Provider Manual

- Quality Assurance and Improvement
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, detailed processes and site lists for QI services.

If, at any time, you have a question or concern about the information in this Manual, you can reach our Quality Resource Management Department by calling 503-813-3819.
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Section 8: Quality Assurance and Improvement (QI)

8.1 Quality Assurance and Improvement Program Overview
KPNW is co-managed by Kaiser Foundation Health Plan of the Northwest (KFHP-NW), Kaiser Foundation Hospitals (KFH), and Northwest Permanente, P.C. (NWP). These entities collaborate to provide ongoing systematic assessment of care and service.

The KFHP-NW Regional President and NWP Executive Medical Director assume ultimate responsibility and accountability for the direction, implementation, and success of the program. The Senior Director of Clinical & Service Quality and Vice President of Medical Operations & Chief Operating Officer are accountable for implementing and maintaining an ongoing Quality Program and assign appropriate accountability to operations managers within the delivery system.

The KPNW Quality Program supports practitioners and providers to provide the highest quality care by using a systematic, integrated approach to plan, design, measure, assess, and improve clinical outcomes, operational processes, and Member and Provider satisfaction. All Northwest Permanente (NWP) and non-NWP contracted/affiliate practitioners and providers are expected to participate in Kaiser Permanente’s Service, Quality, Safety, and Resource Management programs.

Quality of care and service activities cross all sites, departments, disciplines, and committees that contribute to the continuum of care throughout the delivery system and network, including: primary care, specialty care, behavioral health services, nursing services, skilled and intermediate nursing care, clinical support services, health education services, member services, medical offices, hospitals, ambulatory surgery centers, home health/hospice agencies, and contracted care.

Kaiser Permanente may take corrective actions in accordance with your Agreement and applicable laws and regulations in the event that Kaiser Permanente reasonably determines that the Provider’s performance may adversely affect the care provided to Members.

8.2 Contact information
Assistant Regional Medical Director, Quality Management & Systems, 503-813-2271
Senior Director, Medical Operations, Quality-Service, 503-813-3943
Director, Quality Resource Management, 503-813-3810

8.3 Compliance with Regulatory and Accrediting Body Standards
Kaiser Permanente participates in review activities by the National Committee for Quality Assurance (NCQA), the Center for Medicare/Medicaid Services (CMS), our internal Medical Director Quality Review (MDQR), and the states of Oregon and
Washington in order to demonstrate Kaiser Permanente’s compliance with regulatory requirements and accreditation standards.

In accordance with these standards, we require you to provide to Kaiser Permanente, on an annual basis, measures of clinical quality, access, and member satisfaction results to support the Health Plan Employer Data and Information Set (HEDIS) data collection and our Quality Assurance and Performance Improvement Programs.

NCQA has accredited Kaiser Foundation Health Plan of the Northwest’s (KFHP-NW) commercial HMO health plan since 1995. In 2007, we received “Excellent” Accreditation, for our HMO and Medicare product lines. Accreditation is subject to renewal every three years and the next review is planned for early 2010.

NCQA accreditation is a voluntary review process which evaluates how we ensure that our members receive high-quality care.

Additionally, Kaiser Sunnyside Medical Center and each of the plan hospitals KFHP-NW contracts with must be accredited by The Joint Commission (TJC).

Kaiser Permanente expects all of its Providers to be in compliance with all regulatory requirements and to maintain insurance as required by the Agreement. If you receive any recommendations from regulatory entities or accrediting organizations, please provide Kaiser Permanente with the surveys’ recommendations along with the action plan to resolve the identified issues.

KPNW maintains files of available quality data on provider performance, which is considered at the time of initial contract evaluation, and is reassessed annually. Affiliation agreements assure integration of quality information (care, service, and complaints), utilization, risk management, and credentialing. Affiliated Care Quality Program responsibilities are documented in each written contract or memoranda of understanding (MOU). NWP physicians and KFHP-NW managers collaborate with affiliated community providers to continually improve the quality of care and service to KP members. When a concern about performance is identified, KPNW proposes solutions and works with the affiliated provider to ensure performance remains within contract specifications.

