KPCO Provider Manual

- Quality Assurance and Improvement
Providing quality care is our top priority. This section of the Manual was created to help guide you and your staff in working with Kaiser Permanente’s quality assurance and improvement (QI) policies and procedures. It provides a quick and easy resource with contact phone numbers, and detailed processes and site lists for QI Services.

If at any time you have a question or concern about the information in this section, you can reach our Quality Department by calling 303-344-7293.
# Section 8: Quality Assurance and Improvement (QI)

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1</td>
<td>Quality Assurance and Improvement Program Overview</td>
<td>4</td>
</tr>
<tr>
<td>8.2</td>
<td>Contact Information</td>
<td>6</td>
</tr>
<tr>
<td>8.3</td>
<td>Compliance with Regulatory and Accrediting Body Standards</td>
<td>7</td>
</tr>
<tr>
<td>8.4</td>
<td>Sentinel Events</td>
<td>7</td>
</tr>
<tr>
<td>8.5</td>
<td>Do Not Bill Events (DNBE)</td>
<td>8</td>
</tr>
<tr>
<td>8.5.1</td>
<td>Notification of Adverse Event to Kaiser Permanente</td>
<td>9</td>
</tr>
<tr>
<td>8.5.2</td>
<td>Claims Submission and Adjustments Related to a “Do Not Bill Event”</td>
<td>9</td>
</tr>
<tr>
<td>8.6</td>
<td>Quality Reports</td>
<td>10</td>
</tr>
<tr>
<td>8.7</td>
<td>Practitioner/Provider Credentialing</td>
<td>10</td>
</tr>
<tr>
<td>8.7.1</td>
<td>Credentialing and Re-credentialing Processes</td>
<td>12</td>
</tr>
<tr>
<td>8.7.2</td>
<td>Practitioner Notification of Status of Credentialing Application</td>
<td>13</td>
</tr>
<tr>
<td>8.7.3</td>
<td>Practitioner Right to Review and Correct Erroneous Information</td>
<td>13</td>
</tr>
<tr>
<td>8.7.4</td>
<td>Practitioners on Corrective Action Plan Status</td>
<td>13</td>
</tr>
<tr>
<td>8.7.5</td>
<td>Confidentiality of Credentialing Information</td>
<td>13</td>
</tr>
<tr>
<td>8.8</td>
<td>Peer Review</td>
<td>13</td>
</tr>
<tr>
<td>8.8.1</td>
<td>Fair Hearing Process</td>
<td>15</td>
</tr>
<tr>
<td>8.9</td>
<td>Monitoring of Practitioner Office Site Complaints</td>
<td>15</td>
</tr>
<tr>
<td>8.10</td>
<td>Compliance with Medical Record Requirements</td>
<td>15</td>
</tr>
<tr>
<td>8.11</td>
<td>Accessibility Standards</td>
<td>16</td>
</tr>
<tr>
<td>8.12</td>
<td>Non-Compliance Accessibility Standards</td>
<td>20</td>
</tr>
</tbody>
</table>
Section 8: Quality Assurance and Improvement (QI)

All Colorado Permanente Medical Group (CPMG) and non-CPMG (network/contracted) practitioners and providers are expected to participate in Kaiser Permanente’s Quality Oversight Program.

The goal of the Quality Oversight Program is to support and enact the vision and value proposition of the Kaiser Permanente Colorado Region: creating highly satisfied customers with superior health care value. Our Quality Oversight Program meets this goal by providing oversight of and direction for quality of care, patient safety, and risk avoidance throughout the region. The Program is responsible for evaluating the effectiveness of all aspects of care, including clinical quality, access to services, service quality, and utilization.

Kaiser Permanente’s Quality Oversight Program provides an ongoing systematic assessment of the care and service received by its members. This process is outlined in the Region’s Quality Program Description and is available upon request. If you would like a copy of the program description, please contact your Provider Representative at 1-866-866-3951.

The Quality Oversight Program is broad in scope and includes activities of structure, process and outcomes and encompasses service, quality, and patient safety. In addition to the quality and peer review processes, regional committees and clinical programs such as chronic disease management, risk management, resource management, service quality, infection control, member services, prevention, credentialing, and bioethics play a vital role in the program’s service, quality and resource management structure.

8.1 Quality Assurance and Improvement Program Overview

Wendee Gozansky, MD, Vice President, Chief Quality Officer, Colorado Permanente Medical Group, is the Colorado Permanente Medical Group (CPMG) physician with responsibility for Kaiser Permanente’s quality management and improvement activities within the Colorado Region. Dr. Gozansky is one of two chairs for the Regional Quality Oversight Committee (QOC). Dr. Gozansky partners with the Vice President of Quality and Safety. They are accountable to the Executive Medical Director of CPMG and the President of the Colorado Region, respectively. The President of the Colorado Region and the Executive Medical Director of CPMG are accountable to the National Quality Committee (NQC) and the Quality and Health Improvement Committee (QHIC), a sub-committee of the Kaiser Foundation Health Plan/Hospitals Boards of Directors.
The President of the Colorado Region and the CPMG Executive Medical Director have established the Regional QOC, a standing committee, to oversee the quality activities of the Region. The Regional QOC oversees service, quality, safety and resource management activities related to the Central, Metro, North and South Colorado service areas. Committee and sub-committee membership include those with authority to see that all areas of the organization are conducting service, quality and resource management activities and taking necessary actions to address all identified areas of concern. This structure of committees and all related activities is commonly referred to as Kaiser Permanente’s Quality Oversight Program.

