Provider Manual

- Quality Assurance and Improvement
Providing quality care is our top priority. This section of the Manual was created to help guide you and your staff in working with Kaiser Permanente’s quality assurance and improvement (QI) policies and procedures. It provides a quick and easy resource with contact phone numbers, and detailed processes and site lists for QI Services.

If at any time you have a question or concern about the information in this section, you can reach our Quality, Risk and Patient Safety Department by calling 303-344-7293.
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Section 8: Quality Assurance and Improvement (QI)

All Colorado Permanente Medical group (CPMG) and non-CPMG (network/contracted) practitioners and providers are expected to participate in Kaiser Permanente’s Service, Quality, Safety and Resource Management Program.

The goal of the Service, Quality, Safety and Resource Management Program is to support and enact the vision and value proposition of the Kaiser Permanente Colorado Region: creating highly satisfied customers with superior health care value. Our Integrated Patient Care Quality Program meets this goal by promoting the continuous assessment and improvement of the quality of care, service, patient safety and cost delivered to the members and the quality of the business practices that support healthcare delivery.

Kaiser Permanente’s Service, Quality, Safety and Resource Management Program provide an ongoing systematic assessment of the care and service received by its members. This process is outlined in the Region’s Integrated Patient Care Program Description and is available upon request. If you would like a copy of the program description, please contact your Provider Representative at 1-866-866-3951.

The Service, Quality, Safety and Resource Management Program is broad in scope and includes activities of structure, process and outcomes and encompasses service, quality, cost effectiveness and patient safety. In addition to the quality and peer review processes, regional committees and clinical programs such as chronic disease management, risk management, resource management, service quality, infection control, member services, prevention, credentialing, and bioethics play a vital role in the program’s service, quality and resource management structure.

8.1 Quality Assurance and Improvement Program Overview

Wendee Gozansky, MD, Vice President, Chief Quality Officer, Colorado Permanente Medical Group, is the Colorado Permanente Medical Group (CPMG) physician with responsibility for Kaiser Permanente’s quality management and improvement activities within the Colorado Region. Dr. Gozansky is one of three co-chairs of the Regional Service, Quality and Resource Management Committee (Regional SQRMC). Dr. Gozansky partners with Justin Chang, MD, Vice President of Quality and Innovation. They are accountable to the Executive Medical Director of CPMG and the President of the Colorado Region, respectively. The President of the Colorado Region and the Executive Medical Director of CPMG are accountable to the National Quality Committee (NQC) and the Quality and Health Improvement Committee (QHIC), a sub-committee of the Kaiser Foundation Health Plan/Hospitals Boards of Directors.

The President of the Colorado Region and the CPMG Executive Medical Director have
established the Regional SQRMC, a standing committee, to oversee the quality activities of the Region. The Regional SQRMC oversees service, quality, safety and resource management activities related to the Denver/Boulder, the Southern Colorado and the Northern Colorado service areas. All committees include in their membership those with authority to see that all areas of the organization are conducting service, quality and resource management activities and taking necessary actions to address all identified areas of concern. This structure of committees and all related activities is commonly referred to as Kaiser Permanente’s Service, Quality, Safety and Resource Management Program.

All quality and resource management committees are structured to include 51 percent physician membership wherever possible to secure protection from discoverability and confidentiality of all information.

The purpose of the Service, Quality, Safety and Resource Management Program is the assurance of high quality and appropriate health care for all Health Plan members across all settings of care, including our affiliates, i.e., contract practitioners, hospitals, nursing homes, home health agencies, etc. Activities that support the Region’s Service, Quality, Safety and Resource Management Program include, but are not limited to, review of:

- clinical issues relevant to our population (regional clinical initiatives)
- safety
- morbidity and mortality
- complications
- adverse events
- medication errors
- service/satisfaction
- cost effectiveness (includes both over/under utilization)
- credentialing/re-credentialing (both practitioners and providers)
- health services contracting (which may result in documentation of a structured review of medical offices and medical record keeping practices)
- practitioner and provider availability
- accessibility (includes appointments and key elements of telephone service)
- systems to improve the health status of our members with chronic conditions (case and disease management)
- clinical practice guidelines
- continuity and coordination of care
- medical documentation systems
- complaints about care and service
- appeals
- preventive health programs
- business practices
Additionally, our program includes a process to coordinate, support and track retrospective review of occurrences throughout the region. If you have a thought, concern, or experience which suggests there may be a quality management issue, please contact the following to arrange a review:

- Dr. Jacqueline Jamison at 303-360-1095 and/or the
- Quality Review Coordinators at 303-344-7875 or 303-344-7325

To protect your confidentiality, you will not be identified as the person originating the issue and because of confidentiality reasons; we are not allowed to share the results of the review with you. If you witness a high quality encounter, please let the Quality, Risk, and Patient Safety department know this as well. It will also be investigated and appropriately publicized. Results of these activities will be included, as appropriate, in the credentialing and re-credentialing/re-negotiations process.

8.2 Contact information

<table>
<thead>
<tr>
<th>Colorado Quality Leaders</th>
<th>Name/Title</th>
<th>Office Address</th>
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</tr>
</tbody>
</table>
If you have questions about the structure of our quality management activities or wish to provide comments about our program, please feel free to contact any of the above leaders. We value your input. If you wish to discuss or report clinical problems, please call any of the above individuals.

