8. Quality Assurance and Improvement (QA & I)

8.1 Northern California Quality Program and Patient Safety Program

The KP Quality Program includes many aspects of clinical and service quality, patient safety, behavioral health, accreditation and licensing and other elements. The KP quality improvement program assures that quality improvement is an ongoing, priority activity of the organization. Information about our quality program is available to you in the "Quality Program at Kaiser Permanente Northern California" document, including:

- Awards and recognition for our quality program presented by outside organizations
- Programs and systems within KP that promote quality improvement
- Our quality improvement structure
- Areas targeted by our quality goals

To obtain a copy of the "Quality Program at Kaiser Permanente Northern California" document, call our Member Services Contact Center (MSCC) at **1-(800) 464-4000** or TTY: **711**. Ask for a copy of the "Quality Program at KP". Alternatively, you can view and print the document by visiting the KP website at **http://www.kaiserpermanente.org**. Click on "Locate our Services," select "Forms and Publications," then "Quality Report" and finally "Quality Program at Kaiser Permanente". Additional information on KP's Northern California Quality Program and Patient Safety Program can be found at: **http://www.kp.org/quality**

Patient safety is a central component of KP's care delivery model. We believe our distinctive structure as a fully integrated health care delivery system provides us unique opportunities to design and implement effective, comprehensive safety strategies to protect Members. Providers play a key role in the implementation and oversight of patient safety efforts.

At KP, patient safety is every Member's right and everyone's responsibility. As a leader in patient safety, our program is focused on safe care, safe staff, safe support systems, safe place, and safe patients.

If you would like independent information about KP's health care quality and safety, the following external organizations offer information online:

> The National Committee for Quality Assurance (NCQA) works with consumers, purchasers of health care benefits, state regulators, and health plans to develop standards that evaluate health plan quality. KP is responsible to manage, measure, and assess patient care in order to achieve NCQA accreditation which includes ensuring that all Members are entitled to the same high level of care regardless of the site or provider of care.

KP is currently accredited by NCQA, and we periodically undergo re-accreditation. KP Northern California Region (KPNC) provides the appropriate information related to quality and utilization upon request, so that KP may meet NCQA standards and requirements, and maintain successful NCQA accreditation. You can review the report card for KFHP, Northern California, at **http://www.ncqa.org**.

The Leapfrog Group is a national nonprofit organization founded by larger employers and purchasers to drive movement in quality and safety in American health care. The group gathers information about medical care and patient safety relevant to urban hospitals via an annual Leapfrog Survey. The survey assesses hospital safety, quality, and efficiency based on national performance measures that are of specific interest to health care purchasers and consumers. All KP hospitals in California participated in the most recent survey. Survey results are publicly reported and provide hospitals with information to benchmark their progress in improving the care that is delivered.

To review KP hospital survey results, visit:

http://www.leapfroggroup.org/cp

To review the hospital's Safety Grades, visit:

https://www.hospitalsafetygrade.org/

The Office of the Patient Advocate (OPA) provides data to demonstrate the quality of care delivered at KPNC, as well as a comparison of our performance to other health plans in the state. To view the Clinical and Patient Experience Measures along with explanations of the scoring and rating methods used visit:
http://reportcard.opa.ca.gov/rc2013/medicalgroupcounty.aspx

The Joint Commission (TJC) is a hospital accreditation organization that is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. To earn and maintain its accreditations, KFH hospitals must undergo an onsite surveying by The Joint Commission survey team at least every 3 years. Providers who are privileged to practice at any KFH hospital are expected to adhere to TJC standards when practicing within the facility(ies). For further information, visit **http://www.jointcommission.org**

8.2 Quality Assurance and Improvement (QA & I) Program Overview

KP's Quality Assurance and Improvement Program uses a multi-disciplinary and integrated approach, which focuses on opportunities for improving operational processes, health outcomes, and Member and Provider satisfaction.

