

9. Quality Assurance and Improvement (QA & I)

9.1 Northern California Quality 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 to KP
- 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 the Member Services Contact Center at **1-(800) 464-4000** or **TTY: 711**. Additional information on KP’s Northern California Quality 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 our Members. Providers play a key role in the implementation and oversight of patient safety efforts.

At KP, patient safety is every patient’s right and everyone’s responsibility. As a leader in patient safety, our program is focused on safe culture, 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 large 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, KFHP 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 KFHP hospital are expected to adhere to TJC standards when practicing within the facility(ies). For further information visit: <http://www.jointcommission.org>.

9.2 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:

- Patient access to care
- Patient 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.

9.3 Provider Credentialing and Recredentialing

As an important part of KP's Quality Management Program, all credentialing and recredentialing 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 and recredentialing 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, licensed nurse midwives, behavioral health practitioners, acupuncturists and optometrists. Organizational Providers (OPs) include, but are not limited to, hospitals, SNFs, home health agencies, hospice agencies, 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.

9.3.1 Practitioners

KP requires that all practitioners within the scope of KP's credentialing program be credentialed prior to treating Members and must maintain credentialing at all times. 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 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 adverse decision regarding the practitioner's ability to treat Members, appeal rights will be granted in accordance with

applicable legal requirements and KP policies and procedures. The practitioner will be notified of those rights when 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.

9.3.2 Practitioner Rights

9.3.2.1 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 notice will state to whom, and in what format, to submit corrections.

9.3.2.2 Practitioner Rights to Review Information

Upon written request, and to the extent allowed by law, a practitioner may review information submitted in support of their 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 during which practitioners may review the file.

9.3.2.3 Practitioner Right 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:

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

9.3.2.4 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.

9.3.3 Organizational Providers (OPs)

KP requires that all OPs within the scope of its credentialing program be credentialed prior to treating Members and maintain credentialing at all times. 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

9.3.3.1 Corrective Action Plan or Increased Monitoring Status for OPs

Credentialing and recredentialing determinations are made by the KP 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.

9.4 Monitoring Quality

9.4.1 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.

9.4.2 Member Complaints

Written complaints 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 other requirements contained in your Agreement concerning the procedure for addressing specific complaints made by Members (either written or oral). If the problem is not amenable to immediate resolution at the point of service, the Member may submit a grievance. Refer to Section 7.5.3 for information on Member grievances.

9.4.3 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. 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.

9.4.4 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.

9.5 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.

9.5.1 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
- 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 patients
- Concerns regarding the possibility of failure to appropriately diagnose or treat a Member/patient
- 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

9.5.2 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.

9.5.3 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.

9.5.3.1 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) which results in a patient's 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 results in life-threatening bodily injury to an individual (including pain or disfigurement) that interferes with or results in loss of functional ability or quality of life and requires continuous physiological monitoring and/or surgery, invasive procedure, or treatment to resolve the condition.
- **Permanent Harm:** An event or condition that results 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

9.5.3.2 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
SNF	Care Coordinator	Within 24 hours
Transitional Residential Recovery Services (TRRS)	Care Coordinator	Within 24 hours

9.5.4 Sentinel Event/Reportable Occurrences—Home Health & Hospice Agency Providers

9.5.4.1 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 9.5.3.1) 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 email. The KP contact will notify the local KP Risk Management Department about all the reports.

- Falls resulting in death or serious injury

- Any unexpected death or any Member safety events resulting in severe, permanent or 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
- Severe permanent or temporary harm to a Member associated with the use of physical restraints or bedrails
- Member is a perpetrator or victim of a crime or of 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

9.5.4.2 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
- Medication administration 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

9.6 QA & I Reporting Requirements for Chronic Dialysis Providers

9.6.1 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
- 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

Providers must also submit the above information for patients who were on dialysis prior to joining KP.

9.6.2 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® or 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.

