10.0 Quality & Health Management

10.1 Quality & Health Management Program

The Kaiser Permanente Mid-Atlantic States (KPMAS) Quality of Care and Service Program (the "Program") applies to the patient care delivery system of KPMAS. The Program addresses all medical, behavioral health and service activities provided to internal and external customers, participating practitioners, participating providers and enrollees. All KPMAS Participating Providers and staff are involved in this process, with key staff serving on Quality of Care and Service Program Committees. Members and Participating Providers may request information about the Program including a report of our progress toward quality improvement goals by calling or writing the Member Services Department at:

Kaiser Permanente
Member Services Unit
2101 East Jefferson Street
Rockville, MD 20852

Inside the Local Calling Area:	☎ 301-468-6000
Toll free Outside the Local Calling Area:	☎ 800-777-7902
TDD for the Hearing Impaired:	☎ 301-816-6344

The activities monitored and reviewed by the Quality of Care and Service Program includes, but is not limited to, the following:

- Monitoring access and member satisfaction
- Development and measurement of compliance with clinical practice guidelines and standards of care
- Focused studies of preventive and chronic care
- Identification of individual adverse outcomes and risk events
- Peer Review
- Incorporation of recommendations from external review bodies including the National Committee for Quality Assurance (NCQA) and KPMAS's Health Plan Quality Oversight (HPQO)

In addition, the Quality of Care and Service Program establishes effective monitoring and evaluation of care and services to ensure the care and service that KPMAS offers its customers meets or exceeds accepted national standards. The Program accomplishes this by:

1. Developing mechanisms to identify, monitor, evaluate and improve important aspects of care and service, including high-volume, high-risk services, by:
    - Ensuring that information from monitoring and evaluation activities is disseminated and used to improve quality of care and service in inpatient, ambulatory, and affiliated settings:
    - Supporting the development and use of evidence-based clinical practice guidelines and formulating implementation plans and outcomes monitoring;
    - Ensuring full qualifications and competence of health care professionals through adherence to KPMAS's credentialing and recredentialing standards;
    - Assuring compliance with accreditation and regulatory standards;
    - Monitoring access standards and evaluating KPMAS's compliance with these standards;
    - Providing appropriate oversight of delegated functions and monitoring delegate's performance against pre-established standards.

2. Providing consistent and timely identification and analysis of opportunities for improvement and intervene to improve care, where appropriate, by:
   - Evaluating the continuity and coordination of care provided to KPMAS members;
   - Promoting member satisfaction and improvements in the health status of members;
   - Viewing complaints about care or service as opportunities for improvement;
   - Providing periodic feedback to members and practitioners regarding measurement and outcomes of quality improvement activities.

3. Improving the health status of KPMAS members whenever possible by:
   - Continually integrating evidence-based clinical standards into quality programs and including these in the development of benchmarks;
   - Surveying members periodically about their perceived health status;
   - Promoting effective health management and case management for members identified with chronic diseases;
   - Encouraging all members to utilize appropriate preventive health services in order to promote member wellness;
   - Identifying and reducing access barriers for any segment of the member population.

4. Continuing to be a recognized leader in local, state and national efforts to promote quality healthcare for all populations, within and outside KPMAS, by:
   - Collaborating with public and private health agencies in quality improvement activities;
   - Demonstrating value to purchasers through outcome-oriented quality assurance and clinical quality improvement activities;
   - Aligning the Program with well-recognized evidence-based clinical goals.

5. Continuing to develop and implement the people strategy by increasing KPMAS employee engagement and satisfaction, attracting diverse and highly talented physicians and staff, fostering a learning environment, and ensuring continuity of organizational knowledge and culture that supports the mission, vision and values of KPMAS by:
   - Creating meaningful practices that reward the organization, physicians, staff and our members.
   - Demonstrating that we respect and value our work force by:
     - Developing their competencies and rewarding their accomplishments
     - Collaborating with each individual and team in order to develop clear, targeted, and measurable expectations
     - Ensuring that highly achieving, talented, committed physicians and staff remain with the organization.

10.2 Clinical Practice Guidelines

Clinical practice guidelines are systematically designed tools to assist participating practitioners and patient decisions regarding specific medical conditions and preventive care. Guidelines are informational and are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by participating practitioners in any particular set of circumstances for each patient.