8.3.1 Quality Oversight for Hospitals
Kaiser Permanente’s Quality Resource Management Department (QRM) reviews the Participating Provider’s JOINT COMMISSION Core Measures, Member Satisfaction results, and publicly reported measures such as those reported to TJC (Quality Check) NCQA, the Leapfrog Group, the Oregon Hospital Quality Indicators collaborative, or CMS (Hospital Compare). Annually QRM requests submission of the Hospital Bylaws, the Hospital Quality Plan, and the Quality Program Description for review.
8.3.2 Clinical Quality Goals
KPNW has programs in place that are designed to promote high quality care and service. The Annual Quality Program Evaluation contains key results and summaries of our performance on a variety of quality initiatives and measures included in the Health Plan Employer Data and Information Set (HEDIS). High priority clinical targets are identified annually to focus on improving the health of our members, and include prevention, disease management, pediatric care, and women’s health measures among others.

8.3.3 Service Quality Goals
Striving to continually improve service for our members is an ongoing goal for KPNW. To evaluate our members’ satisfaction with access and service, and their care experiences, we conduct or participate in various member satisfaction surveys including the Consumer Assessment of Health Plans Study (CAHPS). The survey results are used to identify our strengths and opportunities, and to strategically set our performance goals. KPNW’s goals are to provide helpful and courteous staff; to improve members’ satisfaction with access to care including primary and specialty care; phone access for information, advice, or appointments; and the ability to get care quickly.

For more information about the KPNW Quality Program or to request the Annual Quality Program Description, Evaluation and/or Workplan, please call Quality Resource Management at (503) 813-3810.

8.3.4 Publicly Reported KPNW Performance

On-line clinical performance information is increasingly available to Kaiser Permanente members and patients, practitioners, and providers. Health plans and hospitals in communities nationwide join a growing list of health care organizations that publicly report performance information as a result of law or regulation, employer or consumer projects, voluntary efforts, or commercial enterprise. Found on a wide variety of websites, performance information includes comparative data on clinical performance, patient satisfaction, and other measures.

The following websites publicly report Kaiser Permanente performance information:

- The Joint Commission’s (TJC) Quality Check® - a comprehensive guide to the more than 15,000 Joint Commission-accredited health care organizations and programs throughout the United States that includes information such as hospital quality measures, core measure data, and compliance with Patient Safety Goals. www.qualitycheck.org

- Center for Medicare & Medicaid Services (CMS) Hospital Compare - provides national hospital performance comparisons on quality information, patient
satisfaction survey information, and pricing information.
www.hospitalcompare.hhs.gov.

- CMS Medicare Options Compare – provides comparison information on health plans based on price, benefit structure, and member satisfaction. www.medicare.gov.

- The Leapfrog Group - a voluntary initiative aimed at mobilizing employer purchasing power to alert America’s health industry that big leaps in health care safety, quality and customer value will be recognized and rewarded. www.leapfroggroup.org.

- National Committee for Quality Assurance (NCQA) Health Plan Report Card – designed to help consumers answer questions about health plans that would be difficult or impossible to answer on their own. For instance, does this health plan provide good customer service? Will I have access to the care I need? Does the plan check doctors' qualifications? http://hprc.ncqa.org.


- Measuring Care & Service Quality for the Northwest – The Kaiser Permanente website provides quality performance such as HEDIS® quality of care and use of services data with the ability to drill down to the medical office level, as well as CAHPS® member satisfaction data and the status of accreditations. www.kp.org.

### 8.4 Sentinel Events

A Sentinel Event is an unexpected occurrence involving a Kaiser Permanente member that results in death or serious physical or psychological injury, or the risk thereof, or which otherwise affects the quality of care and service, operations, assets, or reputation of Kaiser Permanente. The phrase “or the risk thereof” includes any process variation for which an occurrence (as in “close call” or “near miss”) or recurrence would carry a significant chance of a serious adverse outcome. Such events are called “sentinel” because they signal the need for immediate investigation and include one of the following (even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient’s illness or underlying condition):

- a. Suicide of any individual receiving care, treatment or services in a staffed around-the-clock care setting or within 72 hours of discharge.
- b. Unanticipated death of a full-term infant in the hospital.
- c. Abduction of any individual receiving care, treatment or services.
d. Discharge of infant to wrong family.

e. Rape.

f. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.

g. Surgery on the wrong patient or wrong body part (including invasive procedures, and implants).

h. Unintended retention of a foreign object in an individual after surgery or other procedure.

i. Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter).

j. Prolonged fluoroscopy with cumulative dose >1500 rads to a single field, or any delivery of radiotherapy to the wrong body region of >25 percent above planned radiotherapy dose.

