# QUALITY ADMINISTRATIVE GUIDELINES



## 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.

## Medical Care Access Goals for Primary Care Offices

Access to medical care services is a key component of health care quality. Members must be able to access their providers, although in a life-threatening situation they are expected to obtain care at the nearest medical facility.

Tufts Health Plan recognizes the diversity with which providers handle member calls, arrange urgent care, and schedule routine care. Tufts Health Plan expects that members be heard and their medical needs met in a manner that is reasonable and provides quality medical care.

Tufts Health Plan has developed medical care access goals that all provider offices are expected to adopt and review with their office staff. The goals include suggestions that PCPs may adopt to provide better service to their patients. Many providers may have already included these suggestions in their telephone triage system.

Members periodically contact Tufts Health Plan with concerns about office waiting times, appointment availability, and similar issues. Tufts Health Plan uses these guidelines to determine whether member concerns are reasonable and provides feedback to the members and providers as necessary.

Since the PCP is ultimately responsible for coordinating the member's care, these guidelines are not as directly pertinent to a specialist's office. They do, however, provide a sense of what is reasonable in terms of appointment dates, waiting times, telephone callback times, etc. As such, they are a good way to measure how well an office is functioning.

All medical care access goals are evaluated at least annually by Tufts Health Plan management and revised, as necessary, based on the results of access surveys and the input of plan providers.

Providing medical care is not a completely predictable experience. Emergencies and episodic increases in the demand for services, at times, overwhelm the ability of an individual office to meet each of these goals. However, in the normal course of providing medical care, primary care offices must regularly meet these expectations.

## Office Visit Appointments

- **Emergency care:** appointments scheduled on the same day as requested with an available clinician
- **Urgent care:** appointments scheduled to occur within 24 hours of request with an available clinician
- **Nonurgent symptomatic care:** appointments for nonurgent episodic illness are scheduled to occur within 10 calendar days of request with an available clinician
- **Preventive care:** for history and physical check-ups with no acute illness, the PCP or other appropriately licensed clinician sees the member within 45 days of the request

## Office Waiting Time

In most situations, member should not have to wait more than 30 minutes past their appointment time to be seen. If a longer wait is anticipated, staff members must explain the reason for the delay and offer to book the member for another appointment, if desired. Office staff should return any copayment if the appointment is rescheduled.

## Overflow Patients

If an office has more urgent cases than it can handle, the staff must arrange for urgent care at another site. Routine use of an emergency department in such overflow situations is not acceptable.

## Telephone Callbacks during Office Hours

Members are expected to exercise good judgment about urgent needs for service when contacting their provider outside normal office hours.

An answering service or machine answers telephones after hours. For urgent problems, an answering service offers to contact the provider or a covering provider. An answering machine provides a number through which a provider can be contacted for urgent problems. Providers normally return urgent calls within one hour.

If a provider uses a nurse triage service for telephone screening after hours, the provider must instruct the nursing staff to identify himself or herself as a nurse who is covering for a provider. The nurse must also communicate to the member that if it is a life-threatening situation, the member must hang up and either call 911 or go to the nearest emergency department, as appropriate. At the completion of the call, the nurse must verify that the member is comfortable with the nurse's advice and tell the member of his or her right to speak to the covering provider. All practitioners or providers used for covering purposes must be licensed as required by law.

**Note:** Routine use of an emergency department to supply after-hours care is not an acceptable coverage arrangement.

## 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.

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: _____

| **Physical accessibility** | | **Physical appearance** | |
|---|---|---|---|
| Handicapped accessible with signage | Y ☐ N ☐ | Visual cleanliness | Y ☐ N ☐ |
| Ramp from parking into building | Y ☐ N ☐ | Adequate lighting | Y ☐ N ☐ |
| Elevator if office is on the second floor or above | Y ☐ N ☐ | Free of odor | Y ☐ N ☐ |
| Doorknobs are pull-down | Y ☐ N ☐ | Refuse disposal available | Y ☐ N ☐ |
| Doorways are at least 3.5 feet wide | Y ☐ N ☐ | Office hours posted | Y ☐ N ☐ |
| At least one bathroom has adequate space for a wheelchair or assistant | Y ☐ N ☐ | Exit signs readily visible | |
| Entrance is safely accessible (e.g., free of snow and ice) | Y ☐ N ☐ | Record/file area secure/confidential and locked when unattended; legible file markers; records easily located | Y ☐ N ☐ |
| Stairs have handrails | Y ☐ N ☐ | Policies/procedures for patient confidentiality available | Y ☐ N ☐ |
| At least one examining room has adequate space for a wheelchair | Y ☐ N ☐ | Adequate seating | Y ☐ N ☐ |
| | | Smoke detectors present | Y ☐ N ☐ |
| | | If lab on site, current CLIA certificate is displayed | Y ☐ N ☐ |
| **Adequacy of medical/treatment record keeping** | | **Adequacy of appointments** | |
| Health information and data: staff has immediate access to key information, such as patients' diagnoses, allergies, test results, treatments and medications | Y ☐ N ☐ | Routine office visit within 1 week of request with an available clinician | Y ☐ N ☐ |
| File area locked when unattended | Y ☐ N ☐ | Urgent care within 24 hours with an available clinician | Y ☐ N ☐ |
| Office utilizes a reminder system(s) to prompt and alert the staff to ensure regular screenings and preventative practices | Y ☐ N ☐ | 24-hour coverage | Y ☐ N ☐ |
| Office has a scheduling system(s) for booking appointments and record keeping is orderly | Y ☐ N ☐ | | |
| Legible file markers | Y ☐ N ☐ | | |
| Legible documentation | Y ☐ N ☐ | | |
| **Adequacy of waiting and examining room space** | | **Score of _____ = %** (Score of 85% or greater is passing) | |
| 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 or restricted access. | Y ☐ N ☐ | | |
| 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 ☐ N ☐ | | |
| Use of clean linen and/or paper on exam tables | Y ☐ N ☐ | | |
| Accessible equipment | Y ☐ N ☐ | | |

## 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.

## Behavioral Health/Substance Use Disorder Treatment Access Standards

All contracted inpatient and outpatient behavioral health and substance use disorder (BH/SUD) providers are expected to meet the standards described below.

### Temporal Access

Tufts Health Plan covers emergency BH/SUD care at any licensed facility when medically necessary. Emergency care is available at any Tufts Health Plan contracted facility with emergency services.

- Tufts Health Plan designated facilities (DFs) must have BH/SUD emergency and triage services available 24 hours a day.
- A member with life-threatening and non-life-threatening needs must be seen immediately in the emergency room
- Urgent care must be available within 24 hours of a member's request. Any Tufts Health Plan BH/SUD provider may provide this care.
- Nonurgent care must be available within 10 calendar days of a member's request. Any Tufts Health Plan BH/SUD provider can provide this care.

### Geographic Access

Outpatient BH/SUD care is available within 30 miles of the member's home or workplace. For certain areas of subspecialty care, a greater distance may be required.

## 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.

### 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.

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