Tufts Health Plan Quality Management Department

Clinical Quality Process

> **Keeping Quality at the Forefront**
>
> WE need YOU to inform us of potential quality of care issues (e.g. SREs, Health Care Acquired Conditions, and Occurrences) that you encounter in your work every day!
>
> **You are our greatest source of information!**

- The Quality Management Department is dedicated to investigating potential adverse events to ensure that our members are receiving quality care.
- Quality of care concerns tend to be related to inpatient events but include care across the healthcare provider spectrum, including skilled nursing facilities, rehabilitation hospitals, VNA, surgical day care centers and mental health providers.
- Reporting of potential adverse events to the Quality Management Department comes from many sources – providers, claims data, Medical Director reviews, media and our employees.
- When an adverse event is reported to the Quality Management Department, it is assigned to one of the Clinical Quality Specialists for investigation.
- Adverse events can be reviewed through medical records and correspondence with our providers.
- Following completion of the investigation (e.g. review of medical records, outreach to the provider, review with one of the Medical Directors), the case is assigned a rating for severity of the issue (1-6) and a rating for preventability (0-2).
- The Quality Management Department maintains a confidential database that tracks and trends adverse events by provider.
- Closed cases are reported to the Quality of Care Committee (QOCC) at their monthly meeting.

Reporting an Occurrence or a Member Grievance:

Please remember that members are not involved in the review, so please do not inform the member.

- ✓ If the source of the quality event is a member or member representative, complete a ”Quality Improvement Member Grievance Form” (see below) as this is considered a grievance, and the processing of a grievance is time sensitive and starts when a member or member representative informs anyone at Tufts Health Plan of any dissatisfaction.
- ✓ Use Tufts Health Plan’s CQI Occurrence criteria to identify potential quality of care concerns.

To report a quality event (occurrence):

- ✓ Identify adverse event
- ✓ Complete a “Quality Improvement Occurrence Report Form”
- ✓ Submit the form by fax to 617-673-0973 or email to: Adverse_Events_Submission@tufts-health.com

Do not hesitate to contact any of the Clinical Quality Specialists with any questions or concerns.

The Quality Management Department contacts:

Marie Cunningham RN
Director, Medical Policy and Clinical Quality
Ext. 54891

Tomas Alessandri, BSN, RN
Clinical Quality Specialist
Ext. 52752

Margaret Sullivan, RN
Clinical Quality Specialist
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CQI Department Occurrence Codes and Criteria:

Code	Category	Criteria
070	Readmission to Hospital	Within 48 hours of discharge from ED; within 10 days of discharge from inpatient stay; within 1 week of outpatient or same day surgery or procedure or any other readmission that warrants review
071	Inadequate Coordination of Care	Includes delay in diagnosis and/or treatment, inadequate discharge plan (e.g. discharge instructions without follow-up plan), inadequate COC with outpatient healthcare providers, inadequate COC with VNA/home health agencies/ transportation services, inadequate communication between provider and outpatient providers (e.g. PCP, Behavioral Health providers)
072	Complication from Surgery or Other Invasive Procedure	Invasive procedures include (but are not limited to): surgery; OB procedures; indwelling lines and catheters; all scopes; injections and equipment failures Complications include: infections requiring antibiotics; wound dehiscence; anesthesia complications; path report inconsistent with diagnosis; intra-operative complications; return to OR; cardiovascular events; neurological events; pulmonary events; bleeding problems; performance of inappropriate operation or procedure; foreign body left in patient; vascular catheter associated infections; surgical site infections; post-operative DVT/PE; accidental perforation/ laceration
073	Death	Excludes: anticipated deaths due to chronic diagnosis processes Includes: all unexpected deaths including intra-operative or post-operative; any self-inflicted while an inpatient and all fetal demises greater than 20 weeks of gestation
074	Harm to Self or Others	Harm to self, harm to others, harm from others requiring admission or transfer to a more acute medical or behavioral health facility. Includes harm to self, harm to others, harm from others during inpatient, ED, or any behavioral health setting
076	Adverse Medical Outcome Secondary to Lack of Care	Medication errors; falls with and without injury; stage 2, 3, 4, or unstageable pressure ulcer; deep tissue injury not present on admission; injury related to restraint or seclusion; catastrophic events with unexpected outcomes resulting in a life threatening situation; severe impairment; serious loss of functional levels (such as paralysis, hemodialysis, coma, loss of limb, or ventilator dependence); any infestations (lice, etc.); elopement; fire setting; sexual activity on inpatient unit; failure of staff to find potentially harmful objects on patient prior to admission; abuse of patient; air embolism; blood incompatibility; burns; manifestations of poor glycemic control (e.g. DKA or hypoglycemic coma not present on admission)

