 2013, April 2014, November 2014, February 2015, June 2015, October 2015, February 2016, May 2016, February 2017, November 2017, February 2018, November 2018, February 2019

Subject: POTENTIAL QUALITY ISSUES (PQI)

Policy

The Plan maintains a system for the recognition, tracking, trending and resolution of Potential Quality Issues (PQIs), including mortalities and morbidities, and considers this system as one of the most critical components of the Quality Management Program. The purpose of this policy is to describe the process for identifying mortalities, morbidities and any potential quality issue (PQI) or occurrence that is not consistent with routine Plan operations or situations that may potentially or actually result in injury, harm or loss to an enrollee, employee, or visitor of VCHCP.

Scope

All occurrences meeting the criteria for mortality, morbidity, or potential quality issue review as defined by the Peer Review Committee (PRC) in the course of providing medical and mental health services to Plan enrollees. This includes grievances.

Definitions

Mortality – enrollee death while under treatment from a Plan contracted provider.

Morbidity – unexpected complication of treatment ordered by a Plan provider. Morbidities may also include, but are not limited to, delays or failure to provide adequate care or other omissions in the provision of care to enrollees.

Quality Issue – occurrences where the care and/or treatment of an enrollee did not meet the standard of care as determined by the QAC. May also include service issues, which affect the enrollee's health and/or safety. Quality issues may also be identified from enrollee grievances.

Incident – for the purposes of this policy, any occurrence that is not consistent with the routine operation of VCHCP and that potentially may or actually did result in injury, harm or loss to any enrollee, visitor or employee of VCHCP.

Confidential report of PQI and/or Incident - written document or form for reporting Potential Quality Issues and/or incidents.

Discussion

1. The Quality Management Program is coordinated with performance monitoring activities throughout the organization, including but not limited to utilization management, credentialing, monitoring and resolution of Member Service Logs, identification of Member/Provider complaints/grievances and appeals from a variety of sources, assessment of member satisfaction, and medical records review. Particular attention will be paid to PQIs (Potential Quality Issues) derived from these and other sources.
2. The peer review process is evaluated and updated at least on an annual basis and whenever necessary.
3. The Plan Medical Director shall be accountable for all of the following:

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- a. Ensuring that PQIs are fully investigated by the Plan under the supervision of the Medical Director;
- b. Ensuring that PQIs are tracked by the Peer Review Committee throughout the investigative and resolution process;
- c. Ensuring that the final resolution, including any corrective action plans (CAPs) is presented to the Peer Review Committee for discussion and final approval and in turn, summary reports are presented to the Quality Assurance Committee;
- d. Ensuring that the status of PQI tracking/trending/resolution is presented to each Standing committee meeting;
- e. Supporting the Plan's position that the system of recognition, tracking, trending and resolution of PQIs is one of the most critical components of the Quality Management Program.

Procedure:

1. PQI's may be identified through:
 - a. information gathered through concurrent, prospective, and retrospective utilization review.
 - b. referrals by health plan staff or providers.
 - c. facility site review
 - d. focused studies
 - e. claims data
 - f. pharmacy utilization data
 - g. member/ provider satisfaction surveys
 - h. encounter data
 - i. medical records audits
 - j. phone log detail
 - k. grievances
2. PQI's may be reported by any of the following:
 - a. any VCHCP staff member
 - b. any health care professional or provider of services to VCHCP members
 - c. any VCHCP member or member representative
 - d. any member of any VCHCP Committee
 - e. anonymous person
3. Identified quality of care issues are elevated to review by the Medical Director or designee for confirmation of PQI status and need for Peer Review. The Service Administrator may request review by the Medical Director or designee for any other appropriate issue.
4. All mortalities and readmissions are reported to or reviewed by the Peer Review Committee. Any aspect of care defined as high risk, high volume or problem prone may be reviewed as a potential systems issue.