9.6.2.1 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

- 1' VAM services testing frequency
 - Transonic Flow QC System®—Monthly*
 - Another method of VAM approved by Governing Body or office of CMO
 - As otherwise prescribed by a Nephrologist
- 1' Graft flow > 600 ml/min—continue to test at monthly intervals and trend results
- 1' 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
- 1' If trends remain constant and are not decreasing, repeat the test at the scheduled time
- 1' Graft flow rate < 500 ml/min—refer for angiogram and evaluation

Fistula

- 1' VAM services testing frequency
 - Transonic Flow QC System®—Every other month*
 - Another method of VAM approved by Governing Body or office of CMO
 - As otherwise prescribed by a nephrologist
- 1' Fistula flow rate >400 ml/min—continue to test at monthly intervals and trend results.
- 1' 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.
- 1' 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.
- 1' 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.

The Provider performs access flow measurements at frequencies other than that outlined above under the following conditions:

- 1' After a surgical procedure to create a new vascular access
- 1' Within a week following an access intervention, including but not limited to, a fistulogram, de-clotting, angioplasty or a surgical revision
- 1' As ordered by a Nephrologist

9.6.3 Performance Target Goals/Clinical Indicators

9.6.3.1 Chronic Dialysis Patients

The following performance targets are the clinical indicators for hemodialysis and peritoneal dialysis KP Members and shall be reported by the Provider to KP within 15 Calendar Days from the end of the calendar quarter. The submission of the indicators shall be in a format acceptable to KP via an electronic file or other method designated by KP. Each contracted dialysis company must report the indicators on a quarterly basis for each of its participating dialysis centers in their Agreement:

REGIONAL RENAL ESRD QUALITY IMPROVEMENT PROGRAM DIALYSIS FACILITY SPECIFIC TARGETS			
MODALITY	MEASUREMENT	DESCRIPTION	TARGET
In-Center HD	Vascular Access	Percentage of patients in a given reporting period with a central venous catheter in place. If Fistula or Graft in use, but CVC in place, CVC will count as the highest risk access.	< 20%
		Adequacy of Dialysis	
	Positive Blood Cultures	Report all positive blood cultures according to NHSN guidelines	100% of known positive blood cultures are reported
PD	Adequacy of Dialysis	Percent of all patients at clinic whose last valid Kt/V of the month ≥ 1.7	$\geq 95\%$
	Peritonitis Rates	12-month rolling peritonitis rate	\leq to 0.33 episodes per patient year

9.6.4 DNBE/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 5.18.5 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 5.18.5) 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:

Regional Medical Services Contracting Department
Attn: Provider Services
5820 Owens Drive, 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 Medical Record Number (MRN)
- Date(s) of service
- Place of service
- Referral number or emergency claim number
- General category description of DNBE(s) experienced by the Member

9.7 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.

9.7.1 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:

- Copies 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

9.7.2 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

9.7.3 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

9.8 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.

9.8.1 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 DNBs
- Any CMS deficiency with a CAP or California Department of Public Health (CDPH) deficiency or citation with a CAP
- Reports to CDPH of unusual occurrences involving KP Members

9.8.2 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 patient 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 patients and family members
- For each visit: date, purpose and updated information
- Advance Directive

9.9 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: <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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
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.

9.10 Access and Availability Guidelines

Access to care is evaluated according to applicable law and regulation and considers responses to member satisfaction questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS), provider surveys, and Member complaints and grievances.

To assure all Members can access medical care in a safe and timely manner, KP utilizes access guidelines. KP's compliance with regulated access guidelines is measured by DHCS and/or DMHC through email or phone surveys conducted among contracted providers of professional services. Providers may be contacted by a regulator's third party contractor requesting information about available appointment times. HSAG/DataStat surveys providers on behalf of DHCS; Mazars surveys providers on behalf of DMHC. Results of such surveys are part of KP's QI Program because they help KP monitor our success in providing accessible care. In accordance with the Quality Assurance and Quality Improvement section of your KP Agreement (typically section 2.4.1 therein), Providers have an obligation to cooperate with KP's QI Program, including participation in phone surveys evaluating access to care.

Safe, efficient, and accessible practice sites are also essential components to delivering accessible, high quality care and services to Members. Facility standards are measured through KP office site reviews (for select Provider types). Results are used to inform KP quality improvement activities. Adhering to the guidelines in this section 9.10 increases access to care and overall Member satisfaction.