KPMAS has adopted and implemented evidence-based Clinical Practice Guidelines developed by Permanente Medical Groups and by the Care Management Institute in conjunction with Permanente physician-experts from across the Kaiser Permanente program. These guidelines cover preventive, acute, and chronic care. Preventive care guidelines include, but not limited to, Prenatal Care, Preventive Care for all ages, Breast Cancer Screening, Cervical Cancer

Screening, Colorectal Cancer Screening, Prostate Cancer Screening, Tobacco Screening Guidelines, and Abdominal Aortic Aneurysm Screening. Clinical practice guidelines address the primary care management of common diagnoses, such as adult and pediatric asthma, diabetes mellitus, hypertension, attention deficit hyperactivity disorder, coronary artery disease, and adult depression.

Clinical practice guidelines are available to Kaiser Permanente Participating Providers at www.kp.org/providers/mas under Provider Information and Clinical Library or by contacting the Quality Department at ☎ 301-816-5763.

10.3 Contracted Provider Participation

Participating Providers are required through their Kaiser Permanente contract to comply with the KPMAS Quality Improvement Program. Mid-Atlantic Permanente Medical Group (MAPMG) and Participating Providers agree to provide KPMAS with access to medical records, participate in quality improvement (QI) program activities and allow the use of performance data. Participating Providers are given regular updates on the status of health plan activities through the Permanente Journal, Network News, and other provider mailings.

KPMAS encourages participating providers to participate in the QI program through membership and participation in Quality Improvement Committees. Participating providers are also encouraged to provide feedback to quality management (QM) staff through response to newsletter topics and through practitioner satisfaction surveys.

KPMAS provides ongoing educational services to participating providers through new provider orientation materials, provider manual updates, provider meetings and provider training by provider education staff.

10.4 Access and Availability Standards

KPMAS has established standards for availability of participating providers. These performance standards are reviewed no less than annually. KPMAS has established mechanisms to incorporate ongoing review of both availability and performance measures. This process for measurement of participating provider availability identifies opportunities for improvement and implementation of appropriate interventions to ensure participating provider availability to the KPMAS membership.

10.5 Credentialing & Re-credentialing Process

The credentialing process is designed to ensure that all licensed independent practitioners and allied health practitioners under contract with MAPMG are qualified, appropriately educated, trained, and competent. All participating practitioners must be able to deliver health care according to KPMAS standards of care and all appropriate 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) and KPMAS.

KPMAS Participating Providers must meet MAPMG credentialing requirements. KPMAS credentialing policies and procedures are intended to protect our members and ensure quality. .The Mid-Atlantic States Credentialing and Privileging Committee (MASCAP), chaired by MAPMG's Associate Medical Director of Quality and Health Plan's Vice President of Quality, Regulatory and Risk Management, oversees all credentialing and re-credentialing activities.

Initial credentialing and re- credentialing are part of the practitioner/provider contract process. No participating provider may see KPMAS members prior to being approved through the credentialing process. All physicians who cover for network providers must be credentialed by MAPMG. Providers will be credentialed upon initial application to the KPMAS provider network; re-credentialing occurs every three years thereafter except for those with Kaiser Permanente ambulatory surgery and procedural sedation privileges for whom re-credentialing occurs every two years. All participating providers must satisfactorily complete the re-credentialing process to maintain an active status. This process is described in detail below in Section 10.7. Practitioners will be notified within sixty (60) calendar days in writing of the actions taken to approve or disapprove the applicant for participation with KPMAS.

Provider Responsibilities

Provider responsibilities in the credentialing process include:

- Submission of a completed application and all required documentation before a contract is signed
- Producing accurate and timely information to ensure proper evaluation of the credentialing application
- Provision of updates or changes to their application within 30 days
- Provision of a current certificate of insurance when initiating a credentialing application. A certificate of insurance must also be submitted at annual renewal.
- Cooperation with site visit and medical record-keeping review process

Provider Rights

Provider rights in the credentialing process include:

- Being provided a copy of the MASCAP Policies and Procedures upon written request.
- Reviewing the information contained in your credentials file, except for peer references, recommendations, and peer-review protected information.
- Correcting erroneous information contained in your credentialing file within 10 days upon notification of a discrepancy. These corrections should be sent in writing to PPQA-MAS@kp.org. The organization is not required to reveal the source of information that was not obtained to meet verification requirements or if the federal or state law prohibits disclosure.
- Being informed of the status of your application, upon request. You will be informed of the stage of the process your application is in within two business days. The response will be provided in the manner you made the request.
- Appealing decisions of the MASCAP Committee if you are denied credentialing, had your participating status changed, been placed on a performance improvement plan, or have had any adverse actions taken against you.

