

Quality Administrative Guidelines

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Quality Improvement Program

Tufts Health Plan's Corporate Quality Improvement (QI) Program is designed to facilitate member access to high-quality and culturally competent medical and behavioral health care, access to primary and specialty care, continuity and coordination of care across various health care settings. Tufts Health Plan measures and tracks key aspects of care and services, uses data-driven monitoring to identify improvement opportunities, implement interventions, and analyzes data to determine overall intervention effectiveness in improving clinical care.

These are the primary components of the program:

- Ongoing monitoring and evaluation
- Continuous QI
- Customer satisfaction
- Practitioner/provider credentialing
- Utilization management

The goals of the program are to:

- Continuously improve the quality and safety of clinical care and service, including physical and behavioral health (including substance use disorder) care, and service, including community-based services and long-term services and supports (LTSS) that members receive from contracting health care providers
- Assure adequate access and availability to clinical care and services
- Increase member satisfaction
- Improve the quality of service that providers and members receive from Tufts Health Plan
- Increase provider satisfaction
- Improve the health and wellness of identified segments of the member community while responsibly managing health care costs

Tufts Health Plan evaluates success in achieving annual goals each year and document the results in the Quality Management and Improvement and Utilization Management Program Evaluations.

Providers cooperate with QI activities in order to:

- Improve the quality of care, services and the member's experience, including the collection and evaluation of data and participation in QI programs
- Allow the organization to collect and use performance measurement data
- Assist the organization in improving clinical and service measures

Regarding cooperation with the QI Program, in accordance with their contract with Tufts Health Plan, providers must comply with inquiries from Tufts Health Plan QI Program staff, including requests for medical records/ documentation to support the investigation of member grievances and/or quality occurrences.

The Board of Directors has overall responsibility for the QI program. A Care Management Committee (CMC) is responsible for overseeing the implementation of the QI program, including the annual QI Work Plan, and for determining that funding is adequate to support program activities and goals. An annual summary of the QI work plan may be found [here](#).

- Specific positions, committees, and organizational units play a significant role in QI activities, including:
 - Quality Management Committee (QMC)
 - Quality of Care Committee (QOCC)
 - Quality Performance Improvement Team (QPIT)
 - QI work groups
 - QI project teams

Plan providers offer input into the program by participating in CMC, QOCC, and the Medical Specialty Policy Advisory Committee (Medical/Behavioral Health).

National Committee for Quality Assurance (NCQA)

As an NCQA-accredited health plan, Tufts Health Plan adheres to NCQA standards and guidelines to measure, analyze and improve the health care services provided for members.

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS measures are industry-standard indicators of the quality-of-care health plan members receive. Tufts Health Plan evaluates HEDIS data monthly and annually to monitor trends and identify opportunities to improve care for members. Interim and annual rates are also evaluated against national and regional HEDIS benchmarks to assess the performance of provider networks.

HEDIS data is incorporated into provider performance reports, which are tools intended to drive quality improvement. Tufts Health Plan shares performance reports on several key HEDIS measures with provider practices. Providers may contact Provider Services at 888-884-2404 Monday–Friday, 8 a.m.–5 p.m. for more information.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

CAHPS is a standardized survey that measures member experience with services provided by their health plan and its provider network. This survey addresses members' experience with care received by their providers, as well as access to and coordination of services. CAHPS survey responses are used annually to help develop action plans, performance goals, and improve strategies to ensure Tufts Health Plan is offering the highest quality of care and services to members.

Provider Site Visit Requirements

Provider site visits may be conducted for any of the following reasons:

- When more than one member complaint/grievance is received about a practitioner's office regarding the physical accessibility, physical appearance, adequacy of waiting and examining room space or adequacy of medical/treatment record keeping within six months
- Member satisfaction results indicate an office site may not meet Tufts Health Plan standards
- Tufts Health Plan employee reports, and/or other concerning data and information is received from a member or provider indicating a site may not meet Tufts Health Plan standards
- Other information is required for QI purposes and cannot be reasonably collected using alternative methods
- Other circumstances as deemed necessary

Tufts Health Plan personnel or a designated representative with appropriate training will perform the site visit within thirty days of Tufts Health Plan's determination that a site visit is warranted.

Site visits resulting in deficiencies requiring a corrective action will require the practitioner to submit a corrective action plan within 30 days to the Quality Management Department. All sites receiving a failing score (defined by a score of less than 85%) will be subject to a follow-up site visit within six months of the visit.

If the site still does not receive a passing score or demonstrate adequate improvements in the deficient areas from the previous visit the results will be documented. The site will continue to be visited every six months until the deficiencies are remedied, or the site receives a passing score, or it is determined that further action is required by Tufts Health Plan.