The quality of care Members receive is monitored by KP's oversight of Providers. You may be monitored for various indicators and required to participate in some KP processes. For example, we monitor and track the following:

- Member access to care
- Member complaint and satisfaction survey data of both administrative and quality of care issues
- Compliance with KP policies and procedures
- UM statistics
- Quality of care indicators and provision of performance data as necessary for KP to comply with requirements of NCQA, CMS (Medicare), TJC, and other regulatory and accreditation bodies
- Performance standards in accordance with your Agreement
- Credentialing and recredentialing of Providers

In any of the above situations, when KP reasonably determines that the Provider's performance may adversely affect the care provided to Members, KP may take corrective actions in accordance with your Agreement. As a Provider, you are expected to investigate and respond in a timely manner to all quality issues and work with KP to resolve any quality and accessibility issues related to services for Members. Each Provider is expected to remedy, as soon as reasonably possible, any condition related to patient care involving a Member that has been determined by KP or any governmental or accrediting agencies, to be unsatisfactory.

8.3 Provider Credentialing and Recredentialing

As an important part of KP's Quality Management Program, all credentialing, recredentialing, and privileging activities are structured to assure applicable Providers are qualified to meet KP policy, NCQA standards, and other regulatory requirements for the delivery of quality health care and service to Members.

The credentialing, recredentialing and privileging policies and procedures approved by KP are intended to meet or exceed the managed care organization standards outlined by the NCQA.

KP has developed and implemented credentialing and recredentialing policies and procedures for Providers. Practitioners include, but are not limited to, MDs, DOs, oral surgeons, podiatrists, chiropractors, physician assistants, advanced practice nurses, behavioral health practitioners, acupuncturists and optometrists. Organizational Providers (OPs) include, but are not limited to, hospitals, SNFs, home health agencies, hospices, dialysis centers, congregate living facilities, behavioral health facilities, ambulatory surgical centers, clinical laboratories, comprehensive outpatient rehabilitation facilities, portable x-ray suppliers, federally qualified health centers and community based adult services

centers. Services to Members may be provided only when the Provider meets KP's applicable credentialing criteria and has been approved by the appropriate Credentials and Privileges Committee.

Providers must also submit, upon renewal, ongoing evidence of current licensure, insurance, accreditation/certification, as applicable, and other credentialing documents subject to expiration.

8.3.1 Practitioners

KP requires that all practitioners within the scope of KP's credentialing program be credentialed prior to treating Members and must maintain credentialing. Recredentialing will occur at least every 36 months. Recredentialing may be adjusted to 24 months if privileges are required at a Kaiser Foundation Hospital. Credentialing may occur more frequently.

Requirements for initial and recredentialing for practitioners include, but are not limited to:

- Complete, current and accurate credentialing/recredentialing application
- Current, valid healing arts licenses, certificates and/or permits to practice in the State of California
- Clinical privileges are current and in good standing, if applicable
- Evidence of board certification or other national certification is current and in good standing, if applicable
- Evidence of appropriate education, clinical training, and current competence in practicing specialty
- Evidence of professional liability coverage equal to, or greater than, current KP standards
- Supporting References of Competence
- No history of State, Federal, Medicaid or Medicare sanctions/limitations/exclusions
- No significant events as identified through KP performance data (at recredentialing only)

KP adheres to the NCQA standards for credentialing and recredentialing of hospitalists. Hospitalists who provide services exclusively in the inpatient setting and provide care for Members only as a result of Members being directed to the hospital setting are deemed appropriately credentialed and privileged in accordance with state, federal, regulatory and accreditation standards when credentialed and privileged by the hospital in which they treat Members. However, KP reserves the right to credential any practitioner.

A KP Credentials and Privileges Committee (RCPC) will communicate credentialing determinations in writing to practitioners. In the event the committee decides to deny

initial credentialing, terminate existing credentialing or make any other negative decision regarding the practitioner, appeal rights will be granted in accordance with applicable legal requirements and KP policies and procedures. The practitioner will be notified of those rights at the time the practitioner is notified of the committee's determination.

All information obtained by KP during the practitioner credentialing and recredentialing process is considered confidential as required by law. For additional information regarding credentialing and recredentialing requirements and policies, please contact TPMG Consulting Services.

