

## CLINICAL QUALITY MANAGEMENT PROGRAM (CQMP)

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### 1.0. **CLINICAL QUALITY MANAGEMENT PROGRAM (CQMP)**

The *Managed Care Support Contractors (MCSCs) and Designated Providers (DPs) (from this point forward to be referred to as the contractor)* shall operate a CQMP which results in demonstrable improvement *in the quality of* health care provided *to* beneficiaries, and *in* the process and services delivered by the contractor. *The CQMP is defined as the integrated processes, both clinical and administrative, that provide the framework for the contractor to objectively define and measure the quality of care received by beneficiaries. This CQMP shall demonstrate how the contractor's goals and objectives, leadership, structure, and operational components are designed to achieve the efficient and effective provision of timely access to high quality health care. As part of the CQMP, the contractor shall develop a CQMP Plan with goals and objectives followed by a CQMP Annual Report (AR) describing the results of the quality activities performed during each program year.*

### 2.0. **CQMP PLAN**

**2.1.** *The contractor shall develop a written CQMP Plan which is defined as a detailed description of the purpose, methods, proposed goals and objectives designed to meet the intent of the program. The contractor shall fully describe in a written CQMP Plan the structural and functional components of the program, to include:*

- Table of Contents
- Executive Summary
- *Organizational structure (describe the relationship of the CQMP to the organization)*
- *Description of committee(s) structure, membership, functional responsibilities, and interface with other committees and meeting frequency*
- *Staff qualifications and responsibilities:*
  - *Describe the minimum staffing qualifications by position*
  - *Describe by position the responsibilities and authorities of personnel involved in the performance of quality management activities*
- *Quality review processes:*
  - *Identification, review, evaluation, intervention, and reporting of Quality Issues (QIs) and grievances*
  - *Criteria for selection of quality improvement projects and/or studies, or other improvements initiative*
  - *Description of patient safety initiatives and quality program activities intended to:*
    - *reduce medical errors*
    - *increase patient safety*
    - *promote health and prevent disease or injury*
    - *promote provider and beneficiary educational activities*

- National guidelines/benchmarking used for quality reviews
- Reporting processes and requirements
- Measurable goals and thresholds for internal monitoring and improvement of the clinical quality plan and program
- Response to recommendations from prior year's CQMP AR submission review

**2.2.** Forty-five calendar days prior to the beginning of each fiscal year, the contractor shall submit their annual CQMP plan to the Government using the E-Commerce Extranet (<https://tma-ecomextranet.ha.osd.mil>). *The appropriate TRICARE Regional Office (TRO) shall review the plan and make recommendations for revision if necessary within 45 calendar days or provide written acceptance through the Contracting Officer (CO). In the absence of clinical quality management staff in the Designated Provider Program Office (DPPO), the Clinical Quality Division of the Office of the Chief Medical Officer (OCMO) will review the plans submitted by the DP programs and provide recommendations for revision or written acceptance within 45 calendar days through the contracting officer. The contractor shall provide a revised plan addressing the recommendations within 20 business days to the TRO/DPPO.*

### **3.0. CQMP ANNUAL REPORT (CQMP AR)**

See [Chapter 15, Section 6, paragraph 1.0](#). *The TROs and DPPO will provide relevant comments to the contractors based on review of the annual clinical quality management program annual report. The report will be reviewed in conjunction with the annual plan for the particular period of performance. Recommendations for revision or acceptance of the annual report shall be provided in a written format to the contractor within 45 calendar days of receipt of the annual program report.*

### **4.0. COMMON TERMS AND DEFINITIONS**

**4.1. Quality Improvement Initiative (QII).** The purpose of a QII is to improve processes internal to the organization and may include improvements in clinical administrative processes, program related issues or new methods in accomplishing outcomes of the program such as cycle time, effectiveness, efficiency, reporting tools, related processes between departments affecting desired outcomes, etc. Common tools for improvements in processes may include various methods that include core elements such as baseline data, interventions/actions, re-measurement, monitoring and follow-up. Process improvements shall be appropriately documented to demonstrate purpose of improvement, baseline measure(s), actions/interventions, re-measurement(s) and outcomes.

**4.2. Quality Improvement Project (QIP).** A QIP is a set of related activities designed to achieve measurable improvement in processes and outcomes of care. Improvements are achieved through interventions that target health care providers, practitioners, plans, and/or beneficiaries. QIPs may address administrative processes, beneficiary health, error reduction or safety improvement, beneficiary functional status, beneficiary or provider satisfaction, program related issues or to serve as a valid proxy for high-volume or high-risk issues. They may result after being identified from a CQS as an opportunity for improvement. QIPs should be structured with appropriate elements such as clearly defined sample sizes and inclusions/exclusion criteria. They shall be appropriately operationalized, meaning appropriate scientific methodology and rigor should be applied such as using written

research questions and statistically significant analysis as applicable. Lastly, QIPs shall be appropriately documented by including the common elements of a QIP:

- Common Elements of a QIP:
  - Description and purpose of topic
  - Description of the population
  - Rationale for selection of the QIP
  - Description of methodology used
  - Baseline data
  - Description of data collection
  - Goals and time frames
  - Action Plan/Interventions
  - Periodic Re-measurements and outcomes

**4.3. Clinical Quality Study (CQS).** An assessment conducted of a patient care problem for the purpose of improving patient care through peer analysis, intervention, resolution of the problem, and follow-up. A CQS should be appropriately operationalized, meaning appropriate scientific methodology and rigor should be applied such as using written research questions and statistical significant analysis as applicable. Typically these do not require evidence-based interventions, multiple measurement cycles, or sophisticated statistical analysis.