For additional information, refer to the sample credentialing site visit checklist:

Practitioner name: _____ Address: _____ Telephone: _____ THP ID: _____ Date and time of site visit: _____	Provider unit: _____ Other practitioners at same site (attach additional sheet if necessary): _____ Office contact: _____
<p>Physical accessibility</p> Handicapped accessible with signage Y <input type="checkbox"/> N <input type="checkbox"/> Ramp from parking into building Y <input type="checkbox"/> N <input type="checkbox"/> Elevator if office is on the second floor or above Y <input type="checkbox"/> N <input type="checkbox"/> Doorknobs are pull-down Y <input type="checkbox"/> N <input type="checkbox"/> Doorways are at least 3.5 feet wide Y <input type="checkbox"/> N <input type="checkbox"/> At least one bathroom has adequate space for a wheelchair or assistant Y <input type="checkbox"/> N <input type="checkbox"/> Entrance is safely accessible (e.g., free of snow and ice) Y <input type="checkbox"/> N <input type="checkbox"/> Stairs have handrails Y <input type="checkbox"/> N <input type="checkbox"/> At least one examining room has adequate space for a wheelchair Y <input type="checkbox"/> N <input type="checkbox"/>	<p>Physical appearance</p> Visual cleanliness Y <input type="checkbox"/> N <input type="checkbox"/> Adequate lighting Y <input type="checkbox"/> N <input type="checkbox"/> Free of odor Y <input type="checkbox"/> N <input type="checkbox"/> Refuse disposal available Y <input type="checkbox"/> N <input type="checkbox"/> Office hours posted Y <input type="checkbox"/> N <input type="checkbox"/> Exit signs readily visible Y <input type="checkbox"/> N <input type="checkbox"/> Record/file area secure/confidential and locked when unattended; legible file markers; records easily located Y <input type="checkbox"/> N <input type="checkbox"/> Policies/procedures for patient confidentiality available Y <input type="checkbox"/> N <input type="checkbox"/> Adequate seating Y <input type="checkbox"/> N <input type="checkbox"/> Smoke detectors present Y <input type="checkbox"/> N <input type="checkbox"/> If lab on site, current CLIA certificate is displayed Y <input type="checkbox"/> N <input type="checkbox"/>
<p>Adequacy of medical/treatment record keeping</p> Health information and data: staff has immediate access to key information, such as patients' diagnoses, allergies, test results, treatments and medications Y <input type="checkbox"/> N <input type="checkbox"/> File area locked when unattended Y <input type="checkbox"/> N <input type="checkbox"/> Office utilizes a reminder system(s) to prompt and alert the staff to ensure regular screenings and preventative practices Y <input type="checkbox"/> N <input type="checkbox"/> Office has a scheduling system(s) for booking appointments and record keeping is orderly Y <input type="checkbox"/> N <input type="checkbox"/> Legible file markers Y <input type="checkbox"/> N <input type="checkbox"/> Legible documentation Y <input type="checkbox"/> N <input type="checkbox"/>	<p>Adequacy of appointments</p> Routine office visit within 1 week of request with an available clinician Y <input type="checkbox"/> N <input type="checkbox"/> Urgent care within 24 hours with an available clinician 24-hour coverage Y <input type="checkbox"/> N <input type="checkbox"/>
<p>Adequacy of waiting and examining room space</p> Sharps disposal Y <input type="checkbox"/> N <input type="checkbox"/> Biohazard waste disposal Y <input type="checkbox"/> N <input type="checkbox"/> Provisions for universal precautions (wearing gloves, masks, hand washing) Y <input type="checkbox"/> N <input type="checkbox"/> Medications and prescription pads locked or restricted access. Y <input type="checkbox"/> N <input type="checkbox"/> If samples are available, staff should be able to show a log tracking dispensation, demonstrate how samples are labeled for patients, and be able to describe how stock is monitored for expiration dates. Y <input type="checkbox"/> N <input type="checkbox"/> Use of clean linen and/or paper on exam tables Y <input type="checkbox"/> N <input type="checkbox"/> Accessible equipment Y <input type="checkbox"/> N <input type="checkbox"/>	<p>Score of ____ = ____ % (Score of 85% or greater is passing)</p>

Medical Records

Tufts Health Plan requires medical records be maintained in a manner that is current, detailed, organized and that permits effective and confidential patient care and quality review.

The medical record, whether electronic or on paper, must contain the patient's past medical treatment, past and current health status, and treatment plans for future health care. Well-documented medical records facilitate communication, coordination, and continuity of care and promote the efficiency and effectiveness of treatment.