These rights may be exercised by contacting the Practitioner and Provider Quality Assurance Department (PPQA) at ☎ 301-816-5853 or by fax at ☎ 855-414-2630. Written correspondence may also be emailed to PPQA-MAS@kp.org or sent to:

Kaiser Permanente
Practitioner and Provider Quality Assurance - 6 West
2101 East Jefferson Street
Rockville, MD 20852

Credentialing Files

- Credentialing files remain confidential according to KPMAS policies and procedures.

Credentialing files are acted upon according to KPMAS policies and procedures

Credentialing Process

All applications will be processed and verified according to KPMAS credentialing policies and procedures. The elements of the initial credentialing process include, but are not limited to, the following:

- Application
- Current and unrestricted license in each jurisdiction where practitioner provides services
- License sanctions
- DEA Certificate in each jurisdiction where practitioner provides services
- CDS Certificate
- Board Certification and Maintenance of Board Certification
- Graduate Professional Training
- Current Post-Graduate Education
- Professional School Graduation
- Hospital Privileges
- References
- Professional Liability Coverage
- Claims History
- NPDB Query
- Work History
- Medicare and Medicaid Status and Sanctions
- Office Visit Report
- Mid-Level Practitioner Practice Agreement

Site Visits

KPMAS participating primary care physicians (PCPs), OB/GYN, and high- volume behavioral health offices will be subject to a site visit. This site visit includes a review of medical record-keeping practices. The Mid-Atlantic States Credentialing and Privileging Committee and Regional Quality Improvement Committee (RQIC) uses the review results in the selection and ongoing quality monitoring of network sites. Additional site visits may be conducted as needed based on member complaints or to meet an action plan for a previously identified deficiency. Feedback is provided to each practice with the completed site review tools and request for action plan if indicated.

Participating Hospital Privileges

It is the policy of KPMAS to contract with and credential only those practitioners who have privileges at a participating hospital. In the event that there is a change in participating hospitals, participating providers with privileges at a terminated hospital will be notified of the change in hospital status, and of the need to obtain privileges at an alternative participating hospital or terminate their participation with Kaiser Permanente.

Board Certification Policy

If not already board certified, all physicians are required to obtain the American Board of Medical Specialties (ABMS) recognized board certification in their contracted specialty within five (5) years of completion of training. Physicians must maintain specialty board certification throughout the life of their employment or contract with MAPMG. Providers whose certification lapses during the course of their contract or employment, will be given two (2) years following the expiration of their board certification to obtain recertification (MAPMG hourly physicians are not given the two (2) year grace period). Physicians who were practicing in a specialty prior to

the establishment of board certification of that specialty are exempt from this policy with respect to that specialty. The following boards are accepted by KPMAS:

- American Board of Medical Specialties (ABMS)
- American Osteopathic Association (AOA) Directory of Osteopathic Physicians. American Podiatric Medical Association (APMA)
- American Board of Foot and Ankle Surgery (ABFAS)
- American Board of Oral & Maxillofacial Surgeons
- American Midwifery Certification Board (AMCB)
- American Academy of Nurse Practitioners (AANP)
- American Nurses Credentialing Center (ANCC)
- National Certification Corporation (NCC)
- American Association of Nurse Anesthetists (AANA)
- National Commission on Certification of Physician Assistants (NCCPA)
- Pediatric Nursing Certification Board (PNCB)

Board Certification Exception Policy

Exceptions to the requirement for board certification of participating providers in the specialty for which they deliver care to KPMAS members may be made in individual circumstances in accordance with the principles outlined in the MAPMG Board Certification Policy.

