Kaiser Permanente Northwest Provider Manual 2018

Quality Assurance and Improvement

We created this section of the manual 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 you have a question or concern about the information in this manual, contact our Quality Resource Management Department at 503-813-3810.

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Section 7: Quality Assurance and Improvement (QI)

Overview

KPNW consists of Kaiser Foundation Health Plan of the Northwest (KFHP-NW), Kaiser Foundation Hospitals (KFH), and Northwest Permanente, P.C. (NWP). These entities collaborate to systematically assess care and service.

The KFHP-NW regional president and NWP executive medical director collaborate in the program's direction, implementation, and success. The Health Plan's Vice President of Quality and Service and NWP's Vice President for Quality, Care Experience, and Patient Safety collaborate to implement and maintain 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 (PMG) and non-PMG contracted/affiliate practitioners and providers are expected to participate in Kaiser Permanente's Service, Quality, Safety, and Resource Stewardship 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, ancillary 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 if we determine that your performance might adversely affect member care.

7.1 Contact Information

Leong Koh, MD; VP of Quality, Care Experience and Patient Safety, 503-422-9203

Nancy Lee; VP Quality and Service, 503-813-3123

Laura Duffey; Senior Director, Quality & Patient Safety, 503-813-3958

Mary Pohlman; Quality Resource Manager, Credentials, 503-813-2666

7.2 Compliance with Regulatory and Accrediting Body Standards

Kaiser Permanente participates in review activities by the National Committee for Quality Assurance (NCQA), Center for Medicare and Medicaid Services, internal audits, and Oregon and Washington regulatory bodies to demonstrate our compliance with regulatory and accrediting standards and requirements.

In accordance with these standards, we require you to provide to Kaiser Permanente, and allow us to use data on, measures of clinical quality, access, and member satisfaction. This data is required annually at minimum, or more frequently if indicated based on an evaluation of performance.

Kaiser Permanente expects its hospitals to have and maintain Joint Commission accreditation and requires all providers and facilities to be in compliance with all regulatory requirements

(e.g., CMS). Performance on quality indicators should be submitted per the agreed-upon contractual measures and requirements. If you receive recommendations or notices of non-compliance from any accreditation or regulatory organizations, please provide Kaiser Permanente with the surveys' recommendations along with the action plan to resolve the identified issues. Email this information to NWQA@kp.org or mail it to:

Quality Resource Management
500 NE Multnomah St.
Ste. 100, Floor 5
Portland, OR 97232

Kaiser Permanente annually monitors the status of the above listed accreditations, licensures, certifications, etc.

7.3 Sentinel Events

The Joint Commission defines a sentinel event as a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches the patient and results in death, permanent harm, or severe temporary harm. You must provide **immediate** notification to Kaiser Permanente in accordance with Kaiser Permanente's Sentinel Event Policy.

Report sentinel events to the Quality Resource Management Department at 503-813-3810. 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 of this policy or to request a sentinel event summary brochure, call 503-813-3810.

7.4 Do Not Bill Events (DNBE)

Kaiser Permanente follows guidelines and policies established by the Centers for Medicare and Medicaid Services (CMS).

The Health Plan's "Do Not Bill Event" policy is based on payment rules that waive fees for all or part of health care services directly related to the occurrence of certain adverse events as defined by the CMS National Coverage Determinations for surgical errors and the published listing of CMS Hospital Acquired Conditions. This policy applies to all claims for Health Plan members enrolled in the Kaiser Permanente Medicare Plus™ plan as well as members enrolled in Commercial Health Plan products such as the Kaiser Permanente Signature™ and Select™ plans.

Surgical "Do Not Bill Events" include an event in any care setting related to:

- Wrong surgical or invasive procedure(s) performed on a patient
- Surgical or other invasive procedure(s) performed on the wrong part of the body
- Surgical or other invasive procedure(s) performed on the wrong patient
- Unintended retention of a foreign object after surgery or procedure

Hospital-acquired conditions include a condition or event that occurs in a general hospital or acute care setting such as:

- Intravascular air embolism

- Hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products
- Stage 3 or 4 pressure ulcers acquired after admission to a health care facility
- Falls and trauma, including fractures, dislocations, intracranial injuries, crushing injuries, burns, or electric shock
- Manifestations of poor glycemic control: diabetic ketoacidosis, nonketotic hyperosmolar coma, hyperglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hypersomality
- Surgical site infections following certain elective procedures
- Deep vein thrombosis
- Vascular-catheter associated infection
- Catheter-associated urinary tract infection
- Mediastinitis after coronary artery bypass grafting

7.4.1 Notification of Adverse Event to Kaiser Permanente

After discovering an adverse “Do Not Bill Event” or condition affecting a member, providers should contact the KPNW Quality Department at 503-813-3810, or call Member Services at 503-813-2000.

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

Participating hospitals and facilities must include “Present on Admission” indicators on all member claims. Participating providers should make sure their billing staff are aware when a “Do Not Bill Event” involving a member’s care has occurred before submitting the claim to Kaiser Permanente.

When a “Do Not Bill Event” is recognized before claim submission, the UB-04 or CMS 1500 form should include:

- The applicable International Classification of Diseases (ICD) codes.
- All applicable standard modifiers, including CMS National Coverage Determination (“NCD”) modifiers for surgical errors.
- All services provided, including those related to a “Do Not Bill Event” with an adjustment in fee to reflect the waiver of fees directly related to the event(s).
- Any member cost share related to a “Do Not Bill Event” should be waived or reimbursed to the member. An affected member may not be balanced billed for any services related to a “Do Not Bill Event.”