- Common elements of CQS:
  - Description of CQS and purpose of topic
  - Rationale for the selection of the CQS
  - Define the study question
  - Description of methodology used
  - Select the indicators/measures
  - Description of data collection
  - Description of the population and sampling techniques (if applicable)
  - Report of findings to include a definition of the study, description of data collection, statement of hypothesis, analytic methods and population employed, data analysis and interpretation
  - Plan for follow-up of the CQS to include interventions and measurements as applicable

**4.4. Potential Quality Issue (PQI).** A clinical or system variance warranting further review and investigation for determination of the presence of an actual QI.

**4.5. Quality Issue (QI).** A verified deviation from acceptable standards of practice or standards of care as a result of some process, individual, or institutional component of the health care system.

## **5.0. CQMP STRUCTURAL AND FUNCTIONAL REQUIREMENTS**

**5.1.** The contractor shall allow their respective TRO and DPPO clinical staff active participation in their CQMP and non-voting membership in their region level Quality Management Committees. The contractor shall develop and implement written policies and procedures to identify PQIs, steps to resolve identified problems, suggest interventions to

resolve problems, and provide ongoing monitoring of all components of the contractor's operations and the care and treatment of TRICARE beneficiaries.

**5.2.** Using the most current National Quality Forum (NQF) Serious Reportable Events (SREs) and Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators, the contractor shall identify, track, trend, and report interventions to resolve the PQIs and QIs. Additionally, the contractor shall report potential SREs to the TRO or DPPO within two business days from when the contractor becomes aware of the event. The report shall include the beneficiary's name, last four digits of sponsor's Social Security Number (SSN), beneficiary date of birth, enrollment status, brief summary of the event, location of event, and any contractor actions taken to date. The contractor shall report by a secure means, closure of the reported SRE within two business days to include closure date and summary of actions taken.

## **6.0. PATIENT SAFETY OR QUALITY ISSUE (QI) IDENTIFICATION**

The contractor shall apply medical judgment, evidence based medicine, best medical practice and follow the TRICARE criteria as set forth in [paragraphs 5.0.](#) and [5.1.](#) for the identification, evaluation and reporting of all PQIs and confirmed QIs. The contractor shall assess every medical record reviewed for any purpose and any care managed/observed/monitored on an ongoing basis for PQIs.

### **6.1. Quality Intervention**

The contractor shall implement appropriate quality interventions using evidence based medicine/guidelines and best medical practices to reduce the number of QIs and improve patient safety. When the contractor confirms a QI, the determination shall include assignment of an appropriate severity level and/or sentinel event, and describe the actions taken to resolve the quality problem. For Quality Intervention Reporting, see [Chapter 15, Section 3, paragraph 17.0.](#)

### **6.2. Definitions**

**6.2.1. PQI.** A clinical or system variance warranting further review and investigation for determination of the presence of an Actual QI.

**6.2.2. No QI.** Following investigation there is no QI finding.

**6.2.3. QI.** 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** - QI is present with minimal potential for significant adverse effects on the patient.
- **Severity Level 2** - QI is present with the potential for significant adverse effects on the patient.
- **Severity Level 3** - QI is present with significant adverse effects on the patient.

- **Severity Level 4** - QI with the most severe adverse effect and warrants exhaustive review.
  - **Sentinel Event\*** - 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.
- \* **Joint Commission definition of Sentinel Event**

### **6.3. PQI Jurisdiction**

*The contractor with geographic jurisdiction has the ability to have meaningful "quality interventions," and has the best opportunity to demonstrate improved quality by providers within its jurisdiction. Thus, consistent with TOM requirements, cross-region PQI issues are handled as follows: The contractor who receives and/or identifies the potential quality issue shall conduct an initial clinical assessment based upon the case and all supporting information on hand and if a potential quality issue exists, forward the case and all supporting information to the MCSC with geographic jurisdiction for the case review, investigation, and intervention(s).*

### **7.0. AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ) PATIENT SAFETY INDICATORS**

Annually, the contractor shall utilize the current patient safety indicator software, provider level, available from the AHRQ, to evaluate the safety of care delivered in the network. The software is designed for use with administrative data sets and will not require manual chart abstraction. The contractor shall run the appropriate data for all of the patient safety indicators and use the analysis of the results to identify PQIs and patient safety issues for individual providers, groups or facilities. Analysis will also be used to provide focus for specific patient safety interventions and/or study activity that will be implemented at the direction of the contractor.

**FIGURE 7-4-1 TIMELINE FOR ANNUAL CQMP PLAN AND CQMP REPORT**