10.6 Re-credentialing Process

After initial credentialing, KPMAS participating providers will be re-credentialed every three (3) years except for those with Kaiser Permanente ambulatory surgery and moderate sedation privileges who shall be re-credentialed every two (2) years by following the applicable accreditation agency guidelines, such as those set forth by the NCQA and Kaiser Permanente. The elements of the re-credentialing process include, but are not limited to, the following:

- Application
- Current and unrestricted license in each jurisdiction where the practitioner provides services
- License sanctions
- Drug Enforcement Administration (DEA) Certificate in each jurisdiction where the practitioner provides services
- Controlled Dangerous Substances (CDS) Certificate
- Board Certification and Maintenance of Board Certification
- Hospital Privileges
- Professional Liability Coverage
- Claims History
- NPDB Query
- Work History
- Medicare and Medicaid Status and Sanctions
- Mid-Level Practitioner Practice Agreement
- Practitioner Quality Profile
- Member Complaints

Notification

It is incumbent upon participating providers to notify PPQA by calling ☎ 301- 816-5853 or emailing PPQA-MAS@kp.org regarding any updates or changes to their application or credentials within thirty (30) days of the occurrence. These updates and/or changes will be reviewed according to the credentialing procedures outlined by KPMAS and will be included in the participating provider credentials file. These may include, but are not limited to, the following:

- Voluntary or involuntary medical license suspension, revocation, restriction, or report filed
- Voluntary or involuntary hospital privileges reduced, suspended, revoked, or denied
- Any disciplinary action taken by a hospital, health maintenance organization (HMO), group practice, or any other health provider organization
- Medicare or Medicaid sanctions, or any investigation for a federal healthcare program
- Medical malpractice action

10.7 Provider Profiling

As part of our mission and commitment to our member, KPMAS monitors care and service delivery by measuring several quality indicators to assess effectiveness. KPMAS' participating PCPs participate in this effort to ensure quality care.

KPMAS has established thresholds for performance measures in key areas that may include customer satisfaction, referral, and quality measures, among others.

Satisfaction measures consist of three components:

1. Overall satisfaction with the office visit,
2. Satisfaction with wait times for telephone answering, scheduling an appointment, and the waiting room,
3. Rate of members transferring out of the primary care office and into another practice (excluding members leaving the plan).

Clinical quality measures are indicators of quality and appropriateness of care. KPMAS approved guidelines, Health Plan report cards, and national statistics may be included in a comparative data analysis.

Member Complaints & Grievances All quality-related complaints and grievances are tracked and trended through KPMAS Quality Management and may become part of participating providers profiles.

Referral measures measure the rate of visits for both specialty care and emergency room visits per thousand members. This rate, for example, could be compared to a range of PCP office practices.

Utilization statistics that reflect rates and patterns of care will be presented along with appropriate benchmarks, where possible.

Healthcare Effectiveness Data and Information Set (HEDIS)/NCQA Quality indicators are used as measures of practitioner and health plan performance in the delivery of care. Selected services are evaluated and reported monthly and annually based on the HEDIS technical specifications.

10.8 Medical Record-Keeping Practices

KPMAS participating providers are responsible for maintaining the full medical record of members who elect to receive their health care through their office. The KPMAS Medical Care Program has developed specific criteria for maintaining the medical record. These standards are a part of the periodic site review done within each network office. The standards for medical record-keeping practices and the standard requirements for medical charts are as follows:

Standards for Medical Record-Keeping Practices

1. Medical records are maintained in a confidential manner, filed in a locked cabinet and out of public view
2. Each patient has an individual medical record. Individual medical records can be easily retrieved from files, filed alphabetically or numerically
3. Each page is identified with name of patient and birth date, or medical record number
4. All progress notes are dated (including year); provider can be identified; signatures include title
5. There are biographical/personal data
6. Notes are legible
7. There is a date for return visit or a follow-up; plan for each encounter
8. Consultants' summaries, laboratory and imaging study results reflect primary physician review
8. Allergies and adverse reactions to medications are prominently displayed
9. There is a note from a consultant in the record if a consultation is requested
10. Significant illnesses and medical conditions are indicated on the problem list
11. There is a completed immunization record

Standards for Medical Records for Medical Charts:

1. Clearly identifiable member information on each page:
   - Name
   - Date of birth/age
   - Sex
   - Medical record number
   - Physician name
   - Physician identification number

2. All progress notes will:
   - Be dated (including the year)
   - Clearly identify the provider
   - Include appropriate signatures and titles