Other issues should be reported to your Provider Representative at 1-866-866-3951. The staff is available to address issues with affiliated (contract) providers and practitioners.

To receive a copy of the Regional Integrated Patient Care Quality Program Description or additional information on our progress towards meeting our goals, please contact the Quality Department at 303-344-7293.

8.3 Compliance with Regulatory and Accrediting Body Standards

Kaiser Permanente participates in the National Committee for Quality Assurance (NCQA), Centers for Medicare and Medicaid Services, and National Quality Committee (NQC) for the review of activities in order to demonstrate Kaiser Permanente’s compliance to regulatory and accrediting bodies. In addition, KePRO, the designated Quality Improvement Organization (QIO) for Colorado, occasionally conducts quality reviews on Kaiser Permanente Medicare Advantage members*. The State Department of Health Care Policy and Financing conducts reviews on our Medicaid members*. If you receive direct correspondence from either of these agencies, please notify our Regional Quality department so that we can help coordinate and expedite the review for you.

In accordance with these regulations, you are expected to provide to Kaiser Permanente, on an annual basis, measures of clinical quality, appointment access, member (patient) satisfaction survey results, as well as Healthcare Effectiveness Data and Information Set (HEDIS) data collection if applicable via access to your patient’s medical records for HEDIS medical record reviews. Also in accordance with regulations, physicians are required to cooperate with QI activities. The organization may use Practitioner performance data for quality improvement activities.

Kaiser Permanente expects all of its Participating Providers to have and maintain appropriate accreditation/certification, to be in compliance with all regulatory bodies (i.e. CMS), and to maintain a current certificate of Liability insurance. If you receive any recommendations from these organizations, please provide to Kaiser Permanente along with the surveys’ recommendations and the action plan to resolve the identified issue or concern. You may contact our Quality Department at 303-344-7293.
Kaiser Permanente monitors the status of the above listed accreditations, on an annual basis through Kaiser Permanente’s Regional Compliance Department at 303-344-7672.

### 8.4 Sentinel Events

Occurrences involving a Kaiser Permanente member, staff or physician, etc. and defined as a Sentinel Event, that result in death or serious physical or psychological injury (loss of limb or function) or meet the criteria as defined by the National and Regional Sentinel Event Policy, requires IMMEDIATE notification to Kaiser Permanente in accordance with Kaiser Permanente’s policy. A full copy of the policy and the process for reporting sentinel events is available by contacting Kaiser Permanente’s Regional Risk Management Incident line at 303-344-7298.

All Sentinel Event reports are considered confidential and privileged quality/peer review documents.

### 8.5 Do Not Bill Events (DNBE)

It is Kaiser Permanente’s policy to waive the fees for all or part of the health care services directly related to the occurrence of certain events, referred to as “Do Not Bill” (DNBEs). The Health Plan’s “Do Not Bill Event” policy is based on payment rules that waive fees for all or part of health care services directly related to the occurrence of certain adverse events as defined by the CMS National Coverage Determinations for surgical errors and the published listing of CMS Hospital Acquired Conditions. The “Do Not Bill Event” policy applies to all claims for all KP Members and Patients.

Surgical “Do Not Bill Events” include but may not be limited to an event in any care setting related to:
- Wrong surgical or invasive procedure(s) performed on a patient;
- Surgical or other invasive procedure(s) performed on the wrong part of the body;
- Surgical or other invasive procedure(s) performed on the wrong patient; and
- Unintended retention of a foreign object after surgery or procedure, except when the risk of removal exceeds the risk of retention (upon retention of a foreign object, the procedure giving rise to the retention is not a DNBE. However, if medically indicated, the removal of the object may be a DNBE.

Hospital-Acquired Conditions include a condition or event that occurs in a general hospital or acute care setting include but may not be limited to:
• Intravascular air embolism that occurs while being cared for in a health care facility;
• Hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products;
• Stage 3 or 4 pressure ulcers acquired after admission to a health care facility;
• Falls and Trauma (fractures, dislocations, intracranial injuries, crushing injuries, burns, electric shock);
• Manifestations of poor glycemic control: diabetic ketoacidosis, nonketotic hyperosmolar coma, hyperglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity;
• Surgical site infections following certain elective procedures; including certain orthopedic surgeries (Spine, neck, shoulder, elbow) and bariatric surgery for obesity (Laparoscopic Gastric Bypass, Gastrorenteroectomy, Laparoscopic Gastric Restrictive Surgery);
• Deep vein thrombosis; or pulmonary embolism following total knee replacement and hip replacement procedures;
• Vascular-catheter associated infection;
• Catheter associated urinary tract infection; and
• Mediastinitis after coronary artery bypass grafting
• Any other HACs added by CMS at a later date will be evaluated for inclusion in the policy.

8.5.1 Notification of Adverse Event to Kaiser Permanente

Providers should notify the Health Plan when an adverse event, “Do Not Bill Event” or unexpected condition adversely impacting a Member is discovered by contacting the Kaiser Permanente Risk Management Incident line at 303-344-7298. This number is not intended for member use. Kaiser Permanente members should be directed to contact the Member Services Call Center at 303-338-3800 or 1-800-632-9700.

