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

Medical Care Access Goals for Primary Care

Access to medical care is a key component of health care quality. Members must have access to their providers, although in life-threatening situations members 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 will be heard, and their medical needs met in a manner that is reasonable and provides quality medical care.

Emergencies and episodic increases in the demand for services at times may overwhelm the ability of an individual office to meet the expectations for medical care access. However, in the normal course of providing medical care, provider offices should regularly meet these expectations. 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 for PCPs to provide better service to their patients. Many providers may have already included these suggestions in their telephone triage system.

Members may periodically contact Tufts Health Plan regarding 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.

All medical care access goals are evaluated at least annually by Tufts Health Plan and revised, as necessary, based on the results of access surveys and provider input. Provider office hours for Tufts Health Plan SCO members should be in parity with office hours for Commercial and Medicaid fee-for-service members.

Office Visit Appointments

Appointments must be scheduled as follows:

Appointment	Tufts Medicare Preferred HMO	Tufts Health Plan SCO
Emergency care	Appointments are scheduled on the same day with an available clinician	
Urgent care	Appointments are scheduled within 24 hours with an available clinician; if the office has more urgent cases than it can handle, the staff arranges for urgent care at another site	Appointment must be available within 48 hours.
Nonurgent symptomatic care	Appointments are scheduled within 48 hours with an available clinician for nonurgent episodic illness	Appointment must be available within 48 hours.
Preventive care/non-symptomatic care	For history and physical checkups with no acute illness, the practitioner or other appropriately licensed clinician sees the member within 30 calendar days from the date of the request. **Note:** Members are covered for one routine physical exam per year.	

Telephone Callbacks

During Office Hours

The office determines if the member's call is urgent and the following procedures are followed:

- Urgent calls will be returned within one hour
- Nonurgent calls will be returned on the same day

After Office Hours

Members are expected to exercise appropriate judgment about urgent needs for service when contacting their providers 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, as necessary. 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 triage service for telephone screening after hours, the provider must instruct the nursing staff to identify themselves as a nurse who is covering for a provider. The nurse must also communicate to the member that during a life-threatening situation, the member must hang up and either call 911 or go to the

nearest emergency department (ED), 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 their right to speak to the covering provider. All providers used for covering purposes must be licensed as required by law.

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

Office Waiting Time

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

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:_____ Provider unit:_____

Address: _____ Other providers at same site (attach additional sheet if necessary):_____

Telephone: _____

THP ID:_____

Date and time of site visit:_____ 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 not on 1st floor)	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 ☐	Policies/procedures for patient confidentiality available	Y ☐ N ☐
Stairs have handrails	Y ☐ N ☐	Adequate seating	Y ☐ N ☐
At least one examining room has adequate space for a wheelchair	Y ☐ N ☐	Smoke detectors present	Y ☐ N ☐
Adequacy of medical/treatment record keeping		**Adequacy of appointments**	
Staff has immediate access to key health information/data (e.g., diagnoses, allergies, test results, treatments, medications)	Y ☐ N ☐	Routine office visit within 1 week of request with an available clinician	Y ☐ N ☐
Office has a scheduling system(s) for booking appointments and record keeping is orderly	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 ☐
File area locked when unattended	Y ☐ N ☐		
Legible file markers			
Legible documentation	Y ☐ N ☐		
Adequacy of waiting and examining room space			
Sharps disposal	Y ☐ N ☐	**Score of 33 = %**	
Biohazard waste disposal	Y ☐ N ☐	(Score of 85% or greater is passing)	
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 ☐		

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.

Outpatient Behavioral Health/Substance Use Disorder Treatment Access Standards

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

Temporal Access

Emergency care will be made available to all Tufts Health Plan members at any Tufts Health Plan contracting facility with emergency services available. Emergency care must be available 24 hours a day, 7 days a week at each Tufts Health Plan BH/SUD facility.

A member with life-threatening needs must be seen immediately. A member with nonlife-threatening needs must be seen within six hours. Each facility is a licensed hospital with a full-time specific BH/SUD emergency and triage team. Tufts Health Plan also covers emergency BH/SUD care at any licensed facility when medically necessary.

Urgent care must be available within 48 hours of a member's request and may be provided by any Tufts Health Plan behavioral health provider. Nonurgent care must be available within 10 business days of a member's request.

Geographical Access

Most 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.

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. 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