3. Patient biographical/personal data are present
4. Notes are legible
5. Working diagnoses are consistent with findings
6. There is clear documentation of the medical treatment received by the patient
7. Plans of action and treatment are consistent with diagnosis(es)
8. There is a date for a return visit of other follow-up plan for each encounter
9. Unresolved problems from previous visit are addressed
10. There is evidence of appropriate use of consultants
11. There is evidence of continuity and coordination of care between primary and specialty physicians
12. Consultant summaries, laboratory, and imaging study results reflect ordering physician review as evidenced by:
    - Initials of the referring PCP following review
    - Recorded date of review
    - Comments recorded in progress note regarding interpretation and findings
    - Indication of treatment notice to patient

13. Allergies and adverse reactions to medications are prominently displayed. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.

14. There is documentation of past medical history as regards diagnoses of permanent or serious significance, and past surgeries or significant procedures. Pediatric patients will have similar documentation and/or prenatal and birth information.
15. If a consultation is requested, there is a note from the consultant in the record
16. Significant illnesses and medical conditions are indicated on the problem list
17. There is a notation concerning use/non-use of cigarettes, alcohol, and substance abuse for patients 12 years of age and over
18. The history and physical document examination results with appropriate subjective and objective information for presenting complaints
19. There is evidence that preventive screening and services are offered in accordance with KPMAS's practice guidelines
19. The care appears to be medically appropriate
20. There is a completed immunization record and problem list

10.9 Participating Provider Responsibility for Patient Confidentiality

As part of their contract with KPMAS, all members are assured that all personal and medical information pertaining to them remains confidential. To this end, it is the shared responsibility of all participating providers and their staff to maintain patient confidentiality. Participating providers must follow the level of confidentiality maintenance as stated in Section 7.3. Participating provider responsibilities to members are detailed in Section 7.4.

10.10 Advance Directives

Advance Directives are written instructions, such as a living will or a durable power of attorney for health care, recognized under appropriate state law. Advance directives are detailed in Section 7.8.

10.11 Self-Care and Prevention

The Regional Health Engagement and Women's and Maternal Child Health Programs administer a comprehensive health education and prevention plan for informing and encouraging members to use educational services, tools, and resources to practice healthy behaviors and self-manage ongoing conditions. The Regional Program helps ensure that Kaiser Permanente members learn appropriate and effective prevention and self-care through evidence-based medicine and provides members with the information, skills, and confidence to prevent or manage specific health problems through an active partnership with their health care team. Regional Program work and support involves the skill-set of a diverse team specialized in health education and is guided by clinical subject matter experts who direct the clinical content and accuracy of the educational tools and resources provided to members. Our front-line physicians are familiar with the suite of health education programs and can directly provide health education to members or refer them to pertinent resources. Programs are also integrated into the electronic medical record (EMR), providing providers and other team members the ability to directly promote and/or register patients for programs.

Healthy living classes provide self-management skill building in a group setting and are available to all members at no additional cost. Members can register for classes directly through the member portal. Alternatively, registration for classes can be coordinated by health care teams and scheduled through the EMR and the centralized Contact Center.

Classes range in length between one-time meeting and multi-session. All classes are designed to support care recommendations and healthy lifestyle goals set forth by health care teams.

Class curricula utilize the concepts of adult learning theory and teach-back instruction to engage participants in dialogue. Participants are encouraged to continue their efforts by working with their health care teams and utilize resources distributed and discussed in class. Online classes are also being offered for some topics. The following class topics are currently available:

- **Prevention**
- **Disease Management**
- **Prenatal classes**
- **Physical Therapy**
- **Older adult classes**

For members who are unable to attend the scheduled classes, an on-demand version of the class, including any resources provided, is available on the Kaiser Permanente website. Questions can be routed to the health education team through the recorded portal, and responses to those questions will be sent directly to the email address the member provided.

Kaiser Permanente's web site offers convenient services, instant information and personal advice from health care professionals. Services include pediatric preventive care and adult preventive care guidelines, the Healthwise Knowledgebase (online health encyclopedia), online health education videos and audio podcasts, prescription and non-prescription drug encyclopedia, the ability to ask an advice nurse or pharmacist a question and receive a response within 24 hours, links to health-related resources, and more.

The web site also offers customized online programs for health risk appraisal (total health assessment), weight management/physical activity, nutrition, stress management, caring for chronic conditions, and tobacco cessation, which assess health risk, readiness to change lifestyle behaviors, and self-efficacy.