A credible and thorough analysis to establish the root cause(s) of a sentinel event, including the root causes and action plans, shall be completed within 45 days of the event or the date that the event was discovered. Sentinel events (including Kaiser Permanente Health Plan members receiving care in a contracted facility or by a contracted practitioner) will require root cause analysis, as defined by The Joint Commission. KPNW will review and/or participate in the root cause analysis done by a contracted facility through existing quality systems.

You are required to provide IMMEDIATE notification to Kaiser Permanente in accordance with Kaiser Permanente’s Sentinel Event Policy. For immediate notification of a sentinel event call the KPNW Quality Pager at 503-904-8475. The pager is staffed 24 hours a day/7 days per week.

All Sentinel Event reports are considered confidential and privileged quality/peer review documents. A full copy of the policy is available through Kaiser Permanente’s Quality Resource Management Department. To request a copy call 503-813-3810.

8.5 Patient Safety

Patient safety is an ongoing and relentless commitment to build safer systems that prevent accidental injury to our patients and is an integral part of the Kaiser Permanente Quality Program. Patient safety is every patient’s right and every leader’s, employees’, and practitioner’s responsibility.

Our members and the general public equate patient safety with quality. Consequently, all Health Plan and Medical Group employees and our contracted affiliates have a responsibility to promote and improve patient safety. A focus on patient safety should guide groups and individuals in all aspects of health care delivery and should be the cornerstone of quality improvement and risk mitigation initiatives.
As stated in the Member Rights and Responsibilities section, at Kaiser Permanente we promote a partnership between members and their health care professionals. We encourage members to ask the following three questions:

1. What is my main problem?
2. What do I need to do about it?
3. Why is it important for me to do this?

8.6 Practitioner Credentialing

In order to ensure the quality of Practitioners who treat Kaiser Permanente Members, Kaiser Permanente credentials or provides oversight of the credentialing function for all Practitioners. All Practitioners must be fully credentialed and “approved to participate” before treating Kaiser Permanente members.

8.6.1 Credentialing and Recredentialing Processes

As an important part of Kaiser Permanente’s Quality Management Program, all credentialing and recredentialing activities are structured to assure contracted practitioners and providers are qualified to meet Kaiser Permanente’s standards for the delivery of quality health care and service to its members and assure that credentialing activities are conducted in a non-discriminatory manner.

The credentialing/recredentialing policies and procedures approved by Kaiser Permanente are intended to meet, at the minimum, the standards outlined by the National Committee for Quality Assurance (NCQA).

All practitioners wishing to participate in the Kaiser Permanente affiliated network must successfully complete the initial credentialing process and demonstrate their on-going ability to meet credentialing standards through a biennial recredentialing process. Practitioners are required to provide Kaiser Permanente with the information needed to review and verify their credentials.

The Quality Resource Management (QRM) Department is responsible for collecting and verifying credentialing information, while the Credentialing Committee reviews the complete credentialing or recredentialing files to determine if the practitioner will be approved for new or continued participation in the Kaiser Permanente Network.

Each contracted practitioner must provide and/or demonstrate that the criteria listed below are met.

- **A completed Oregon Practitioner Credentialing application** which includes practitioner demographics, practice information, work history, educational background, and a personal attestation to the practitioner’s physical and mental well being and accuracy of the information provided.
**Note:** Practitioners who are being recredentialed will receive their application approximately three months prior to their scheduled recredentialing date.

- A copy of a **current valid license** to practice and acceptable medical licensure history.

- **Active clinical privileges in good standing** at a contracted hospital which is also the practitioner’s primary admitting facility. This requirement may be waived if the practice specialty does not admit patients.

- A **valid DEA or CDS certificate**, as applicable to the specialty.

- Appropriate **education and training** for the practice specialty, and board certification.

**Note:** Education is not re-verified at recredentialing. Board certification is re-verified at recredentialing to assure that a board-certified practitioner continues to be board certified. In addition, if a practitioner is newly board-certified, documentation of the certification should be provided with the recredentialing application.