7.5 Practitioner Credentialing

To ensure the quality of providers who treat Kaiser Permanente members, we credential or oversee the credentialing function for all practitioners. All practitioners must be fully credentialed and approved to participate before treating Kaiser Permanente members.

7.5.1 Credentialing and Recredentialing Processes

The credentialing process follows applicable accreditation agency guidelines such as those set by the National Committee for Quality Assurance (NCQA). Credentialing and recredentialing are part of the provider contract process. Kaiser Permanente Quality Resource Management oversees all credentialing and/or recredentialing activities and ensures they're conducted in a non-discriminatory manner.

You must provide the following information for the initial credentialing of each practitioner:

- A completed Kaiser Permanente application that includes provider demographics, practice information, work history, educational background, professional affiliations, attestation as to the accuracy of the information provided, and release.
- A copy of a current, valid, and unrestricted state license where your practice is located.
- An active clinical privilege in good standing at the hospital that is the provider'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 including board certification status, as appropriate.
- Evidence of current, adequate malpractice insurance.
- Acceptable history of malpractice claims experience.
- Compliance with medical record and facility and office site reviews.
- Additional verifications including a query of the National Practitioner Data Bank and a query for Medicare/Medicaid sanctions.

7.5.2 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. You can make requests by calling the Credentials Department at 503-813-3810.

7.5.3 Practitioner Right to Review and Correct Erroneous 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 must respond within 15 days with the correct or complete information.

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

7.5.4 Practitioners on Corrective Action Plan Status

To ensure quality and safety of care between recredentialing cycles, the KPNW Credentials Committee routinely monitors practitioner performance. The 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. The Committee may request, at recredentialing or between recredentialing cycles, additional information or an action plan.

7.5.5 Confidentiality of Credentialing Information

All information obtained during the credentialing and recredentialing process is considered confidential except as required by law.

7.6 Peer Review

The peer review process is a mechanism to evaluate potential quality of care concerns to determine if standards of care are met and 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.

PMG physicians and contracted practitioners deliver services in many contracted hospitals in the Northwest. Contracted 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 PMG 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.

7.7 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 recordkeeping practices. At the time of each initial credentialing site visit, we complete a standardized site visit review form/audit tool. The audit tool includes a set of criteria that assesses:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and exam room space
- Availability of appointments
- Adequacy of medical/treatment recordkeeping
- Standards and thresholds for acceptable performance against criteria

OFFICE SITE REVIEW STANDARDS

Category Description	
Access to Care	The practice site must demonstrate compliance with access to care and appointment guidelines outlined in Section 5, Access Standards to Medical Care.
Cultural Competence	The practice must ensure that key factors are in place to develop and provide programs and services that address the needs of the diverse Member population which it serves.
Waiting Area	The waiting area must have adequate space (i.e. at least 4 chairs per provider working at the same time)
Exam Room	The practice must have adequate space for patient scheduling (i.e., at least two private exam rooms for each provider working concurrently)
Office Site Safety	
Access for the Disabled To obtain: The Americans with Disabilities Act/Questions and Answers Contact: U.S. Equal Employment Opportunity Commission 1801 L Street NW Washington, D.C. 20507 Telephone: (800) 669-3362 – Voice: (800) 800-3302 - TDD	All office sites must comply with specifications included in the Americans with Disabilities Act unless the site qualifies for legal exceptions. These requirements include: • a designated handicapped parking space with wheelchair access (a ramp or other alternative) to the building • an elevator if there are two or more stories • a bathroom that is handicapped accessible or alternative access is available • access to drinking water by a water fountain at wheelchair level or other alternatives • office personnel are available to assist with handicapped patients as needed
CDS and/or DEA Certificate	A controlled drug/substance (CDS) or Drug Enforcement Agency (DEA) certificate must be available upon request.
Storage of Medical Records	• Medical records must be stored in a secure area away from patient access and in a manner that permits prompt retrieval. • Written policies and procedures exist on the

7.7.1 Frequency of Facility and Office Site Review

Initial office site visits occur before the credentialing decision.

7.7.2 Non-Compliance with Site Review Standards

KPNW established separate thresholds for office site standards and institutes actions for improvement with sites that don't meet thresholds. Sites that don't 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.

7.7 Accessibility Standards

Accessibility Standards for Medical Care	Standard
Preventive non-symptomatic care: including but not limited to well child visits, annual preventive screening visits, immunizations	30 calendar days
Routine, non-urgent symptomatic care for primary care: associated with the presentation of medical signs not requiring immediate attention	10 calendar days
Routine, non-urgent symptomatic care for specialty care: associated with the presentation of medical signs not requiring immediate attention	14 calendar days
Urgent medical care: associated with the presentation of medical signs that require immediate attention but are not life-threatening.	48 hours
Emergency medical care: services required for the immediate alleviation of acute pain or the immediate diagnosis and treatment of an unforeseen illness or injury. Prudent layperson applies.	Immediate Available 24/7
After-hours care	Available 24/7 by answering services or direct pager
Accessibility Standards for Behavioral Health Care	**Standard**
Routine office visits	14 calendar days
Urgent care: severe crisis that isn't life-threatening, including impaired ability to function in normal roles due to symptoms	Within 48 hours
Emergency (non-life threatening): severe crisis not life-threatening but with potential to become so without intervention	Within 6 hours
Emergency: patient's perception of life-threatening	Immediate
After-hours care	Available 24/7 by answering services or direct pager