Members also have access to online procedural preparation and chronic condition management videos that allow them to view what to expect of a medical procedure or how to manage certain aspects of their care. These programs are available through every primary and specialty care physicians' home page accessible through My Doctor Online at kp.org/doctor.

Members have access to wellness coaches via telephone appointment, with health education professionals skilled in motivational counseling techniques, to discuss lifestyle behaviors that impact the risk and management of chronic conditions. Coaching session topics include healthy eating, physical activity, stress management, tobacco cessation, and weight management. Sessions address members' ambivalence to change, and based on preferences, the member is referred to other program resources (i.e. classes, online tools). Coaching sessions, which are available in English and Spanish, are set in 20-minute time frames, with no limit to the number of sessions scheduled.

The prenatal education program provides tools and resources to women or couples from early pregnancy through delivery to ensure they have a healthy pregnancy and feel prepared for new parenthood and breastfeeding. Members can attend prenatal classes virtually. The prenatal education program consults with health care team staff to ensure that all materials and tools being developed are evidence-based and consistent with the needs of the members.

The Regional Program promotes and markets available tools, resources and classes for members through:

- member mailings of class schedules and online tools;
- specific class flyer mailings to target audiences;
- using the Kaiser Permanente website,
- digital signage in some medical centers,

- promotion of programs and classes through other classes, and
- a health education line that members can call to learn more about class offers or leave messages if there are any questions.

10.12 Managing Chronic Diseases Program (Disease Management)

KPMAS care management programs help participating practitioners monitor and manage patients with chronic conditions. Members with diabetes, asthma, coronary artery disease, chronic kidney disease, hypertension, and/ or depression are enrolled into care management programs through a registry.

These programs are designed to engage patients to help care for themselves, better understand their condition(s), update them on new information about their disease, and help manage their disease with assistance from their health care team and the population care management department. This information and education is designed to reinforce the patient's treatment plan.

Members in these programs receive mailings, phone calls, secure e-mail messages, and/or text messages periodically, including care gap reminders. These communications introduce the programs and provide education on topics such as the latest information on managing their condition, physical activity, tobacco cessation, medication adherence, planning for visits and knowing what to expect, and coping with multiple diseases. Participating practitioners may receive member-level information to help manage their panel, and quality process and outcome information to help improve practices. Patients do not have to enroll in the programs; they are automatically identified into a registry. If there are patients who have not been identified for program inclusion, or who have been identified as having a condition but do not actually have the condition, they can be "activated" or "inactivated" by contacting the Quality Department at ☎ 301-816-5763.

To obtain information and tools to care for your patients with chronic diseases, contact the Quality Department at ☎ 301-816-5763.

10.13 Patient Safety Events

This statement affirms the commitment Kaiser Foundation Health Plan of the Mid- Atlantic States, Inc. (KFHP-MAS) must improve care through continuous learning. Patient Safety event reporting is an important part of error prevention. KFHP-MAS learns from patient safety events to promote system education, initiate process improvement and prevent and mitigate health care error. The purpose of this provision is to outline the tenets of the KFHP-MAS patient safety event reporting criteria that will result in the best patient outcomes.

Patient Safety Event: An event, incident or condition that could have resulted or did result in harm to a patient. Patient Safety Events are not determined based upon perceived negligence or wrongdoing on the part of a staff member or department. Not all patient safety events are preventable. Event analysis is warranted in order to identify a defective process design, a system breakdown, equipment failure or human error.

Adverse Event: A patient safety event that resulted in harm to a patient.

Sentinel Event: A subcategory of adverse events is a Sentinel Event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

a. Death;
b. Permanent Harm; and/or

c. Severe Harm.

An event is also considered sentinel if it is one of the following:

- Suicide of any patient receiving care, treatment or services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the organization's emergency department (ED);
- Discharge of an infant to the wrong family;
- Abduction of any patient receiving care, treatment or services;
- Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose;
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
- Fire, flame or unanticipated smoke, heat or flashes occurring during an episode of patient care;
- Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure;
- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery;
- Unanticipated death of a full-term infant;
- Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter);
- Any intrapartum (related to the birth process) maternal death;
- Severe maternal morbidity (not primarily related to the natural course of the patient's illness or underlying condition) when it reaches a patient and results in permanent harm or severe temporary harm;
- Any elopement (unauthorized departure) of a patient from a staffed around-the-clock care setting (including the ED) leading to the death, permanent harm or severe temporary harm of the patient;
- Rape, assault (leading to death, permanent harm or severe temporary harm), or homicide of any patient receiving care, treatment or services while on site at the organization;
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor or vendor while on site at the organization.