- **Explanations for any gaps in work history** (initial credentialing only).

- Evidence of **current, adequate malpractice insurance** in the amount of $1,000,000 per occurrence/$3,000,000 aggregate or $2,000,000 per occurrence /$2,000,000 aggregate.

- **Acceptable history of malpractice claims** experience.

- **Compliance with medical record keeping and facility site review.** This requirement is applicable to:
  - Primary Care practitioners (defined as Internal Medicine, Family Practice, Pediatrics and OB/GYNs).

  - Acceptable documented performance for all practice information related to Kaiser Permanente members. This includes activities/findings of peer review, medical record keeping and office site reviews and member complaints.

**Note:** This requirement applies only to practitioners being recredentialed.

### 8.6.2 Practitioner Notification of Status of Credentialing Application
Upon request the Credentials staff will inform the practitioner of the status of his/her credentialing or recredentialing application. Requests can be made by calling the Credentials Department at (503) 813-3810

8.6.3 Practitioner Right to Review and Correct Erroneous Information
A practitioner may review his/her credentials application and any related information.

Where appropriate, a practitioner has the right to review the information submitted in support of his/her application and will give Kaiser Permanente Northwest 24 hours notice of intent to review. When notified by Kaiser Permanente Northwest of inconsistent or missing information, a practitioner has the responsibility to respond within 15 days with the correct or complete information.

Where appropriate, a practitioner may correct erroneous information. As a condition of making this application, a practitioner understands that any material misrepresentations, misstatements in, or omissions from this application whether intentional or not, shall constitute cause for automatic and immediate denial of participation. If participation has been granted prior to the discovery of misrepresentation, misstatement or omission, discovery may result in immediate suspension or termination of such participation.

8.6.4 Practitioners on Corrective Action Plan Status
To ensure quality and safety of care between recredentialing cycles, the KPNW Credentials Committee performs ongoing monitoring of the practitioners performance. The KPNW Credentials Committee acts on important quality or safety issues in a timely manner by taking appropriate action against a practitioner when occurrences of poor quality are identified and the practitioner is part of the root cause and by reassessing the practitioner’s ability to perform the services that he/she is under contract to perform. KPNW considers a full range of actions depending on the nature of adverse circumstances, including appropriate interventions, if applicable. The KPNW Credentials Committee may request at recredentialing or in between recredentialing cycles additional information or an action plan, as appropriate, for a practitioner with concerns.

8.6.5 Confidentiality of Credentialing Information
All information obtained during the credentialing and recredentialing process is considered to be confidential except as otherwise required by law.

8.7 Peer Review
The peer review process is a mechanism to evaluate potential quality of care concerns to determine whether standards of care are met and to identify opportunities for improvement. The process is used to monitor and facilitate improvement at the individual practitioner and system levels to assure safe and effective care.

Northwest Permanente physicians and contracted practitioners deliver services in a number of different contract hospitals in the Northwest. Contract hospitals are required
to have internal peer review processes that are separate and independent from those of KPNW given the legal protections regarding confidentiality and privilege. We provide a parallel process of review when there are concerns about one of our NWP physicians. Please notify the Quality Resource Management Department at 503-813-3810 to report concerns. Under state and federal laws and regulations, peer review activities are both confidential and privileged.

8.8 Compliance with Facility and Office Site Reviews
KPNW assures that the clinical offices of all primary care practitioners, OB/GYN, and high-volume behavioral health care practitioners meet KPNW standards for quality, safety, accessibility, and medical/treatment record-keeping practices. At the time of each initial credentialing site visit, a standardized site visit review form/audit tool is completed. The audit tool includes a set of criteria which includes assessment of:

1. Physical accessibility
2. Physical appearance
3. Adequacy of waiting and examining room space
4. Availability of appointments
5. Adequacy of medical/treatment record keeping
6. Set of standards and thresholds for acceptable performance against criteria

8.8.1 Frequency of Facility and Office Site Review
Initial office site visits occur prior to the credentialing decision.

8.8.2 Non-Compliance with Site Review Standards
KPNW established separate thresholds for both medical record keeping practice standards and office site standards. KPNW institutes actions for improvement with sites that do not meet thresholds. Sites that do not achieve a passing score in either or both sets of standards are reevaluated using the same standardized site visit review form/audit tool at least every six months until the performance standards have been met.