8.5.2 Claims Submission and Adjustments Related to a “Do Not Bill Event”

A participating Hospital/Facility must include “Present on Admission” indicators on all Member claims. Providers should ensure that their billing staff is aware when a “Do Not Bill Event” involving a Member’s care has occurred prior to submitting the claim to Kaiser Permanente for processing.

When a “Do Not Bill Event” is recognized prior to claim submission, the UB-04 or CMS-1500 form should include:
• The applicable International Classification of Diseases (ICD) codes
• All applicable standard modifiers (including CMS National Coverage Determination ("NCD") modifiers for surgical errors)
• Additionally, the UB-04 or CMS 1500 form should reflect all service provided including those related to a “Do Not Bill Event” with an adjustment in fee to reflect the waiver of fees directly related to the event(s).
• Any Member Cost Share related to a “Do Not Bill Event” should be waived or reimbursed to the Member. An impacted Member may not be balanced billed for any services related to a “Do Not Bill Event”.

8.6 Quality Reports

In order for Kaiser Permanente and the participating provider to be in compliance with accrediting and regulatory bodies, various reports must be generated to track any quality issues. Prior to report generation, investigations into the quality of care in specific individual cases, called Special Issue (SI) review, can be generated by a variety of sources including, but not limited to, the following:

➢ Allegations of professional negligence (formal or informal)
➢ Member complaints/grievances related to quality of care
➢ Risk Management referral (Significant Events, Potentially Compensable Events or Do Not Bill Events)
➢ Physician concern (Colleague, Specialty consultant, Primary care, Affiliated provider, External (non-plan)
➢ Staff concern
  • Infection Control
  • Other Quality Monitoring
  • Infection Control
  • Infection Control
  • Ambulatory Surgery Occurrence Review
  • Patient Safety Review
  • Other occurrence review (e.g. contract hospital)
➢ Regulatory Concern
➢ Hospital concerns

8.7 Practitioner/Provider Credentialing

In order to ensure the quality of practitioners/providers who treat Kaiser Permanente Members, Kaiser Permanente Colorado (KPCO)/Colorado Permanente Medical Group
(CPMG) credentials or provides oversight of the credentialing function for all participating practitioners/providers and ensures that credentialing is conducted in a non-discriminatory manner. All participating practitioners/providers must be fully credentialed and “approved to participate” before treating Kaiser Permanente Members.

**Practitioners**

The credentialing process is a formal system designed to query, verify, investigate, track and report all information regarding the competency of any preferred practitioner. Preferred practitioners are those health care practitioners who have contracts with KPCO/CPMG to provide health care services to Kaiser Foundation Health Plan members. The credentialing system is designed to ensure that all preferred practitioners and all licensed independent practitioners or other professional health care practitioners under contract with KPCO/CPMG are qualified, appropriately educated, trained and competent practitioners and are able to deliver health care according to KPCO/CPMG’s prevailing standards of care and all appropriate applicable state and federal regulatory agency guidelines to ensure high quality of care and patient safety. The credentialing process follows applicable accreditation agency guidelines, such as those set forth by the National Committee for Quality Assurance (NCQA).

**Providers**

Preferred providers are those institutions (hospitals, skilled nursing facilities, home health agencies, freestanding ambulatory surgery centers and behavioral healthcare centers, etc.) that have contracts with CPMG and/or KFHP to provide services to members. Kaiser Permanente Colorado (KPCO) region (Denver/Boulder, Southern Colorado, and Northern Colorado service areas) evaluates its preferred providers by the same high standards of care and service and expects the same level of care and service that its own medical offices and network of CPMG practitioners provide.

KPCO maintains policies and procedures for the initial and ongoing assessment of these providers. This process includes at a minimum, confirmation that the provider is in good standing with both state and federal regulatory bodies. The federal sanctioned and debarred/opt out list is checked routinely and prior to credentialing or re-credentialing any provider or practitioner. This is to ensure that a provider or practitioner that has opted out, been debarred, or sanctioned by a government health program, e.g. Medicare, does not provide clinical services to members or patients. The process also includes confirmation every three (3) years that the provider has been reviewed and approved by an accrediting body. In situations where the provider has not been reviewed and approved by an accrediting body, Kaiser Permanente (KP) conducts a site visit in order to credential or re-credential the institution. KPCO staff and clinicians with expertise in the type of organization being assessed conduct the site visit.
Evaluation is accomplished through the use of systematic methodology to measure current levels of care and service, identify opportunities for improvement and establish accountability for implementation of needed changes. Components of care and service may include (but are not limited to):

- Leadership
- Facility/office structure and safety
- Quality improvement systems and processes
- Resource stewardship/utilization management, systems, and processes
- Risk Management
- Patient Safety
- Infection Control policies/procedures
- Credentials management
- Medical record keeping practices
- Effectiveness and continuity of care
- Availability
- Customer satisfaction, including member complaints
- Committee participation
- Data and data systems, regulatory compliance as appropriate

When all documentation, verifications, and site visit results are obtained, the designated KFHP and CPMG management leaders determine if the organization meets KPCO standards for participation as an organizational provider.

The evaluation is completed prior to contracting with the preferred provider, at the time of re-credentialing, and as needed retrospectively or concurrently as part of our continuous quality assessment program.

