

## PATIENT SAFETY PROGRAM

### Section 9

---

#### **Patient Safety Program**

WellCare is committed to offer services that ensure the safe delivery of clinical care to its members. WellCare's Patient Safety Plan exists to establish the framework for demonstrating this commitment. Through execution of standardized internal processes and collaborative participation of hospitals, WellCare's active patient safety program goal includes fostering a supportive environment to provide improved patient health care and safety through reduction in avoidable medical errors. Some objectives of WellCare's Patient Safety program include, but are not limited to:

- Support of and ongoing collaboration with participating hospitals to encourage and endorse patient safety activities
- Continue to monitor performance against national patient safety benchmarks
- Educate hospitals about safe practices

In support of safe clinical practices, WellCare's policies and procedures define and also provide for the monitoring of nationally accepted quality of care indicators.

Through tracking and trending of relevant Plan metrics, WellCare can identify opportunities for improvement and facilitate education of a specific practitioner and/or the hospital community at large in order to reduce the potential for patient safety incidents.

The Plan addresses key elements of patient safety, such as coordination of care between hospitals, medical record review findings, adverse event and quality of care grievance tracking/trending, electronic medical records implementation, pharmaceutical management practices and member interactions. Annually, WellCare will define the specific areas of patient safety to be monitored, which may include, but not limited to the following metrics as indicators of safe clinical care:

- Number of quality of care complaints per 1,000 members;

## PATIENT SAFETY PROGRAM

### Section 9

---

- Number of adverse events reported per quarter;
- Percent of physician medical records compliant to standard: drug allergies or "NKA" recorded;
- Percent of hospitals utilizing electronic medical records and automated order entry systems; and
- Number of Therapeutic Duplications and potential Drug to Drug interactions prescribed per thousand members.

Following the objectives as outlined in the Plan, WellCare will utilize newsletters, provider relations representatives and tailored education to periodically communicate the key activities of patient safety initiative, including network patient safety performance data and survey results.

### Quality of Care Issues

Defined as quality of care issues and adverse outcomes, quality of care referrals may be generated by the Administrative Review, Grievance, Risk Management, Case Management and/or Utilization Management department or may be identified through routine record review. Issue types include items such as unplanned readmission for a same or similar diagnosis in less than 30 days, patient fall, serious complication of anesthesia, transfusion error, medication error, serious disability, post-op complications, lack of care which could have resulted in a potentially serious complication, etc.

Record review identifying possible quality of care issues will be referred for peer review. In the event the peer reviewer/panel feels there is a possible quality of care issue, the physician will be asked, in writing, to provide additional information to address the issue. The response is reviewed and a final determination is rendered.

Peer review is categorized in the following manner:

1. Substantiated – there is evidence of a deviation in the standard of care.

## PATIENT SAFETY PROGRAM

### Section 9

---

2. Unsubstantiated – there is no evidence of a deviation from the standard of care.

Once that determination is made, the outcome is classified as either “adverse event” or “no adverse event.” Results of peer review activity will be reported to state and regulatory agencies as appropriate.

### **Hospital Program Overview**

WellCare is dedicated to improving safety and reducing medical errors for patients within hospitals. Participating hospitals are required to have a Patient Safety Program to address high risk areas or complaints regarding clinical care.

### **Patient Safety Requirements**

Each participating hospital must implement a Program with the following requirements:

- A system of classifying complaints according to severity;
- Uniform reporting standards and examples of adverse events;
- A process to communicate staff expectations for prioritization high risk events;
- Mechanisms for coordination of care across disciplines and the organization;
- A review by the medical director, physician advisor, chief of staff or department chairperson and a mechanism for determining which incidents will be forwarded to peer review and credentialing committees;
- Peer review protected infrastructure to promote reporting and sharing of information on patient safety and medical errors;

## PATIENT SAFETY PROGRAM

### Section 9

---

- Hospital education to promote adoption of patient safety practices into their clinical practice guidelines and standards;
- Safety alerts and quick communication of strategies to prevent errors that show a connection to high risk events;
- Avenues for patients to participate in their care decision and make suggestions on improving patient safety;
- The sharing of evidence-based best practices for reducing medical records, improving patient safety and enhancing quality of care;
- Conducting Failure Mode and Effects Analysis (FMEA) for all sentinel events; and
- Participating agreements, which require the implementation of internal programs for corrective actions and continuous improvement.

The participating hospital shall:

- Develop and implement an ongoing, proactive program for defining, identifying and managing risks to patient safety and medical errors throughout the organization with defined executive responsibility for the program;
- Measure the effectiveness of process and system improvements;
- Establish data reporting systems for the collection of data on defined processes that affect patient safety; and
- Implement pertinent best practice for reducing medical errors and enhancing positive care outcomes.

## PATIENT SAFETY PROGRAM

### Section 9

---

#### **Program Compliance**

All network hospitals accredited by The Joint Commission are expected to comply with the most current National Patient Safety Goals.

WellCare will periodically assess the status of hospital's efforts to improve patient safety through data measures, survey results and hospital's actions to further communicate performance improvement findings to WellCare members and providers. WellCare will also seek out and publicize any best practices identified in the promotion of patient safety in the hospital setting.

If a hospital has not been accredited by The Joint Commission or has not implemented a Program, WellCare will require the hospital to submit a plan of action regarding compliance with CMS's standards. . If the plan of action is approved, WellCare will permit the hospital to become compliant with policy within a prescribed time period provided the plan of action is implemented.

In addition, on an annual basis, WellCare will define specific measures to be monitored as indicators of safe clinical care. These will be communicated through the provider newsletters.