8.3.2 Practitioner Rights

8.3.2.1 Practitioner Right to Correct Erroneous or Discrepant Information

The credentials staff will notify the practitioner, orally or in writing of information received that varies substantially from the information provided during the credentialing process. The practitioner will have 30 calendar days in which to correct the erroneous or discrepant information. The notification will state to whom, and in what format, to submit corrections.

8.3.2.2 Practitioner Rights to Review Information

Upon written request, and to the extent allowed by law, a practitioner may review information submitted in support of the credentialing application and verifications obtained by KP that are a matter of public record. The credentials file must be reviewed in the presence of KP credentialing staff. Upon receipt of a written request, an appointment time will be established in which to review the file.

8.3.2.3 Practitioner Rights to Be Informed of the Status of the Credentialing Application

The credentials staff will inform the practitioner of their credentialing or recredentialing application status upon request. Requests and responses may be written or oral. Information regarding status is limited to:

- 8.3.2.3.1 Information specific to the practitioner's own credentials file
- 8.3.2.3.2 Current credentialing status
- 8.3.2.3.3 Estimated committee review date, if applicable and available
- 8.3.2.3.4 Outstanding information needed to complete the credentials file

8.3.2.4 Practitioner Right to Credentialing and Privileging Policies

Upon written request, a practitioner may receive a complete and current copy of KFHP, Northern California Region Credentialing & Privileging Policies and Procedures. For those hospitals where the practitioner maintains active privileges, the practitioner may also

request and receive complete and current copies of Professional Staff Bylaws and The Rules and Regulations of the Professional Staff of Kaiser Foundation Hospital.

8.3 Organizational Providers (OPs)

KP requires all OPs within the scope of its credentialing program be credentialed prior to treating Members and maintain credentialing. Recredentialing will occur at least every 36 months and may occur more frequently. Requirements for both initial and recredentialing for OPs include, but are not limited to:

- Completed credentialing/recredentialing application
- California License in good standing, as applicable
- Medicare and Medicaid certification, if applicable
- Accreditation by a KP-recognized accreditation body and/or site visit by KP
- Evidence of current professional and general liability insurance, in amounts as required by KP
- Other criteria specific to organizational specialty

8.3.3.1 Corrective Action Plan or Increased Monitoring Status for OPs

Credentialing and recredentialing determinations are made by the KP Northern California Regional Credentials and Privileges Committee (RCPC). At the time of initial credentialing, newly operational OPs may be required to undergo monitoring.

Newly operational OPs are typically monitored for at least 6 months. These providers may be required to furnish monthly reports of applicable quality and/or clinical indicators for a minimum of the first 3 months of the initial credentialing period. This monitoring may include onsite visits.

If deficiencies are identified through KP physicians, staff or Members, the OP may be placed on a Corrective Action Plan (CAP) or Performance Improvement Plan (PIP) related to those deficiencies.

The OP will be notified in writing if deficiencies are identified. The notice will include the reason(s) for which the CAP or PIP is required, the monitoring time frames and any other specific requirements that may apply regarding the monitoring process. Within 2 weeks of such notice, the OP must create, for KP review, a time-phased plan that addresses the reason for the deficiency and their proposed actions toward correcting the deficiency. KP will review the draft CAP or PIP and determine whether it adequately addresses identified issues. If the plan is not acceptable, KP representatives will work with the OP to make necessary revisions to the plan. OPs subject to a CAP or PIP will be monitored for 6 months or longer.

For additional information regarding credentialing and recredentialing requirements and policies, please contact Provider Services.

8.4 Monitoring Quality

8.4.1 Compliance with Legal, Regulatory and Accrediting Body Standards

KP expects all Providers to be in compliance with all applicable legal, regulatory and accrediting requirements, to have and maintain accreditation as appropriate, to maintain a current certificate of insurance, and to maintain current licensure. If any entity takes any adverse action regarding licensure or accreditation, this must be reported to KP's Medical Services Contracting Department, along with a copy of the report, the action plan to resolve the identified issue or concern, within 90 Calendar Days of the receipt of the report.

8.4.2 Member Complaints

Written complaints lodged by Members about the quality of care provided by the Provider or Provider's medical staff or KP representatives must be reported within 30 calendar days. The above aggregate reporting is part of the quality management process and is independent of any broader requirements contained in your Agreement concerning the procedure for handling specific complaints (either written or oral).