### 8.7.1 Credentialing and Re-credentialing Processes

Initial credentialing and recredentialing are part of the preferred practitioner/provider contract process. Recredentialing of a preferred practitioner occurs at least every 36 months. Kaiser Permanente Colorado/Colorado Permanente Medical Group requires all preferred practitioners to be board certified in the specialty listed as primary specialty. At least every 36 months, each practitioner completes, signs, and dates a recredentialing application including an attestation of its correctness and completeness. The recredentialing process includes the collection and/or reverification of the credentialing information originally verified, as applicable. The information is again verified from primary sources. Kaiser Permanente Colorado/Colorado Permanente Medical Group Credentials Committee oversees all credentialing and/or recredentialing activities and ensures that credentialing is conducted in a non-discriminatory manner.
Any physician or professional health care practitioner who joins an existing contracted medical service group will be credentialed and recredentialed according to the credentialing policies set forth by KPCO/CPMG before they render services to Kaiser Foundation Health Plan members. All credentialing policies and procedures are available upon request by calling the Credentialing Department at 303-344-7543.

8.7.2 Practitioner Notification of Status of Credentialing Application

A practitioner also has the right, upon request, to be informed of the status of his/her application. Please contact the Credentialing Department at 303-344-7543 should you need to receive a status update on your application.

8.7.3 Practitioner Right to Review and Correct Erroneous Information

The preferred practitioner must produce information for an adequate evaluation of the practitioner’s qualifications and suitability, and must resolve any reasonable doubts about clinical or character matters by satisfying requests for further information. Such information is considered confidential. The preferred practitioner's failure to sustain this burden within 30 calendar days of the date of notification may be grounds for discontinuing contract negotiations or termination of contract privileges. Credentialing information containing misrepresentations or omissions may be grounds for discontinuing contract negotiations or termination of contract privileges. Where permitted by law, the practitioner may review and authorized persons may have access to the application with the exception of references or other information determined to be inaccessible to the practitioner. Also, where appropriate, the practitioner may correct erroneous information.

8.7.4 Practitioners on Corrective Action Plan Status

The federal sanctioned and debarred/opt out list is checked routinely and prior to credentialing or re-credentialing any practitioner/provider. This is to ensure that a practitioner/provider that has opted out, been debarred, or sanctioned by a government health program, e.g. Medicare, does not provide clinical services to members or patients. Additionally, at the time of re-credentialing, member complaints and special issues pertaining to the practitioner/provider are reviewed. Any sanctions, debarred, quality of care or complaints that render a quality issue may be grounds for corrective action or termination.

8.7.5 Confidentiality of Credentialing Information
Credentialing files are maintained in a locked file room, as provided under state law protecting such records from discovery. Personnel in the following departments will treat the content of all credentialing files with strict confidentiality: Credentialing Department/CPMG Human Resources Department, CPMG Administration, Quality, Risk and Patient Safety, Legal Counsel, Quality Managers, Network Development and Provider Contracting Department, CPMG Contracting Department, Supervisors, and the Credentials Committee.

The electronic credentialing database is password protected, and passwords are only issued to personnel on a need to know basis.

8.8 Peer Review

Kaiser Permanente maintains a peer review process to promote and monitor credentialing, quality patient care, member satisfaction, member complaints and administrative compliance with policies, procedures, rule and practices for all Participating Practitioners.

Kaiser Permanente has established thresholds for performance measures which include but are not limited to the following key areas:

1. Member Satisfaction Measures
2. Quality Measures
3. Member Complaints and Grievances
4. Referral Measures
5. Utilization Measures
6. HEDIS/NCQA

Peer Review Investigations known as Special Issues (SI), are reviewed by the Colorado Permanente Medical Group (CPMG) Physician Director of Quality. They may be sent for additional peer review to a CPMG primary care or specialty care peer review committee. If an opportunity for improvement is identified, the practitioner is notified and a SI is developed, implemented and tracked. The entire SI process and its conclusions are confidential, but trended information may be used in credentialing and annual performance review.

Physicians who have a contract with CPMG and disagree with an adverse peer review finding based on quality review or service may request a second review or peer review and hearing and can appeal the decision through this review process. Kaiser Permanente is committed to fairness in the implementation of these processes in the event that an adverse action is imposed.

An Executive Leadership Team of the CPMG, including involvement of Area Medical
Directors as appropriate, may conduct professional reviews of any credentialed practitioner pursuant to Colorado law. There is a review process to assess whether the practitioner in question is lacking in qualifications, has any Medicare or Medicaid sanctions or limitations on licensure, has complaints or provided substandard or inappropriate patient care identified through adverse events, or has exhibited inappropriate professional conduct. Restrictions of the practitioner’s privileges, up to temporary suspension and including termination of such contract are possible consequences. Any terminations with cause related to quality of care issues will be reported to the Colorado Medical Board and the National Practitioners Data Bank, as required by Federal and State laws. Any reportable adverse action for quality may be appealed as described in Section 8.8.

Subject to disclosure required by law, such proceedings shall be confidential. Notification of final findings is communicated to the effected practitioner, including the appeal process, based on the elements above.