Access Indicator	Maximum Appointment/Response Timeframe
Primary Care Practitioners	
Preventive Gynecological Exam	7 Business Days
Non-urgent Care	7 Business Days
Routine/Preventive Care	7 Business Days
Behavioral Health Providers	
Urgent Care	Within 48 hours
Non-Urgent Care	Within 10 Business Days (therapist and any other non-physician treating providers) Within 15 Business Days (physician)
Routine Follow-Up (for Members undergoing a course of treatment for an ongoing mental health or substance use disorder condition)	Within 10 Business Days of the previous appointment (therapist and any other non-physician treating providers)
Specialists and Ancillary Services Practitioners	
Non-urgent symptomatic visit	14 Business Days. The timeframe begins on the day a referral is generated by the PCP and ends the day the patient is scheduled to see the specialist.
Routine Follow-Up	14 Business Days
ALL Providers	
Urgent care (non-life threatening, if left untreated could lead to harmful outcome)	Within 24 hours
Emergency care	Immediately
Wait times in physician's office	Less than 30 minutes. If an emergency occurs that will substantially lengthen a Member's waiting time, the office staff should inform the patient of the delay as soon as possible, and offer to: Reschedule appointments for Members if medically acceptable Have Members see another provider in the office if one is available, and the option is acceptable to the Member
Access to after-hours care	Continuous coverage must be available

Access Indicator	Maximum Appointment/Response Timeframe
Calls Placed to a Provider's	
During business hours	Returned same day the call is received
After business hours	Returned within 24 hours

Providers shall ensure covered services are available (i) during normal business hours, (ii) when medically indicated, on a prompt or same-day basis, and (iii) as otherwise specified in the Agreement, this Provider Manual or applicable laws. Providers shall ensure covered services are readily available and accessible to Members; provided in a timely manner, without delays in appointment scheduling and waiting times; and provided in a manner appropriate for the nature of a Member's condition, and consistent with good professional practice, KP policies and applicable laws. If it is necessary for Provider, a Commercial or Medi-Cal Member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the Member's health care needs, and ensures continuity of care consistent with good professional practice, and as otherwise required by applicable law.

If Provider provides covered services to treat Commercial or Medi-Cal Members who are undergoing a course of treatment for an ongoing mental health (including an autism diagnosis) or substance use disorder condition, Provider must offer follow-up appointments as follows, except as otherwise required or permitted by applicable laws:

- Nonurgent follow-up appointments with a nonphysician mental health care or substance use disorder Provider must be offered within 10 business days of the Member's prior appointment, except as otherwise permitted by law and as described in below. This requirement does not limit coverage for nonurgent follow up appointments with a nonphysician mental health care or substance use disorder provider to once every 10 business days.
- The 10 business day timeframe for a follow-up appointment may be extended if the referring or treating health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the Member.

When Members request same day or future appointments and their medical condition warrants, the appointment should be scheduled as close to the requested day and time as possible. If the Member does not request a specific day or time, an appointment within the time frames noted in the table above should be offered.

The applicable waiting time for an appointment may be extended if the KP referring or treating licensed health care provider, or the KP health professional providing triage or screening services to Members, as applicable, has determined that a longer waiting time

will not have a detrimental impact on the health of the Member. If any Member declines an appointment offered within these guidelines, or if the Provider, in consultation with the KP referring or treating health care provider, determines that a longer waiting time will not have a detrimental impact on the health of the Member, the declination or the professional determination and underlying clinical basis for a delayed appointment should be documented in the Member's medical record maintained by the treating Provider.

For inquiries regarding timeliness of referrals, providers should contact the KP office which issued the referral as noted in the authorization communication. If Members have inquiries regarding timeliness of referrals, Members may contact the Member Services Contact Center. If a Member's plan is regulated by the DMHC, the Member or a Provider may file a complaint with the DMHC regarding timeliness of referrals. Members can file a DMHC complaint as provided in Section 7.5.4, and Providers may file a complaint by contacting the DMHC's provider complaint line at **(877) 525-1295**.