8.4.3 Infection Control

KP requests the cooperation of Providers in monitoring their own practice for reporting of communicable diseases including COVID-19 during the pandemic, aimed at prevention of hospital associated infection (HAI) including, but not limited to, multi-drug resistant organisms such as MRSA, VRE, and C.difficile (C.diff), postoperative surgical site infections, central line associated bloodstream infections, and catheter-associated urinary tract infection. Targeted HAI should be tracked, rates determined and compared to CDC benchmarks when available. When a potential infection is identified, notify the local Infection Preventionist. Confirmed HAI cases in the facility are tracked and entered into the Centers for Diseases and Control (CDC) database called National Health and Safety Network (NHSN) as required per mandated public reporting. When a trend is identified by the affiliated practitioner or Provider, this should be shared with local Infection Control Committee (ICC) and a collaborative approach should be undertaken to improve practices related to infection prevention and control. All HAI summary reports and analysis should be submitted for review on an ongoing basis to the KP ICC and Quality Management (QM) Departments. Results of this review should then be shared with the affiliated practitioner or Provider. The IP and QM Departments will request certain actions and interventions be taken to maximize patient safety, as appropriate.

8.4.4. Practitioner Quality Assurance and Improvement Programs

KP ensures that mechanisms are in place to continually assess and improve the quality of care provided to Members to promote their health and safety through a comprehensive and effective program for practitioner peer review and evaluation of practitioner performance. This policy supports a process to conduct a peer review investigation of a health care practitioner's performance or conduct that has affected or could affect adversely the health or welfare of a Member.

8.4.5 DNBEs / Reportable Occurrences for Providers

As part of its required participation in KP's QI Program and in addition to the Claims submission requirements in Section 5.8 of this Provider Manual, and to the extent permitted by Law, the Provider must promptly notify KP and, upon request, provide information about any DNBE (as defined in Section 5.22 that occurs at its Location or Locations covered by its Agreement in connection with Services provided to a Member. Notices and information provided pursuant to this section shall not be deemed admissions of liability for acts or omissions, waiver of rights or remedies in litigation, or a waiver of evidentiary protections, privileges or objections in litigation or otherwise. Notices and information related to DNBEs should be sent to:

Medical Services Contracting
Attn: Provider Services
5820 Owens Dr, Building E, Floor 2
Pleasanton, CA 94588
Phone: (925) 924-5050
Fax: (877) 228-8306

At a minimum, Providers should include the following elements in any DNBE notice sent to KP.

- KP MRN
- Date(s) of service
- Place of service
- Referral number or emergency claim number
- General category description of DNBE(s) experienced by the Member

8.5 Quality Oversight

The peer review process is a mechanism to identify and evaluate potential quality of care concerns or trends 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. Peer review

provides a fair, impartial, and standardized method for review whereby appropriate actions can be implemented and evaluated. The peer review process includes the following:

- Practitioner Performance Review and Oversight – Practitioner profiling for individual re-credentialing as well as oversight and evaluation of the quality of care provided by practitioners in a department
- Practitioner Peer and System Review – Quality of care concern
- Focused Practitioner Review and Practice Improvement Plan – provides an objective evaluation of all or part of a practitioner's practice when issues are identified around the performance of that practitioner

The primary use of the information generated from these activities is for peer review and quality assurance purposes. Such information is subject to protection from discovery under applicable state and federal law. All such information and documentation will be labeled "Confidential and Privileged," and stored in a separate, secured, and appropriately marked manner. No copies of peer review documents will be disclosed to third parties unless consistent with applicable KP policy and/or upon the advice of legal counsel. Information, records, and documentation of completed peer review activity (along with other information on practitioner performance) shall be stored in the affected individual practitioner's confidential quality file.

Individuals involved in the peer review process shall be subject to the policies, principles, and procedures governing the confidentiality of peer review and quality assurance information.

When a peer review investigation results in any adverse action reducing, restricting, suspending, revoking, or denying the current or requested authorization to provide health care services to Members based upon professional competence or professional conduct, such adverse actions will be reported by the designated leaders of the entities responsible to make the required report (e.g., the chief of staff or hospital administrator) to the National Practitioner Data Bank and/or regulatory agencies, as appropriate.