In addition, the CPMG Board of Directors has defined an impaired physician as a physician whose professional performance has become unreliable by reason of substance abuse (alcohol or drugs) or mental impairment. Pursuant to Colorado law, CPMG has the following policy (5.11 in the Staff Manual) that includes four elements relating to impaired physicians:

- Reporting
- Action
- Merit
- Treatment

Failure to comply with any part of the prescribed treatment in such a program may result in the contract physician’s termination. CPMG encourages physicians to seek help if needed and to report any potential problem. For more details about these subjects, please contact our Quality, Risk and Patient Safety Department at 303-344-7293.

8.8.1 Fair Hearing Process

CPMG extends those affiliate providers that it credentials the same fair hearing rights as extended to CPMG providers in the case of an adverse action for quality of care that may be reportable to the NPDB. These fair hearing rights are described in the “CPMG Staff Manual Policy 4.04 - Professional Review” which can be accessed through the below link.

http://www.providers.kaiserpermanente.org/html/cpp_cod/downloadforms.html?

8.9 Compliance with Facility and Office Site Reviews
Kaiser Permanente may perform medical record and office site reviews for all contracted facilities. For initial credentialing and re-credentialing, Quality Review Coordinators (QRC) obtain all required documentation from the provider. Prior to initial contracting and credentialing, and at the time of recredentialing, KP department confirms that the organization is in good standing with state and federal regulatory bodies. State standing is determined by verifying the relevant and current state licensure for each organization. Federal standing is determined by a monthly check of the Ineligible Individuals and Entities Match Report which includes sanctioned providers and practitioners, debarred practitioners, and opt out practitioners and reinstatement reports maintained by the Regional Compliance Department.

When an organization has not been reviewed and approved by an accrediting body in the past three years, an on-site quality assessment is conducted. Site review criteria are established to appropriately assess the type of facility being surveyed. Kaiser Permanente staff and clinicians with expertise in the type of organization being assessed conduct the site visit. A CMS or state survey may be used in lieu of a KP site visit if it is performed within three years of the initial credentialing or re-credentialing date and meets our standards. Kaiser Permanente may elect to perform a site visit even though the organization is accredited or has a current state site survey.

**Site Review Criteria**

- **Facility Credentialing**
  - Accrediting entity
  - State of Colorado licensure
  - State of Colorado survey
  - Medicare #
  - CLIA certificate

- **General Appearance**
  - Office signs
  - Adequate &/Disabled parking
  - Adequate building disabled building access
  - Waiting room condition
  - HIPPA compliance
  - Adequate patient privacy
  - Office, exam rooms, corridors, exits are free from obstacles
  - Patient care areas have appropriate equipment for patient assessment
  - At least two, well-marked exits with illuminated signs

- **Quality/Risk Management**
  - Written quality program – last revision and review, includes annual goals and objectives
• Policy on handling complaints
• Monitoring results of patient satisfaction, mortality trending, vaccination status, etc.
• Governing body
• Mission statement
➢ Policies and Procedures
• Reviewed and updated
• P&P – Credentialing of physicians and staff
• P&P – Written job responsibilities
• P&P – Employee Safety
• P&P – Equipment Maintenance
• P&P - Fire Safety
• P&P – No smoking
• P&P – Hazardous materials
• P&P – Inclement weather
• P&P – Infection Control
• P&P – Patient Rights and Responsibilities
• P&P – Medical record keeping, documentation and retention
➢ Safety Practices
• Hazardous materials
• Gas cylinders secured
• PPE available and used
• Fire Safety
• No smoking or restricted area with signage
• Emergency procedures
• First Aid kit, Crash-Code cart checks regularly
➢ Continuity of Care
• Facility has made arrangements with nearby hospitals for emergencies?
• Facility has a procedure for immediate notification to KPAACC for all potential transfers to an ED or hospital?
• Facility has a procedure for immediate notification to PCP upon urgent/emergent findings
• Facility has a procedure for arranging follow-up care, patient/family education materials
➢ Medical Record Keeping Practices
• Documentation practices of physician conclusion of procedures
• Confidentiality and Release of Information
• Contracted provider’s documentation in EMR or KPHC
➢ Employee Staffing
• Credentialing/licensure check completed
• Orientation to facility
• Mandatory annual education
• Staffing levels appropriate for facility and patient acuity
• BLS or ACLS

➢ Physician credentialing
  • Credentialing/licensure check completed
  • Certification for procedures as appropriate
  • BLS or ACLS

Additionally, Kaiser Permanente monitors environmental complaints on a monthly basis and determines the affiliated practitioners requiring office site assessments based on an established complaint threshold. All affiliated practitioners within the Kaiser Permanente network who are within the scope of credentialing are monitored:

• Practitioners, who are licensed, certified or registered by the state to practice independently.
• Practitioners the organization employs, contracts, or directs members to in order to receive care.

The site visits are directed and arranged through the Quality, Risk and Patient Safety department for the Denver/Boulder, Northern Colorado and Southern Colorado service areas in collaboration with representatives of the NDPC &/or CPMG contracting department who participate in credentialing and contracting activities.

The reviewing staff employs an environmental survey tool that enables a structured analysis of the following aspects of the office site:

• Physical accessibility,
• Physical appearance, and
• Adequacy of waiting and examining room spaces.