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5. A PQI Work Sheet for each PQI is initiated and updated throughout the PQI process. A QA staff member and the Medical Director will meet regularly to review active cases and their progress through the process.
6. The PQI Work Sheet and all documents related to each PQI will be incorporated into one case file.
7. The PQI Work Sheet will include the following:
 - a. the nature of the PQI
 - b. if involving a member – the member’s name, and ID number
 - c. if involving a provider or providers – the name (s) of the providers and provider type(s).
 - d. if involving an incident – the date of occurrence
 - e. if involving an occurrence – the facility where the problem occurred
 - f. the date of the PQI Report
 - g. the name of the person or entity making the PQI Report
 - h. important aspect of the problem – aspects of care and service
 - i. documentation of each step in the investigation and review process
 - j. associated dates and signatures of personnel conducting the activities
 - k. documentation of the final rating by the Medical Director or Peer Review Committee
8. The Medical Director will determine what additional information is needed to investigate the problem. That information will be requested and collected.
9. After receipt of all required information the Medical Director will assign a member or organization, system and provider rating to the PQI.
10. Any PQI with a rating of S-0 or P-0 will be closed.
11. Any PQI with a rating of S-1 or P-1 will be reported to the Peer Review committee and may be trended to the System and/or Provider.
12. Any PQI with a rating of S-2 or P-2 will be reported to and may be reviewed by the Peer Review committee depending on the specifics of the case.
13. Any PQI with a rating of S-3, S-4, P-3 or P-4 will be brought to the Peer Review Committee for discussion and rating. If the committee determines that a Corrective Action Plan (CAP) is necessary, the committee will implement the CAP, monitor for compliance and improvement and follow through to resolution. Please see the Credentialing Program Policy for details.

Quality Policy: Potential Quality Issues (PQI)

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14. Any PQI with a rating of S-1, S-2, P-1 or P-2 will be recorded in the provider's credentialing file to be reviewed during the next recredentialing cycle.
 15. Any PQI with a rating of S-3, S-4, P-3 or P-4 that occurred at a facility will be referred to that facility for review with a request for follow-up information on the outcome of their internal QA or Peer Review Process.
 16. Any PQI that is rated S-3, S-4, P-3 or P-4 by the committee -may be trended and reported to the credentials committee to include any decisions or recommendations made by the Peer Review Committee.
 17. A summary of PQI activity will be provided to the QA Committee and Standing Committee on a quarterly basis.
 18. Identified PQI corrective action plans (CAPS) will be reported and discussed in the Quality Assurance Committee (QAC) on a quarterly basis. QAC recommendations will be brought back to the Peer Review Committee to identify further actions, if any.
 19. Identified PQI trends on systems and/or providers will be reported and discussed in the Quality Assurance Committee (QAC) on a quarterly basis. QAC recommendations will be brought back to the Peer Review Committee to identify further actions, if any.
 20. All documents, reports and information relating to the investigation and review of a potential quality issue are kept confidential in accordance with peer review protection.
 21. Timeline for PQI completion/review for presentation to Peer Review Committee presentation is 90 - 120 days.
- A. PQI Classification: Attachment A
 - B. PQI Work Sheet: Attachment B
 - C. **References:**
 - Related Policies and Procedures:
 - Member Services Program
 - UM-Treatment Authorization Request Auth Process and Timeline Standards
 - QA Policy: Sentinel Event & Risk Management
 - 28 CCR 1300.70(a) (1), (3)
 - D. Reviewers: David Chernof, M.D., Pamela K. Lindeman; Date: Feb 2005
QA Committee; Date: 02-22-05
 - E. Reviewed/Revised by Sheldon Haas, M.D & Lita Catapang, RN on 04-07-08
Committee Review: QA on 05-19-08

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- F. Reviewed and Revised by: Joan Araujo, RN, Dr. John Fankhauser, Paul Lorenz, Terrie Stanley, RN: June 2009
- G. Revised by C. Albert Reeves MD Jan 2010
- H. Reviewed/No Changes by: Faustine Dela Cruz, RN & Albert Reeves, MD
- Committee Review:
 - QAC: August 23, 2011
- Reviewed/Revised by: Faustine Dela Cruz, RN & Albert Reeves, MD
- Committee Review:
 - QAC: February 28, 2012
- Reviewed/Revised by: Cecilia Cabrera-Urango, RN & Albert Reeves, MD
- Committee Review:
 - QAC: August 28, 2012; Standing Cmte: October 25, 2012
- Reviewed/No Changes by: Faustine Dela Cruz, RN & Albert Reeves, MD
- Committee Review:
 - QAC: February 26, 2013
 - Committee Review:
 - QAC: February 25, 2014
 - Committee Review:
 - QAC: May 27, 2014
- Reviewed/Revised by: Catherine R. Sanders, MD
- Committee Review:
 - Peer Review: November 5, 2014
- Reviewed/No Changes by Catherine R. Sanders, MD
- Committee Review:
 - QAC: February 24, 2015
- Reviewed/Revised by: Catherine R. Sanders, MD
- Committee Review:
 - QAC: June 2, 2015
- Reviewed/Revised by: Catherine R. Sanders, MD
- Committee Review:
 - Peer Review: November 5, 2015
- Reviewed/No Changes by: Catherine Sanders, MD
- Committee Review:
 - PRC: February 4, 2016
 - QAC: February 23, 2016
- Reviewed/Revised by: Catherine R. Sanders, MD
- Committee Review:
 - Peer Review: May 5, 2016
 - QAC: May 24, 2016
- Reviewed/No Changes by Catherine R. Sanders, MD
- Committee Review:

Quality Policy: Potential Quality Issues (PQI)

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- Peer Review: February 2, 2017
- QAC: February 28, 2017

Reviewed/Revised by Catherine R. Sanders, MD

- Committee Review:
 - Peer Review: November 1, 2017
 - QAC: November 27, 2017

Reviewed/No Changes: Catherine Sanders, MD

- Committee Review:
 - PRC: February 1, 2018
 - QAC: February 27, 2018

Reviewed/Revised by: Catherine Sanders, MD

- Committee Review:
 - PRC: November 1, 2018
 - QAC: November 27, 2018

Reviewed/Revised by: Catherine Sanders, MD

- Committee Review:
 - PRC: February 7, 2019
 - QAC: February 26, 2019

Revision Date	Content Revised (Yes/No)	Contributors	Review/Revision Notes
2/2/2017	No	Catherine Sanders, MD	Annual review
11/1/2017	Yes	Catherine Sanders, MD	Updated with DMHC recommendation: Any PQI with a rating of S-2 or P-2 will be reported to and may be reviewed by the Peer Review committee depending on the specifics of the case.
2/1/2018	No	Catherine Sanders, MD	Annual Review
9/11/2018	Yes	Catherine Sanders, MD	Timeline for PQI completion/review

Quality Policy: Potential Quality Issues (PQI)

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			for presentation to Peer Review Committee presentation is 90 - 120 days.
1/2/2019	Yes	Catherine Sanders, MD	Any PQI that is rated S-3, S-4, P-3 or P-4 by the committee may be trended and reported to the credentials committee to include any decisions or recommendations made by the Peer Review Committee.

ATTACHMENT 'A'

VCHCP - PQI Classifications

PQI RATINGS

MEMBER OR ORGANIZATION OUTCOME RATING

Rating	Definition		Rating by Med Dir	Rating by QA Cmte
0-0	Not Applicable	N/A		
0-1	No negative outcome	No negative Outcome to member or to organization		
0-2	Minor negative outcome	Minor negative impact to patient or organization. Impact is reversible		
0-3	Moderate negative outcome	Major negative impact to patient or organization. May have some permanent		

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		residual effects		
0-4	Very serious negative outcome	Permanent morbidity or mortality, severe negative consequences to the organization		

SYSTEM ISSUES

Rating	Definition		Rating by Med Dir	Rating by QA Cmte
S-0	Not Applicable	N/A		
S-1	No System Issue	No Action Required		
S-2	Potential or Minor opportunity to improve system	Informal letter to provider. (Response not required)		
S-3	Potential Significant Event	Letter to Provider of concern, requesting a response. May recommend corrective action plan (CAP) and/or other interventions. S-3s may be referred to the Credentialing Committee with recommendation to the QA Committee		
S-4	Serious or Immediate Threat /Risk to Patient Safety	Immediate communication to provider requesting response. S-4s may be referred to the Credentialing Committee with recommendation to the QA Committee.		

PROVIDER ISSUES

Rating	Definition		Rating by Med Dir	Rating by QA Cmte
P-0	Not Applicable	N/A		
P-1	Care is appropriate	No action required		
P-2	Minor opportunity for improvement. Potential for or actual minor adverse outcome to member	Informal letter to provider. (Response not required)		
P-3	Moderate opportunity for improvement and/or deemed inappropriate. Potential for moderate adverse outcome to member	Letter to provider of concern requesting a response. May recommend CAP and/or other interventions. P-3s may be referred to the Credentialing Committee with recommendation to the QA Committee		
P-4	Significant opportunity for improvement and/or deemed inappropriate. Potential for significant adverse outcome to member	Letter to provider of concern requesting a response. May recommend CAP and/or other interventions. P-4s may be referred to the Credentialing Committee with recommendation to the QA Committee.		