8.5.1 Quality Review

Criteria that trigger a referral for Quality Review are identified through multiple mechanisms. Some sources include, but are not limited to:

- Allegations of professional negligence (formal or informal)
- Member complaints / grievances related to quality of care
- Risk Management (adverse events)
- Medical legal referrals
- Inter- or intra-departmental or facility referrals
- Issues identified by another practitioner

- Utilization Management (UM)
- Member complaints to external organizations

Cases referred for quality review are screened for issues related to the professional competence of a practitioner, which may be subject to peer review. These may include, but are not limited to:

- Concerns regarding the possibility of any breach of professional judgment or conduct towards Members
- Concerns regarding the possibility of failure to appropriately diagnose or treat a Member
- Adverse patterns of care identified through aggregate review of performance measures (e.g., automatic triggers)

To assist in review, the reviewer will use appropriate information from sources that include, but are not limited to:

- Nationally recognized practice standards, preferably evidence-based
- Professional practice requirements
- KP and other clinical practice guidelines
- KP Policies and procedures, including policies related to patient safety
- Regulatory and accreditation requirements
- Community standard of care

8.5.2 OPs' Quality Assurance & Improvement Programs (QA & I)

Each OP must maintain a QA & I program, described in a written plan approved by its governing body that meets all applicable state and federal licensure, accreditation, and certification requirements. When quality problems are identified, the OP must show evidence of corrective action, ongoing monitoring, revisions of policies and procedures, and changes in the provision of services. Each OP is expected to provide KP with its QA & I Plan and a copy of all updates and revisions.

8.5.3 Sentinel Events / Reportable Occurrences for OPs

This section is applicable to Acute Hospitals, Chronic Dialysis Centers, Ambulatory Surgery Centers, Psychiatric Hospitals, Skilled Nursing Facilities and Transitional Residential Recovery Services Providers. All Providers must report sentinel events and reportable occurrences as defined below. OPs must report events and occurrences at its facility or facilities covered by its Agreement.

8.5.3.1 Definitions: Sentinel Events and Reportable Occurrences

Sentinel Event is a subcategory of adverse events. A sentinel event is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of the duration of harm), or permanent harm (regardless of the severity of harm), and other adverse events defined by the Joint Commission and National Quality Forum.

> **Severe Harm**: An event or condition that reaches the individual, resulting in life-threatening bodily injury (including pain or disfigurement) that interferes with or results in loss of functional ability or quality of life that requires continuous physiological monitoring and/or surgery, invasive procedure, or treatment to resolve the condition.
>
> **Permanent Harm**: An event or condition that reaches the individual, resulting in any level of harm that permanently alters and/or affects an individual's baseline health.

Examples of sentinel events and reportable occurrences include, but are not limited to the following:

- Member falls resulting in serious injury, requiring subsequent medical intervention
- Medication error requiring medical intervention, including transfer
- Surgical or invasive procedure resulting in a retained foreign item, or was performed on a wrong Member, wrong side/site, wrong body part, or was a wrong procedure, or used a wrong implant
- Member suicide or attempted suicide resulting in permanent or severe temporary harm while being cared for in a healthcare setting
- A stage 3, 4 or unstageable pressure ulcer acquired after admission
- A cluster of nosocomial infections or significant adverse deviation events
- Outbreaks of infectious disease reportable to the County Health Department
- Official notice concerning revocation (requested or actual) of Medicare/Medi-Cal Certification or suspension of Medicare/Medi-Cal admissions

8.5.3.2 Notification Timeframes

Practitioners and OPs will report sentinel events and reportable occurrences within 24 hours of becoming aware of the event or occurrence. The KP contact will notify the local KP Risk Management Department about all reports. Providers should make reports to KP as follows:

Provider	KP Contact	Timeframe
Practitioner	Referral Coordinator	Within 24 hours
Acute Hospital	Care Coordinator	Within 24 hours
Chronic Dialysis Center	Renal Case Manager or Nephrologist	Within 24 hours
Ambulatory Surgery Center	Care Coordinator	Within 24 hours
Psychiatric Hospital	Care Coordinator	Within 24 hours
Skilled Nursing Facility	Care Coordinator	Within 24 hours
Transitional Residential Recovery Services Provider	Care Coordinator	Within 24 hours

8.5.4 Sentinel Events/Reportable Occurrences—Home Health & Hospice Agency Providers

8.5.4.1 Report Within 24 Hours

Immediately upon discovery, verbally report to the referring KP Home Health Agency, Hospice Agency or facility any sentinel event (as defined above in Section 8.5.3.1) and the following adverse events. The verbal report must be followed by a written notification sent within 24 hours or by the end of the next Business Day by certified mail, return receipt.

- Falls resulting in death or serious injury
- Any unexpected death or any Member safety events resulting in permanent or severe temporary Member harm not primarily related to the natural course of the Member's illness or underlying condition
- The event or related circumstances has the potential for significant adverse media (press) involvement
- Significant drug reactions or medication errors resulting in harm to the Member
- Medication errors resulting in harm to the Member
- Permanent or severe temporary harm to a Member associated with the use of physical restraints or bedrails while being cared for in a health care facility
- Member is either a perpetrator or victim of a crime or reportable abuse while under home health or hospice care

- Loss of license, certification or accreditation status
- Release of any toxic or hazardous substance that requires reporting to a local, state or federal agency

8.5.4.2 Report Within 72 Hours

You must report to the referring KP Home Health Agency, Hospice Agency or facility during KP business hours the following events involving Members that may impact the quality of care and/or have the potential for a negative outcome. Such report should be made within 72 hours of the occurrence. KP will notify the local KP Risk Management Department about all reports. These include but are not limited to the categories below.

- Reportable, communicable diseases, outbreaks of scabies or lice, and breaks in infection control practices
- Re-admission to a hospital
- Medication errors without harm (wrong patient, wrong drug, wrong dose, wrong route, wrong time, wrong day, or an extra dose, or an omission of an ordered drug)
- Disciplinary action taken against a practitioner caring for a KP Member that requires a report to the applicable state board or the National Practitioner Data Bank
- Noncompliance with regulatory and/or accreditation standards requiring corrective action plan

8.6 QA & I Reporting Requirements for Home Health & Hospice Providers

Quality monitoring activities will be conducted at each individual home health and hospice agency site and branch location.

8.6.1 Annual Reporting

On an annual basis, Providers of Home Health and Hospice services, and licensed/certified Providers who manage Members' plan of care on referral, must submit to KP:

- Copy of current license and insurance
- Reports of any accreditation and/or regulatory site visits occurring within the last 12 calendar months
- Copy of current quality plan and indicators
- Results of most recent patient satisfaction survey
- Action plans for all active citations, conditions, deficiencies and/or recommendations

8.6.2 Site Visits and/or Chart Review

A site visit and/or chart review may be requested by KP at any time to monitor quality and compliance with regulations. When onsite reviews are requested by the referring KP Home Health Agency, Hospice Agency, or facility or regional representative, your agency will make the following available:

- Personnel records
- Quality plan and indicators
- Documentation for Member complaints and follow-up
- Member medical records
- Policy and procedure manuals
- Other relevant quality and compliance data

8.6.3 Personnel Records

Providers providing home health and hospice services shall cooperate with KP audits of staff personnel records. Audits are designed to assure personnel providing care to KP Members are qualified and competent. Information reviewed may include but not be limited to:

- Professional License
- Current CPR certification
- Tuberculin or PPD testing
- Evidence of competency for those services provided to KP Members
- Continuing education
- Annual evaluation

8.7 QA & I Reporting Requirements for SNFs

The KP QA & I plan includes quality indicators that are collected routinely. Some of these indicators KP will collect; others will be collected by the SNF Providers. These indicators will be objective, measurable, and based on current knowledge and clinical experience. They reflect structures, processes or outcomes of care. KP promotes an outcome-oriented quality assessment and improvement system and will coordinate with SNF Providers to develop reportable outcomes.