Example Survey Tool

➢ Examination room
  • exam rooms have appropriate equipment for patient assessment
  • at least two rooms per physician with adequate lighting, space and patient privacy
  • patient rest rooms with disabled access
  • needle disposal receptacles in exam rooms
  • sterile procedures done in rooms that have sterile equipment and supplies
  • in-office procedure that require IV sedation follow sedation guidelines and policies

➢ Ancillary services
  • Laboratory – type of service (in-house, CLIA, outside service), certification of staff, CLIA certificate available
  • Pharmacy – drug expiration dates monitored, procedures for acquisition,
storage, dispensing and administration of drugs, records of receipt and disposition of all controlled drugs, and controlled substances are secured, log maintained on all samples given to patients

- Maintenance/Equipment Facility – routine maintenance completed, fire extinguishers in place
- Materials/Supplies – supply storage is clean and neat, and meets State Life Safety codes
- Housekeeping and Laundry – routine cleaning schedule, laundry services is used

➢ Infection Control
- infection control monitoring processed
- there is a procedure for cleaning between patients
- waste cans are lidded and marked as infectious waste if applicable
- sterilization techniques include cold sterilization or autoclave as appropriate
- Appropriate separate sterile/clean/dirty areas

➢ Patient Care and Procedure Assessment
- adequate patient privacy
- patient identification system
- informed consent obtained for all invasive procedures
- emergency procedures in place
- prescription pads are kept locked or in possession of the practitioner
- physician access during office hours for emergencies
- office hours are posted
- access to on-call physician 24 hours/day

8.9.1 Frequency of Facility and Office Site Review

At least every three years the Regional QRC obtains current documentation from each organizational provider, confirms good standing with state and federal regulatory bodies, and coordinates a site visit, if needed. A checklist is maintained at the beginning of each provider file to indicate the status of all documentation.

If a site visit is required to re-credential an organization, this site visit should be scheduled at least three (3) months in advance of the re-credentialing date to allow time for any necessary corrective action.

The quality of practitioner office sites is measured by environmental patient safety complaint criteria. Practitioner offices which exceed the threshold of three complaints in any one category will trigger a review of the individual environmental complaint and a subsequent site visit. The required site visit will address physical accessibility, physical appearance, and adequacy of waiting and exam room spaces and be
performed within 60 calendar days of the complaint threshold being met.

### 8.9.2 Non-Compliance with Site Review Standards

If the practitioner office site or provider scores less than 85 percent on their site review, a corrective action plan may be requested (with response within 30 days), a re-audit is done in 60 days for compliance or the re-audit is performed every six (6) months until the practitioner office site or provider achieves or exceeds this goal.

### 8.10 Compliance with Medical Record Requirements

Medical record documentation is developed and maintained for the primary purpose of fostering continuity of patient care and is a means of communication among health care practitioners treating the patient now and in the future.

Storage of medical records should be well organized and secure with only authorized personnel having access. Policies and procedures to protect the electronic health record (EHR) and the paper records’ integrity and security need to be documented and in practice to ensure compliance with applicable laws, regulations and standards. In addition, annual training of staff concerning the confidentiality and handling of patient information is expected.

Annually, KPCO Health Information Services Department reviews CPMG and Contracted provider’s medical record documentation for content and completeness to comply with regulatory requirements. Consistent and complete documentation in the medical record is an essential part of providing quality patient care. Electronic and/or paper records are part of the review. Monitoring is performed in conjunction with periodic chart review.

The quality review provides a systematic approach to monitoring, developing targets and striving for improvement in the area of documentation and consists of the following items:

**Administrative Documentation**

1. Process in place for error detection and correction
2. Record is organized
3. Pages contain ID number and/or name
4. All entries are dated
5. Record is legible
6. Signature and credential are present
7. Current medications are noted
8. Chief complaint or reason for visit is documented
9. Studies reviewed by ordering provider
10. Operative report present for invasive procedures
11. Advance directive discussed and/or present for patients age 75 and older (primary care providers)
12. Biographical/personal data is present
13. Smoking history is present (14 years and older)
14. Alcohol history is present (14 years and older)
15. Drug history is present (14 years and older)
16. Documentation is timely

Clinical Documentation

1. Allergies/adverse reactions are prominently displayed
2. Clinical documentation is available from urgent care visits
3. Clinical information is available from emergency care visits
4. Clinical information is available from telephone advice calls visits
5. Clinical information is available from online advice
6. Abnormal studies show a clear follow-up plan
7. Consultations reflect a PCP review (primary care)
8. Consultations have a clear follow-up plan
9. Injections and medications administered are noted
10. Significant illnesses/medical conditions are present
11. Preventive screening is offered according to KP Practice guidelines
12. Problem list is present
13. Date of return visit of follow-up plan is present
14. Problems from previous visits are addressed
15. Co-signatures are present
16. Subjective/objective exam is pertinent to patient complaint
17. Lab and other studies are ordered as appropriate
18. Diagnosis are consistent with findings
19. Plan of action/treatment are consistent with diagnoses
20. There is evidence of the appropriate use of consultants
21. Medical care seems appropriate

8.10.1 Frequency of Medical Records Review

The medical record documentation review is performed annually.

Record selection methodology.
CPMG, Midlevel and Colorado Affiliate providers providing care to greater than or equal to 1,000 visits or for at least 50 members (HRN's) with a visit ratio $\geq 3$ in a calendar year are eligible for review.