8.9 Compliance with Medical Record Requirements
The primary purpose of the health record is to facilitate diagnosis, treatment, and continuity & coordination of care. The health record should be maintained in a current, detailed, and organized manner which supports timely, safe and effective care and timely retrieval. Complete and accurate health records are important to comply with accreditation, state licensure and regulating agencies’ requirements.

- The Health Record must be available at the time of the patient visit.
- Only authorized individuals may enter information into the Health Record.
- Records are stored in a manner that allows access by authorized personnel only.
The confidentiality of the Health record and member information is maintained.
KPNW is provided access to KFHP member records to the extent permitted by state and federal law.

The following Kaiser Permanente Medical Record elements are required to support consistent and complete documentation. The performance goal is 95% completion of these elements.

- Each page/screen identifies the patient's name and health record number.
- Author is identified for each entry.
- Date is identified for each entry.
- Entries must be legible and accurate. Typographical errors must not result in change of meaning.
- Current significant illnesses and medical conditions are indicated on the problem list. Resolved and deleted problems are documented and retrievable.
- Allergies and adverse reactions are prominently noted.
- Past medical history and surgeries including serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history includes significant prenatal and birth events, operations, immunization and childhood illnesses, and growth charts.
- Social history includes notation concerning the use of tobacco, alcohol, and substances.
- Progress notes include, assessment, subjective and objective information pertinent to the patient's presenting complaints.
- Encounter diagnoses are consistent with documented findings.
- Treatment plans are consistent with diagnosis, and may include orders, patient instructions, and follow-up plans.
- Follow-up visit return information is noted in days, weeks, months, or as needed.
- Procedures, services, orders and consultations are documented.

Entries in the Health Record should be made at the time of care delivery, or shortly thereafter, and completed within a seven day period. The performance goal is 98% completed within 7 days.

In all settings that a Health Record of a Kaiser Permanente member/patient is used, or that is created, received, maintained or transmitted on behalf of Kaiser Permanente, entities and individuals are bound by the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-91) Privacy and Security Rules, and regulations issued thereunder (collectively “HIPAA”)

For additional information on Health Record Management contact Provider Relations from Portland, Oregon at (503) 813-3376 or from all other areas at (800) 813-2000.
8.9.1 Frequency of Medical Records Review
Initial office site visits occur prior to the credentialing decision.

8.9.2 Non-Compliance with Medical Records Standards
KPNW established separate thresholds for both medical record keeping practice standards and office site standards. KPNW institutes actions for improvement with sites that do not meet thresholds. Sites that do not achieve a passing score in either or both sets of standards are reevaluated using the same standardized site visit review form/audit tool at least every six months until the performance standards have been met.
### 8.10 Accessibility Standards

<table>
<thead>
<tr>
<th>Accessibility Standards for Medical Care</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive non-symptomatic care</strong>: including but not limited to well child visits, annual preventive screening visits, immunizations.</td>
<td>30 calendar days</td>
</tr>
<tr>
<td><strong>Routine, non-urgent symptomatic care</strong>: associated with the presentation of medical signs not requiring immediate attention</td>
<td>10 calendar days</td>
</tr>
<tr>
<td><strong>Urgent Medical Care</strong>: associated with the presentation of medical signs that require immediate attention, but are not life threatening.</td>
<td>48 hours</td>
</tr>
<tr>
<td><strong>Emergency Medical Care</strong>: services required for the immediate alleviation of acute pain or the immediate diagnosis and treatment of an unforeseen illness or injury. Prudent layperson applies.</td>
<td>Immediate Available 24/7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>After Hours Care</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available 24/7 by answering services or direct pager</td>
<td></td>
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</tbody>
</table>

### Accessibility Standards for Behavioral Health Care

<table>
<thead>
<tr>
<th>Routine Office visits</th>
<th>14 calendar days</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent Care</strong>: severe crisis that is not life-threatening, including impaired ability to function in normal roles due to symptoms</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td><strong>Emergency (non-life threatening)</strong>: severe crisis not life-threatening but with potential to become so without intervention</td>
<td>Within 6 hours</td>
</tr>
<tr>
<td><strong>Emergency</strong>: patient’s perception of life-threatening</td>
<td>Immediate</td>
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