Procedure to Report:

- Timely and comprehensive event reporting is key to driving a just patient culture. Organizations are expected to report all events within 48 hours of knowledge.
- All adverse events, patient safety events and sentinel events shall be phoned to the KFHP-MAS Patient Safety and Risk Management Department. Please call ☎ 888-989-1144 and ask for the Risk Manager on call.

Response to Events:

- Equipment involved in a Patient Safety Event shall be tagged and sequestered. Tubing or disposable products shall be kept with the equipment. Until a joint decision is made to release the equipment, the involved equipment shall not be used, cleaned or disturbed.
- Any event that involve criminal behavior, police or security investigation should be immediately phoned to Patient Safety and Risk Management.

Sentinel Event/Significant Event Root Cause Analysis Framework:

- Site leadership will provide a risk management contact.
- A cause analysis team shall initially review the event within three working days of notification of the event. A thorough and credible root cause analysis and action plan

should be completed within 45 calendar days of the event or of becoming aware of the event.

10.14 Provider Demographic Changes-New Locations and Relocations of Practice

When initiating a provider demographic request for a new location or relocation, all requests must come from the provider on company letterhead. This request can be submitted via fax at ☎ 855-414-2623 or thru the Provider Experience email address: provider.relations@kp.org. The demographic requests will be reviewed by a member of our Provider Contracting team. The review process will be completed within thirty (30) business days from date of receipt and a decision will be communicated via letter, unless credentialing is required for the demographic request. Please refer to section 10.5 Credentialing and Re-credentialing Process. Services should not be rendered to our members at your new location or relocation until your requested change has been approved by Kaiser Permanente. Please refer to the following page for a sample of the Provider Demographic Request Form.

Company Logo or Letterhead

<<Date>>

Requestor:
Requestor's Correspondence Address:
Requestor's Phone #:
Email:
Tax ID#:
Effective date of change(s):

Reason for the request:

Address change (Specify if practice location or billing address is changing)

- ☐ Specify if adding or deleting address
- ☐ Include **old** and **new** demographic information when sending request (Street Address, City, State, Zip, Phone, Fax, Tax ID and NPI)
- ☐ Billing/Payment Address/Tax ID/NPI
- ☐ Management Correspondence Address (include Phone & Fax Number)

Practice location addition

- ☐ Include **new** demographic information when sending request (Street Address, City, State, Zip, Phone, Fax, **Tax ID** and **NPI of Location**)
- ☐ Billing/Payment Address/Tax ID/NPI

Adding a provider to an existing group or deleting a provider from an existing group

- ☐ Specify if adding or deleting provider
- ☐ Include the information listed below if adding or deleting a provider:
  - First Name, Middle initial, and Last Name
  - Gender
  - Title (*MD, CRP, CRNP, PA etc.)*
  - Date of Birth
  - NPI #
  - CAQH #
  - UPIN or SSN
  - Medicare #
  - Medicaid Participation State(*s*)
  - Medicaid #
  - Practicing Specialty
  - **Practicing Service Location *only* (*include Phone & Fax Number*)**
    - Indicate whether practicing location is hospital-based or office-based
  - Billing/Payment Address (*include W-9*)
  - Management Correspondence Address (*include Phone & Fax Number*)
  - Hospital Privileges
  - Foreign Languages
  - Effective Date
  - Provider Panel Status: Open or Closed

*****A copy of provider licenses in all practicing states is required*****

Changing the Tax Identification Number and/or the name of an existing group

- ☐ Include **old** and **new** Tax ID Number and/or group name
- ☐ Include effective date of the new Tax ID Number and/or group name
- ☐ Include a signed and dated copy of the new W-9
- ☐ Billing/Payment Address
- ☐ Management Correspondence Address (include Phone & Fax Number)

*****Email the request to the Provider Demographics Department at Provider.Demographics@kp.org or fax to 855-414-2623***