Quarterly Reporting

Quarterly, SNF Quality Assessment indicator trend reports will include, at a minimum, the following:

- Patient falls
- Pressure Ulcers/Injuries
- Medication errors
- Previously reported adverse events and DNBEs
- Any CMS deficiency with a CAP or California Department of Public Health (CDPH) deficiency or citation with a CAP
- Reports to DHCS of unusual occurrences involving KP Members

8.7.2 Medical Record Documentation

KP procedures regarding medical record documentation for SNF Providers are detailed below. Any contradiction with a SNF Provider's own policies and procedures should be declared by the SNF, so that steps can be taken to satisfy both the SNF Provider and KP.

All Member record entries shall be written (preferably printed), made in a timely manner, dated, signed, and authenticated with professional designations by individuals making record entries.

Medical record documentation shall include at least the following:

- Member information, including emergency contact and valid telephone number
- Diagnoses and clinical impressions
- Plan of care
- Applicable history and physical examination
- Immunization and screening status when relevant
- Allergic and adverse drug reactions when relevant
- Documentation of nursing care, treatments, frequency and duration of therapies for Member, procedures, tests and results
- Information/communication to and from other providers
- Referrals or transfers to other providers
- Recommendations and instructions to Members and family members
- For each visit: date, purpose and updated information
- Advance Directive

8.8 Medical Record Review and Standards

KP recommends that all Providers maintain their medical records following standards applicable to their specialty to assure the consistency and completeness of patient medical records.

NOTE: A Provider may demonstrate compliance with these standards by preparing a sample medical record and discussing it with the reviewer or by redacting several medical records for existing patients.

KP MEDICAL RECORD STANDARDS

Summary of Medical Record Standards	Information Required
Patient Identification*	All entries (entry, page, or screen) in a patient's medical record must include the patient's last name, first name, and the patient's unique KP medical record number (MRN).
Personal/Biographical Data*	Patient demographic information which includes: • Birth date • Gender • Marital status • Home address and • Home/work telephone numbers NOTE: For pediatric medical records, this information should also address the child's parent/guardian.
Medical Record Entries*	All notes/entries • Include the name of the rendering provider and, if paper documentation, are authenticated by the provider • Are dated and in sequential order • Are legible to someone other than the writer • Are done in a timely manner
Problem List (PCP only) *	Medical records include a completed "problem list" which notes significant illnesses or medical conditions.
Allergies*	Allergies and adverse reactions to medications or immunizations are noted and prominently displayed inside or on the cover of a hard copy of a medical record, and in any computer-based program. If the patient has no known allergies or history of adverse reactions, this must be also noted.

Summary of Medical Record Standards	Information Required
Medical History*	Medical history must include: • Date of birth • Documentation of past medical history for which includes serious illnesses, past surgeries, or significant procedures. • Pertinent family and social history For **Pediatric Patients**, the history should also include: • Birth history including location, child's birth weight, and any special circumstances regarding the birth. • Growth chart with height, weight, and head circumference to (HC age 2) • Operations and childhood illnesses • Immunizations
Substance Abuse/Tobacco Products	For patients 14 years and older, medical records should document use/non-use of tobacco products, alcohol, or other substances. If the patient has been seen 3 or more times, they should be asked about substance abuse history.
Pertinent History/Exams for Patient "Complaints"	Pertinent history, physical exam for presenting complaints is completed and noted. The patient's vital signs are also noted.
Laboratory/Radiology Tests	Lab and Radiology and other testing are ordered as appropriate, and the ordering practitioner must make a notation in the record indicating abnormal results.
Working Diagnosis Consistent With Findings	Impression/working diagnosis clearly documented for each visit (except for preventive visits where no illness, complaint, etc. is identified.)
Treatment Plans	Treatment plans are consistent with diagnosis.
Follow-up Care/Visits	Date for return visit or other follow-up plan(s) for each encounter are noted when appropriate. The specific time of the follow-up visit is noted in weeks, months, or as needed.
Instruction in Self-Care	Date training/instruction on self-care provided to patient noted.
Unresolved Problems	Problems from previous visits are addressed in subsequent visits.
Use of Consultants	There is evidence of appropriate use of consultants.
Consultant Notes	There is evidence of continuity and coordination of care between primary and specialty providers. If consults are requested, copies of consultant notes are included in the medical record.

