Subject: POTENTIAL QUALITY ISSUES (PQI)

Policy

The Plan maintains a system for the recognition, tracking, trending and resolution of Potential Quality Issues (PQIs) and considers this system as one of the most critical components of the Quality Management Program.

Discussion

1. Quality Management Program structure and process are comprehensively described and represent a complete program according to health plan contractual agreements and applicable standards.

2. The Quality Management Program is fully operational within the provider organization.

3. Quality Management Program responsibilities are assigned to appropriate individuals.

4. Contracted providers and practitioners participate actively in the Quality Management Program.

5. The content of the program is clearly documented and the process is thoroughly outlined.

6. The Quality Management Program is accountable to the Governing Body by way of the Standing Committee.

7. The program is appropriately integrated into the functions of VCHCP operations.

8. The program resources including staff, analytic capabilities, and data resources are adequate to meet the program needs.

9. 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.

10. The program is evaluated and updated at least on an annual basis and whenever necessary.

11. The Plan Medical Director shall be accountable for all of following:

   a. Ensures that PQIs are fully investigated by the Plan, under the supervision of the Medical Director;
   b. Ensures that PQIs are tracked by the QA Committee throughout the investigative and resolution process;
Quality Policy: Potential Quality Issues (PQI)

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c. Ensures that the final resolution, including any corrective action plans (CAPs) is presented to the QA Committee for discussion and final approval;
d. Ensures that the status of PQI tracking/trending/resolution is presented to each Standing committee meeting;
e. Supports 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. MIS reports
   f. claims data
   g. pharmacy utilization data
   h. member/provider satisfaction surveys
   i. encounter data
   j. medical records audits
   k. phone log detail
   l. 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 VCHC members
   c. any VCHCP member or member representative
   d. any member of any VCHCP Committee
   e. anonymous person

3. All PQI’s are entered into the PQI Master Log in the MIS Tracking Module
4. A PQI Work Sheet for each PQI is initiated and updated throughout the PQI process.
5. The PQI Work Sheet and all documents related to each PQI will be incorporated into a one case file.
6. 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. each step in the investigation and review process will be documented in the work sheet.
j. Associated dates and signatures of personnel conducting the activities
k. the final rating by the medical director or QA Committee will be documented on the work sheet.

7. The QA Manager and Medical Director will determine if there is a need to form a PQI Workgroup that includes other members of the VCHCP Administration.

8. The QA Manager and Medical Director or the workgroup 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 an occurrence, 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 closed and an informal letter sent to the provider or questioned entity.

12. Any PQI with a rating of S-2, S-3, P-2 or P-3 will be taken to the QA Committee for review and rating. A CAP may be requested from the provider or problem organization. After the receipt of the CAP the PQI will again be reviewed by the QA Committee.

13. All PQI’s that are rated S-1 or P-1 or higher involving a contracted provider will be recorded in the provider’s Performance Based Review (PBR) credentialing file.

14. A summary of PQI Activity will be provided to the QA Committee on a quarterly basis. The committee may request information on any specific case rated 0 or 1.

15. PQI’s rated S-2 or S-3 or P-2 or P-3 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 QA or Peer Review Process.

A. PQI Classification: Attachment A

B. References:
Related Policies and Procedures:
Member Services Program
Member Grievance and Appeal Process Severity Coding Policy
UM-Prospective Review and Retrospective Review
QA Policy: Sentinel Event & Risk Management
28 CCR 1300.70(a)(1), (3)

C. Reviewers: David Chernof, M.D., Pamela K. Lindeman Date: Feb 2005
QA Committee Date: 02-22-05

D. Reviewed/Revised by Sheldon Haas, M.D & Lita Catapang, RN on 04-07-08
Committee Review: QA on 05-19-08
Quality Policy: Potential Quality Issues (PQI)

Revision Date: 8/09, Jan 2010, May 2011

E. Reviewed and Revised by: Joan Araujo, RN, Dr. John Fankhauser, Paul Lorenz, Terrie Stanley, RN: June 2009
A. Revised by C. Albert Reeves MD Jan 2010
F. Reviewed/No Changes by: Faustine Dela Cruz, RN & Albert Reeves, MD
• Committee Review:
  o QAC: August 23, 2011

Review & Revision History:

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<tr>
<td>Reviewed / No Revision</td>
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<td>Reviewed / Revised</td>
<td>April 7, 2008, August 2009 , Jan 2010</td>
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ATTACHMENT ‘A’
VCHCP - PQI Classifications;

PQI RATINGS

MEMBER OR ORGANIZATION OUTCOME RATING

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<thead>
<tr>
<th>Rating</th>
<th>Definition</th>
<th>Rating by Med Dir</th>
<th>Rating by QA Cmte</th>
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<tbody>
<tr>
<td>0-0</td>
<td>Not applicable</td>
<td>N/A</td>
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<tr>
<td>0-1</td>
<td>No negative outcome</td>
<td>No negative Outcome to member or to organization</td>
<td></td>
</tr>
<tr>
<td>0-2</td>
<td>Minor negative outcome</td>
<td>Minor negative impact to patient or organization. Impact is reversible</td>
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<td>0-3</td>
<td>Moderate negative outcome</td>
<td>Major negative impact to patient or organization. May have some permanent residual effects</td>
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<tr>
<td>0-4</td>
<td>Very serious negative outcome</td>
<td>Permanent morbidity or mortality, severe negative consequences to the organization</td>
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SYSTEM ISSUES

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<th>Definition</th>
<th>Rating by Med Dir</th>
<th>Rating by QA Cmte</th>
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<tbody>
<tr>
<td>S-0</td>
<td>Not Applicable</td>
<td>N/A</td>
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<tr>
<td>S-1</td>
<td>No System Issue</td>
<td>No Action Required</td>
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<tr>
<td>S-2</td>
<td>Potential or Minor opportunity to improve system</td>
<td>Informal letter to provider. (Response not required)</td>
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</tr>
<tr>
<td>S-3</td>
<td>Potential Significant/Sentinel Event</td>
<td>Letter to Provider of concern, requesting a response.-may recommend corrective action plan (CAP) and/or other interventions</td>
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<tr>
<td>S-4</td>
<td>Serious or Immediate Threat /Risk to Patient Safety</td>
<td>Immedicate communication to provider requesting response. S-4s may be referred to Credentialing Committee with recommendation from QA Committee.</td>
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PROVIDER ISSUES
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<th>Rating by Med Dir</th>
<th>Rating by QA Cmte</th>
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<tbody>
<tr>
<td>P-0</td>
<td>Not Applicable</td>
<td>N/A</td>
<td></td>
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<tr>
<td>P-1</td>
<td>Care is appropriate</td>
<td>No action required</td>
<td></td>
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<tr>
<td>P-2</td>
<td>Minor opportunity for improvement. Potential for or actual minor adverse outcome to member</td>
<td>Informal letter to provider. (Response not required)</td>
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<td>P-3</td>
<td>Moderate opportunity for improvement and/or deemed inappropriate. Potential for moderate adverse outcome to member</td>
<td>Letter to provider of concern requesting a response. May recommend CAP and/or other interventions</td>
<td></td>
</tr>
<tr>
<td>P-4</td>
<td>Significant opportunity for improvement and/or deemed inappropriate. Potential for significant adverse outcome to member</td>
<td>Letter to provider of concern requesting a response. May recommend CAP and/or other interventions. P-4s may be referred to Credentialing Committee with recommendations from QA Committee.</td>
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