Serious Reportable Events

Through Massachusetts General Law, chapter 305 of the Acts of 2008, hospitals and ambulatory surgery centers are required to report Serious Reportable Events (SREs) to the Massachusetts Department of Public Health (DPH).[1] Through regulation, the Department has defined SREs to meet the National Quality Forum's definitions of 28 such events.[2]

1. SURGICAL OR INVASIVE PROCEDURE EVENTS
   - A. Surgery or other invasive procedure performed on the wrong site
   - B. Surgery or other invasive procedure performed on the wrong patient
   - C. Wrong surgical or other invasive procedure performed on a patient
   - D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure
   - E. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient
2. PRODUCT OR DEVICE EVENTS
   - A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
   - B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
   - C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting
3. PATIENT PROTECTION EVENTS
   - A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
   - B. Patient death or serious injury associated with patient elopement (disappearance)
   - C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting
4. CARE MANAGEMENT EVENTS
   - A. Patient death or serious injury 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)
   - B. Patient death or serious injury associated with unsafe administration of blood products
   - C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
   - D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
   - E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting
   - F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
   - G. Artificial insemination with the wrong donor sperm or wrong egg
   - H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
   - I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results
5. ENVIRONMENTAL EVENTS
   - A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
   - B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances
   - C. Patient or staff death or serious injury associated with a burn incurred from any

[1] https://www.mass.gov/lists/serious-reportable-event-sres

[2] This list comes from the National Quality Forum's list, linked to through Mass.gov – http://www.qualityforum.org/Topics/SREs/List_of_SREs.aspx#sre1

source in the course of a patient care process in a healthcare setting
   D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting
6. RADIOLOGIC EVENTS
   A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area
7. POTENTIAL CRIMINAL EVENTS
   A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
   B. Abduction of a patient/resident of any age
   C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
   D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting

Health Care Acquired Conditions (HCACs)

The Acute Hospital RFA includes provisions for non-payment of services associated with fourteen hospital acquired conditions listed in the Appendix V MassHealth Billing Instructions for Provider Preventable Conditions. This appendix contains detailed billing instructions that apply to each HCAC.[3]

Per Appendix V, Table (2): Health Care Acquired Conditions[4]

1. Foreign object retained after surgery
2. Air embolism
3. Blood incompatibility
4. Pressure ulcers, stages III & IV
5. Falls and trauma related to
   a. fractures
   b. dislocations
   c. intracranial injuries
   d. crushing injuries
   e. burns
   f. other injuries
6. Catheter-associated urinary tract infection (UTI)
7. Vascular catheter-associated infection
8. Manifestations of poor glycemic control that include
   a. diabetes ketoacidosis
   b. nonketototic hyperosmolar coma
   c. hypoglycemic coma
   d. secondary diabetes with ketoacidosis
   e. secondary diabetes with hyperosmolarity
9. Surgical site infection, mediastinitis following coronary artery bypass graft (CABG)
10. Surgical site infection following certain orthopedic procedures:
    a. spine
    b. neck
    c. shoulder
    d. elbow
11. Surgical site infection following bariatric surgery for obesity:
    a. laparascopic gastric bypass
    b. gastroenterostomy
    c. laparoscopic gastric restrictive surgery
12. Surgical site infection (SSI) following Cardiac Implantable Electronic Device (CIED) procedures
13. Iatrogenic pneumothorax with venous catheterization
14. Deep vein thrombosis (DVT)/pulmonary embolism (PE) following certain orthopedic procedures: *Note: This HCAC category does not apply to pediatric (under 21 years of age) or obstetric patients.*
    a. total knee replacement
    b. hip replacement

[3] https://www.mass.gov/service-details/other-hospital-quality-payment-initiatives
[4] https://www.mass.gov/doc/appendix-v-masshealth-billing-instructions-for-provider-preventable-conditions-3/download