Quality Administrative Guidelines

Quality Improvement Program

Tufts Health Plan's Corporate Quality Improvement (QI) Program addresses the quality of care in all settings in which care is delivered to members. This program has five primary components:

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

The goals of the program are to:

- Continuously improve the quality of clinical care and service that members receive from participating health care providers who are contracting with Tufts Health Plan
- Increase member satisfaction
- Improve the quality of service that providers receive from Tufts Health Plan
- Increase provider satisfaction
- Improve the health of identified segments of the member community

A 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 QM activities, including:

- Quality Management Committee (QMC)
- Quality of Care Committee (QOCC)
- Quality Performance Improvement Team (QPIT)
- QI work groups
- QI project teams (providers offer input into the QM program by participating in committees such as QOCC and MSPAC)
- SCO Quality Improvement Committee

Credentialing Site Visit Requirements

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

- When more than one complaint/grievance is received about a provider's office regarding physical accessibility, physical appearance or the adequacy of waiting and examining room space within six months

- Member satisfaction results indicate an office site may not meet Tufts Health Plan standards
- employee reports, other concerning data and information is received from a member or provider indicating a site may not meet Tufts Health Plan standards
- Other data is required for quality improvement purposes and cannot be reasonably collected using alternative methods
- Other circumstances, as deemed necessary

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

Of the 33 components, at least 28 must be present to obtain a passing score (85%). Select components may be considered not applicable for some types of offices.

Site visits resulting in deficiencies requiring corrective action will require the practitioner to submit a corrective action plan within 30 days to the Quality Management (QM) Department. All sites receiving a failing score 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 does not demonstrate adequate improvements in the deficient areas from the previous visit, the results will be documented and the site will continue to be visited every six months until the deficiencies are remedied, or the site receives a passing score, or if it is determined that further action is required by Tufts Health Plan.

Tufts Health Plan participating providers must comply with Tufts Health Plan medical policies, the Quality Administrative program, and medical management programs that are developed in consultation with participating providers.

Practice guidelines and utilization management guidelines:

- Are based on reasonable medical evidence or a consensus of health care professionals in a particular field
- Consider the needs of the enrolled population
- Are developed in consultation with contracting health professionals
- Are reviewed and updated periodically
- The guidelines are communicated to providers and, as appropriate, to members.
- Decisions with respect to utilization management, member education, coverage of services, and other areas in which the guidelines apply are consistent with the guidelines.

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

Provider name: _____
Address: _____
Telephone: _____
THP ID: _____
Date and time of site visit: _____

Provider unit: _____
Other providers at same site
(attach additional sheet if necessary: _____
_____
Office contact: _____

Physical accessibility

Handicapped accessible with signage	Y ☐ N ☐
Ramp from parking into building	Y ☐ N ☐
Elevator (if office is not on 1st floor)	Y ☐ N ☐
Doorknobs are pull-down	Y ☐ N ☐
Doorways are at least 3.5 feet wide	Y ☐ N ☐
At least one bathroom has adequate space for a wheelchair or assistant	Y ☐ N ☐
Entrance is safely accessible (e.g., free of snow and ice)	Y ☐ N ☐
Stairs have handrails	Y ☐ N ☐
At least one examining room has adequate space for a wheelchair	Y ☐ N ☐

Physical appearance

Visual cleanliness	Y ☐ N ☐
Adequate lighting	Y ☐ N ☐
Free of odor	Y ☐ N ☐
Refuse disposal available	Y ☐ N ☐
Office hours posted	Y ☐ N ☐
Exit signs readily visible	Y ☐ N ☐
Policies/procedures for patient confidentiality available	Y ☐ N ☐
Adequate seating	Y ☐ N ☐
Smoke detectors present	Y ☐ N ☐

Adequacy of medical/treatment record keeping

Staff has immediate access to key health information/data (e.g., diagnoses, allergies, test results, treatments, medications)	Y ☐ N ☐
Office has a scheduling system(s) for booking appointments and record keeping is orderly	Y ☐ N ☐
Office utilizes a reminder system(s) to prompt and alert the staff to ensure regular screenings and preventative practices	Y ☐ N ☐
File area locked when unattended	Y ☐ N ☐
Legible file markers	
Legible documentation	Y ☐ N ☐