All qualified providers are combined to determine the sample size for random review. The number of records reviewed for each provider is determined based upon the universe.

The rate of performance for acceptable charts is greater than or equal to 80 percent on a global measure of all visits at all sites of care within the region, including affiliate providers and the core medical group; PCPs and high volume specialists; paper charts, stand-alone EHRs and the integrated EHR. If global performance falls below threshold then subgroup analysis including the above categories will be performed, and within any subgroups that identify opportunities for improvement the analysis will continue down to the individual practitioner level, if necessary, to raise overall performance of chart quality in the organization.

### 8.10.2 Non-Compliance with Medical Records Standards

**Threshold of performance.**

The KPCO performance standard for record compliance is an overall 80 percent using the HIS outpatient record review tool.

**Reporting.**

In the event performance of a specific physician or department falls below the goal, the responsible operations leader will be notified; for example, the department chief for a core primary care physician, the network medical director for an affiliate physician or group, etc. Opportunities for quality improvement will be made available, such as a follow-up medical record review.

### 8.11 Accessibility Standards

Kaiser Permanente assesses Primary Care and selected Specialty Care physician appointment availability annually to ensure timely access to our practitioners. In summary, appointment availability is assessed for the following:

<table>
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<tr>
<th>Access Requirements</th>
<th>Standards</th>
<th>2013 Goals</th>
<th>Methods of Measurement</th>
<th>Dates of Measurement</th>
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</thead>
<tbody>
<tr>
<td>Primary Care</td>
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<tr>
<td>Access Requirements</td>
<td>Standards</td>
<td>2013 Goals</td>
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<td>Dates of Measurement</td>
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<tr>
<td>Regular and routine care appointments</td>
<td>Regional: Primary care regular/preventive care within 7-10 business days</td>
<td>Integrated Group model: 95 percent of practitioners 3rd available primary care (3rd available measured as the number of days from the day the member calls to the third open appointment slot) regular/preventive appointments are within 7-10 business days.</td>
<td>Integrated Group Model: Computerized Appointment System – The third available appointment metric uses data from practitioner schedules to determine how many appointment slots are still available.</td>
<td>Integrated Group Model: Collected and analyzed weekly.</td>
</tr>
<tr>
<td></td>
<td>Affiliated Network Model: 80% of regular/routine care appointments are within 7-10 business days</td>
<td>Affiliated Network Model: 95 percent patient satisfaction with appointment access</td>
<td>Affiliated Network Model: Survey incorporating self-reported data from the practitioners</td>
<td>Affiliated Network Model: Monitored annually</td>
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<tr>
<td></td>
<td>Integrated Group Model: 95 percent patient satisfaction with appointment access</td>
<td>Affiliated Network Model: N/A</td>
<td>Affiliated Network Model: Surveys conducted daily; reported quarterly</td>
<td>Affiliated Network Model: Monitor at least annually</td>
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<tr>
<td></td>
<td>Affiliated Network Model: N/A</td>
<td></td>
<td>Affiliated Network Model: Analysis of complaints in Access category</td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td>Regional: Within 24 hours</td>
<td>Integrated Group Model: 100 percent</td>
<td>Integrated Group Model: Computerized Appointment System - The third available appointment metric uses data from practitioner schedules to determine how many appointment slots are still available.</td>
<td>Integrated Group Model: Monitor at least annually</td>
</tr>
<tr>
<td></td>
<td>Affiliated Network Model: 90 percent</td>
<td>Affiliated Network Model: 90 percent</td>
<td>Affiliated Network Model: Analysis of Complaints</td>
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<tr>
<td></td>
<td>Affiliated Network Model: Analysis of Complaints</td>
<td></td>
<td>Survey incorporating self-reported data from the practitioners</td>
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<td></td>
<td>Affiliated Network Model: Analysis of Complaints</td>
<td></td>
<td>Affiliated Network Model: Monitor at least annually</td>
<td></td>
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<tr>
<td>Access Requirements</td>
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<tr>
<td>After-hours care</td>
<td>Integrated Group Model:</td>
<td>Integrated Group Model: Maintain an average speed of answer for incoming calls to less than 60 seconds, an abandon rate of less than 5% and a call back time of less than 2 hours.</td>
<td>Integrated Group Model: Avaya Call Management System – service level, average speed of answer, abandonment rate.</td>
<td>Integrated Group Model: Continuously Monitored – Intra-day, daily, weekly and monthly performance reports</td>
</tr>
<tr>
<td></td>
<td>Availability of the Telephonic Medicine Center from 6 p.m. – 7 a.m. M-F, weekends and holidays</td>
<td>Affiliated Network Model: 100% available immediately</td>
<td>Nicelog recording system – monitor quality of processes and outcomes.</td>
<td>Affiliated Network Model: Monitored continuously through member complaints.</td>
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<tr>
<td></td>
<td>Affiliated Network Model:</td>
<td></td>
<td>Affiliated Network Model: Analysis of Complaints Survey incorporating self-reported data from the practitioners</td>
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<td></td>
<td>Availability of practitioners 24 hours, seven days a week via telephone access</td>
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</table>