Summary of Medical Record Standards	Information Required
PCP Review of Consult/Lab Reports	Consultation summaries and lab & imaging reports indicate provider review. There is evidence that follow-up plans are in place for significant abnormal findings.
Patient at Inappropriate Risk	There is no evidence that patient is placed at inappropriate risk by diagnostic or therapeutic intervention.
Immunizations*	An immunization record is present and up to date for all pediatric patients. Adult immunizations are noted as appropriate.
Advance Directive	Document in record, prominently placed, to denote whether an Advance Directive has been executed.
Preventive Services	There is evidence that preventive screening and services are offered according to nationally accepted standards and practice guidelines.
Medications	A medication list is included.
NOTE: *Information and data recorded in the Medical Record and in other Member health & enrollment records must be accurate, complete, and truthful.*	

* Medical records must comply with these standards if only general medical recordkeeping practices are being reviewed.

8.9 QA & I Reporting Requirements for Chronic Dialysis Providers

8.9.1 Reporting Requirements

Providers who deliver chronic dialysis services are expected to send, on a monthly basis via hard copy or electronic file, a Patient Activity Report form containing the following information for Members who are:

- dialyzing for the first time ever
- transferring into the contracted dialysis center from another dialysis center
- returning after transplant
- recovering renal function
- receiving a transplant
- transferring to another dialysis center
- deceased
- changing treatment modality

8.9.2 Vascular Access Monitoring (VAM)

Pursuant to your Agreement, the chronic dialysis Provider is responsible for monitoring the blood flow in all grafts and fistulas of Members at the levels prescribed by the assigned nephrologist. Your Agreement will specify whether you are obligated to perform VAM services either using the Transonic Flow QC System® another method of VAM approved by Governing Body or office of Chief Medical Officer (CMO).

Desirable levels for flow rates are >400 ml/min for fistulas and >600 ml/min for grafts. When blood flow rates fall below the desirable targets, notify the nephrologist and/or KP renal case manager so that an appropriate intervention to prevent the access from clotting can be planned.

8.9.2.1 Surveillance Procedure for an Established Access

1. Obtain an access monitoring order from the nephrologist.
2. The Provider performs monthly access flow measurements once prescribed blood flow and optimal needle size are achieved at the intervals described below:

Grafts

- ✓ VAM services testing frequency
  - Transonic Flow QC System®—Monthly*
  - Another method of VAM approved by Governing Body of office of CMO
  - As otherwise prescribed by a Nephrologist
- ✓ Graft flow > 600 ml/min—continue to test at monthly intervals and trend results
- ✓ Graft flow rate 500 to 600 ml/min - review test results and trend. If trending indicates that flows are decreasing, refer the patient for angiogram and evaluation
- ✓ If trends remain constant and are not decreasing, repeat the test at the scheduled time
- ✓ Graft flow rate < 500 ml/min—refer for angiogram and evaluation

Fistula

- ✓ VAM services testing frequency
  - Transonic Flow QC System®—Every other month*
  - Another method of VAM approved by Governing Body of office of CMO
  - As otherwise prescribed by a nephrologist
- ✓ Fistula flow rate >400 ml/min—continue to test at monthly intervals and trend results.

- ✓ Fistula flow rate 300 to 400 ml/min - Review test results and trend. If trending indicates that flows are decreasing, refer the patient for angiogram and evaluation.
- ✓ If trends remain constant, use slower blood flows and perform a clinical evaluation to verify the adequacy of the treatments at a lower pump speed.
- ✓ Fistula flow rate < 300 ml/min—Refer for angiogram and evaluation

*In the case of the Transonic Flow QC System®, recirculation should be zero percent (0%) when testing the vascular access.

3. The Provider performs access flow measurements at frequencies other than that outlined above under the following conditions:
   - ✓ After a surgical procedure to create a new vascular access
   - ✓ Within a week following an access intervention, including but not limited to, a fistulogram, de-clotting, angioplasty or a surgical revision
   - ✓ As ordered by a Nephrologist