Adequacy of appointments

Routine office visit within 1 week of request with an available clinician	Y ☐ N ☐
Urgent care within 24 hours with an available clinician	Y ☐ N ☐
24-hour coverage	Y ☐ N ☐

Adequacy of waiting and examining room space

Sharps disposal	Y ☐ N ☐
Biohazard waste disposal	Y ☐ N ☐
Provisions for universal precautions (wearing gloves, masks, hand washing)	Y ☐ N ☐
Medications and prescription pads locked/ restricted access	Y ☐ N ☐
Use of clean linen and/or paper on exam tables	Y ☐ N ☐
Accessible equipment	Y ☐ N ☐

Score **of 33 =** **%**
(Score of 85% or greater is passing)

Medical Record Maintenance Procedures and Review

Tufts Health Plan requires medical records to be maintained in a manner that is current, detailed, complete, accurate, and organized, and permits effective and confidential patient care and quality review. As a Medicare Advantage Organization, Tufts Health Plan agrees to do the following:

- Maintain records for at least 10 years from the end of the final contract period or completion of audit, whichever is later, unless there is a special need to retain longer
- Provide medical record access to federal entities, such as the Department of Health and Human Services (HHS) and the Comptroller General, which is head of the Government Accountability Office (GAO), or their designees
- The medical record, whether electronic or paper, communicates the member's past medical treatment, past and current health status, and treatment plans for future health care. Well-documented medical records facilitate communication and the coordination and continuity of care while promoting efficiency and effectiveness of treatment.

Tufts Health Plan considers all records to be confidential and requires that all Tufts Health Plan providers do the following:

- Maintain medical records in a space staffed by office personnel
- Maintain medical records in a locked office when staff is not present
- Permit review or removal of medical records only with Member's authorization
- Release medical and behavioral health records, other member health information and other member information regarding Tufts Health Plan members, only in accordance with state and federal laws regarding confidentiality and disclosure

In addition, Tufts Health Plan participates in QM activities as directed by the contracting agency. These activities often involve medical record reviews. Tufts Health Plan requires that providers provide access to medical records when requested as part of QM activities and maintain confidentiality during medical record review.

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.

Transplants

Medicare-covered transplants do not require prior authorization from Tufts Health Plan or from the PCP/medical group. Members may be referred for evaluation of appropriateness for transplant by either the PCP, or by a specialist to whom the PCP initially referred the member.

Note: The PCP must supply a referral for the transplant center specialist for proper claims adjudication.

Once a member is deemed to be appropriate for a transplant, the inpatient notification process must be performed according to the Tufts Health Plan's timeframe guidelines, as outlined in the Referrals, Prior Authorizations, and Notifications chapter of this Manual.

All solid organ heart, lung, heart-lung, liver, intestinal, kidney, and pancreas transplants must be performed at a Medicare-approved facility. Tufts Health Plan will not compensate services rendered at a non-Medicare-approved facility. Refer to the Medicare-approved facilities lists for Tufts Medicare Preferred HMO and Tufts Health Plan SCO to determine which facilities are Medicare-approved.

For more information regarding transplants, refer to the Transplant Facility Payment Policy.

In addition to the preventive health and disease management programs described above, Tufts Health Plan also works on several other quality initiatives specific to preventable hospital admissions, discharge planning, appropriate nursing facility institutionalization, and identification of abuse/neglect.

Serious Reportable Events

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

The National Quality Forum (NQF) defines serious reportable events ("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 policy and regulatory obligation is to deny or retract payment for services related to care that meets the definition of SREs, SRAEs and/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 a SRE, 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.

Reporting 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 or email it to Adverse_Events_Submission@point32health.org. The QM Department works directly with the involved provider to review the event, identify opportunities for quality improvement and determine how the nonpayment issue will be resolved.

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 and to the CMS Medicare Part C Reporting Requirements for information on reporting SREs and SRAEs
- Refer to the Medicaid website and the following link for information on reporting Provider Preventable Conditions (PPCs):
  - CMS: Hospital-Acquired Conditions