**Member Services Telephone Lines**

<table>
<thead>
<tr>
<th>Member services department</th>
<th>Regional: Percent of calls answered within 30 seconds Abandonment Rate</th>
<th>Regional: 80 percent of calls answered within 30 seconds &lt; 3 percent abandonment rate</th>
<th>Regional: Avaya Centervu Call Management System – measures call volume, service level, average speed of answer, abandonment rate</th>
<th>Regional: Monitored Continuously</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Regional: 80 percent of calls answered within 30 seconds &lt; 3 percent abandonment rate</td>
<td>Avaya Centervu Call Management System – measures call volume, service level, average speed of answer, abandonment rate</td>
<td>Monitored Continuously</td>
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</tbody>
</table>

**Behavioral Health**

<table>
<thead>
<tr>
<th>Life threatening and Non-life threatening emergencies</th>
<th>NCQA: Within 6 hours</th>
<th>Denver/Boulder Service Area Immediately</th>
<th>Denver/Boulder Service Area Study that measures the difference between the time the member calls and the time the member has access to a behavioral health clinician. Sample of 4-week timeframe.</th>
<th>Denver/Boulder Service Area Annually during the fall</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Denver/Boulder Service Area Immediately</td>
<td>Southern Colorado Service Area: Delegated arrangement with Value Options (VO), an NCQA accredited MBHO</td>
<td>Southern Colorado Service Area: Delegated arrangement with VO, an NCQA accredited MBHO</td>
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<tr>
<td>Access Requirements</td>
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<tr>
<td>Urgent care</td>
<td>NCQA: Within 48 hours</td>
<td>Denver/Boulder Service Area:</td>
<td>Denver/Boulder Service Area: Computerized Appointment System – measure from date of appointment made to date of appointment</td>
<td>Denver/Boulder Service Area:</td>
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<td></td>
<td></td>
<td>100%</td>
<td></td>
<td>Monitored Monthly</td>
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<td></td>
<td>Southern Colorado Service Area:</td>
<td>Delegated arrangement with VO, an NCQA accredited MBHO</td>
<td>Southern Colorado Service Area: Delegated arrangement with VO, an NCQA accredited MBHO</td>
<td>Southern Colorado Service Area:</td>
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<td>Delegated arrangement with VO, an NCQA accredited MBHO</td>
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<tr>
<td>Routine office visit</td>
<td>NCQA: Within 10 business days</td>
<td>Denver/Boulder Service Area:</td>
<td>Denver/Boulder Service Area: Computerized Appt System – measured as the average number days from date of appt request to the date of appointment</td>
<td>Denver/Boulder Service Area:</td>
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<td></td>
<td>Average number of days for a routine initial appointment w/ therapist or psychiatrist is 14 calendar days (10 business days) or less</td>
<td>Changes in the accessibility measure are also compared with patient satisfaction with accessibility to services and complaint data.</td>
<td>Monitored Monthly</td>
</tr>
<tr>
<td></td>
<td>Southern Colorado Service Area:</td>
<td>Delegated arrangement with VO, an NCQA accredited MBHO</td>
<td>Southern Colorado Service Area: Delegated arrangement with VO, an NCQA accredited MBHO</td>
<td>Southern Colorado Service Area:</td>
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<td></td>
<td>Delegated arrangement with VO, an NCQA accredited MBHO</td>
</tr>
<tr>
<td>Telephone Service for Screening and Triage</td>
<td>NCQA: Telephones answered within 30 seconds with &lt; 5 percent abandonment rate</td>
<td>Denver/Boulder Service Area:</td>
<td>Denver/Boulder Service Area: Current does not have Centralized Screening and Triage</td>
<td>Denver/Boulder Service Area:</td>
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<td></td>
<td></td>
<td>Currently does not have Centralized Screening and Triage</td>
<td>Southern Colorado Service Area: Delegated arrangement with VO, an NCQA accredited MBHO</td>
<td>Currently does not have</td>
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<td></td>
<td>Southern Colorado Service Area:</td>
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<td>Centralized Screening and Triage</td>
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<td>Southern Colorado Service Area:</td>
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<td>Delegated arrangement with VO, an NCQA accredited MBHO</td>
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</table>
### Specialty Care: Medical and Surgical specialties

<table>
<thead>
<tr>
<th>Access Requirements</th>
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<th>Methods of Measurement</th>
<th>Dates of Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Care: Medical and Surgical specialties</td>
<td>Regional: Within 14 days</td>
<td>Regional: 80 percent of patients booked within 14 days.</td>
<td>Integrated Group Model: Computerized Appointment System – calculated using the booked date and the appointment date.</td>
<td>Integrated Group Model: Monthly</td>
</tr>
<tr>
<td>Routine office visit</td>
<td>Affiliated Network Model: 85 percent of patients booked within 14 days</td>
<td>Affiliated Network Model: Survey incorporating self-reported data from high-volume practitioners. Analysis of complaints</td>
<td>Affiliated Network Model: Annually</td>
<td></td>
</tr>
</tbody>
</table>

#### 8.1.11 Non-Compliance with Accessibility Standards

Kaiser Permanente Colorado continuously measures its performance against the established standards and goals to identify opportunities for improvement. When an opportunity for improvement has been identified, Kaiser Permanente Colorado will implement an action plan to correct any deficiency.