Tufts Health Plan considers all medical records to be confidential and requires that all providers:

- Maintain medical records in a space staffed by office personnel
- Maintain medical records in a locked office when staff is not present
- Not permit unauthorized review or removal of medical records without a patient's authorization
- Provide office staff periodic training in confidentiality of member information

In addition, as a CMS contractor, Tufts Health Plan participates in QI activities as directed by the contracting agency. This often involves medical record reviews. Tufts Health Plan requires that providers provide access to medical records when requested as part of these QI activities. Confidentiality is maintained during and after the review of these medical records.

Preventive Health and Clinical Practice Guidelines

Tufts Health Plan uses evidence-based guidelines that are adopted from national sources or developed in collaboration with specialty organizations and/or regional collaborative groups. There are two types of guidelines:

- Preventive health guidelines, involving screening for disease
- Clinical practice guidelines, outlining a recommended treatment path or use of ancillary services

These guidelines are not intended to replace the practitioner's clinical judgment. Rather, they are standards designed to assist practitioners in making decisions about appropriate health care for specific clinical circumstances. When no such evidence-based guidelines are available from recognized sources, Tufts Health Plan will involve representative practitioners from appropriate specialties in the development or adoption of clinical practice guidelines.

Guidelines are reviewed at least every two years and revised as needed. Literature reviews occur quarterly to ensure that all Tufts Health Plan internally developed guidelines are current. When new guidelines are published, they are reviewed internally by Tufts Health Plan physicians and then posted for contracting Tufts Health Plan providers to review before adoption.

Tufts Health Plan's clinical practice and preventive health guidelines are designed to support preventive health, behavioral health, acute disease treatment protocols, and/or chronic disease management programs. Both medical and behavioral health clinical practice guidelines are available [online](#).

HEDIS/Quality Improvement Programs: Heart failure and diabetes providers

Heart Failure: PCPs receive a list of their panel members identified as having HF along with pharmacy compliance data regarding ACE/ARB RX refills.

Diabetes: The diabetes program provides education and tools to improve the health of members with diabetes. The goal is to improve member's self-management of diabetes and to prevent diabetes-related complications and hospitalizations. Identified members receive an educational mailing that may include a diabetes care card for tracking preventive screening tests or other self-management tools.

PCPs receive annual preventive screening information for their panel of members in need of recommended screenings which include dilated eye exam, A1C screening and monitoring for nephropathy.

Serious Reportable Events

Never Events: Serious reportable events (SREs), serious reportable adverse events (SRAEs), and provider preventable conditions (PPCs).

Definitions

The National Quality Forum (NQF) defines “never events” as “errors in medical care that are of concern to both the public and health care professionals and providers, clearly identifiable and measurable, and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the health care organization”. Tufts Health Plan considers the following types of events as never events:

- **SREs and SRAEs:** Unambiguous, serious, preventable adverse incidents involving death or serious harm to a patient resulting from a lapse or error in a healthcare facility. SREs are developed and endorsed by the NQF. SRAEs are defined by CMS.
- **PPCs:** Conditions that meet the definition of a “health care-acquired condition (HCAC)” or a “provider-preventable condition (PPC)” as defined by CMS in federal regulations at [42 CFR 447.26\(b\)](#).

Nonpayment for SREs, SRAEs and PPCs

Tufts Health Plan's longstanding policy and regulatory obligation has been to deny or retract payment for services related to care which meet the definition of SREs, SRAEs or PPCs once they have been identified. Tufts Health Plan will not compensate providers or permit providers to bill members for services related to the occurrence of SREs, SRAEs and/or PPCs.

Providers are required to notify Tufts Health Plan of SREs, SRAEs and PPCs that occur when providing services to Tufts Health Plan members. Noncompliance with reporting of SREs, SRAEs, and PPCs may result in additional medical record review, Quality of Care Committee review, and payment retraction.

Reporting for SREs, SRAEs, and PPCs

To report SREs, SRAEs or PPCs to Tufts Health Plan, providers should fax their report to Tufts Health Plan's QM Department at 617-673-0973. The QM Department works directly with the provider involved to review the event, identify opportunities for quality improvement, and determine how the nonpayment issue will be resolved. The QM Department may request additional clinical documentation after reviewing the reported SRE, SRAE, or PPC.

Refer to the [Serious Reportable Events, Serious Reportable Adverse Events and Provider Preventable Conditions Payment Policy](#) for more information.

Reference Sources

- Refer to the [National Quality Forum](#) for information on reporting SREs and SRAEs
- [CMS](#): Hospital-Acquired Conditions

PUBLICATION HISTORY

04/03/25	Administrative edits
05/01/26	Updated Serious Reportable Events section with scenarios that may require submission of additional clinical documentation and medical record review