The purpose of the Quality Oversight Program is the assurance of high quality and appropriate health care for all Health Plan members across all settings of care, including our affiliates, i.e., contract practitioners, hospitals, nursing homes, home health agencies, etc. Activities that support the Region’s Quality Oversight Program include, but are not limited to, review of:

- Clinical issues relevant to our population (regional clinical initiatives)
- Safety
- Morbidity and mortality
- Complications
- Adverse events
- Medication errors
- Service/satisfaction
- Credentialing/re-credentialing (both practitioners and providers)
- Health services contracting (which may result in documentation of a structured review of medical offices and medical record keeping practices)
- Practitioner and provider availability
- Accessibility (includes appointments and key elements of telephone service)
- Systems to improve the health status of our members with chronic conditions (case and disease management)
- Clinical practice guidelines
- Continuity and coordination of care
- Medical documentation systems
- Complaints about care and service
- Appeals
- Preventive health programs
- Business practices

Additionally, our program includes a process to coordinate, support and track retrospective review of occurrences throughout the region. If you have a thought, concern, or experience which suggests there may be a quality management issue, please contact the following to arrange a review:
- Dr. Jacqueline Jamison at 303-360-1095 and/or the
  Quality Department 303-344-7293

To protect your confidentiality, you will not be identified as the person originating the issue and because of confidentiality reasons; we are not allowed to share the results of the review with you. If you witness a high-quality encounter, please let the Quality, department know this as well. It will also be investigated and appropriately publicized. Results of these activities will be included, as appropriate, in the credentialing and re-credentialing/re-negotiations process.

8.2 Contact information

<table>
<thead>
<tr>
<th>Colorado Quality Leaders</th>
<th>Name/Title</th>
<th>Office Address</th>
<th>Office Phone</th>
<th>E-Mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wendee Gozansky, MD</td>
<td>VP and Chief Quality Officer</td>
<td>Regional Office 10350 East Dakota Avenue Denver, CO 80247</td>
<td>303-344-7525</td>
<td><a href="mailto:wendolyn.s.gozansky@kp.org">wendolyn.s.gozansky@kp.org</a></td>
</tr>
<tr>
<td>Jacqueline Jamison, MD</td>
<td>Physician Director of Quality and Peer Review</td>
<td>Regional Office 10350 East Dakota Avenue Denver, CO 80247</td>
<td>303-344-7867</td>
<td><a href="mailto:Jacqueline.H.Jamison@kp.org">Jacqueline.H.Jamison@kp.org</a></td>
</tr>
<tr>
<td>Susan Schreiner, MD</td>
<td>Regional Administrator for Quality</td>
<td>Regional Office 10350 East Dakota Avenue Denver, CO 80247</td>
<td>303-501-0586</td>
<td><a href="mailto:Susan.schreiner@kp.org">Susan.schreiner@kp.org</a></td>
</tr>
<tr>
<td>Janet Lucchesi</td>
<td>Director, Quality and Accreditation</td>
<td>Regional Office 10350 East Dakota Avenue Denver, CO 80247</td>
<td>303-344-7845</td>
<td><a href="mailto:janet.l.lucchesi@kp.org">janet.l.lucchesi@kp.org</a></td>
</tr>
<tr>
<td>Mary Jo Strobel</td>
<td>Director Clinical Quality</td>
<td>Regional Office 10350 East Dakota Avenue Denver, CO 80247</td>
<td>303-344-7540</td>
<td><a href="mailto:maryjo.strobel@kp.org">maryjo.strobel@kp.org</a></td>
</tr>
<tr>
<td>Patrick Kusek, MD</td>
<td>Medical Director, Southern Colorado</td>
<td>Co. Springs Administrative Office 1975 Research Pkwy, Suite 250 Colorado Springs, CO 80920</td>
<td>719-262-1522</td>
<td><a href="mailto:patrick.a.kusek@kp.org">patrick.a.kusek@kp.org</a></td>
</tr>
<tr>
<td>Diane Lanese, MD</td>
<td>Medical Director, Northern Colorado</td>
<td>Loveland Administrative Office 4850 Hahns Peak Drive #260 Loveland, CO 80538</td>
<td>303-788-1254</td>
<td><a href="mailto:diane.m.lanese@kp.org">diane.m.lanese@kp.org</a></td>
</tr>
</tbody>
</table>

If you have questions about the structure of our quality management activities or wish to provide comments about our program, please feel free to contact any of the above leaders. We value your input. If you wish to discuss or report clinical problems, please call any of the above individuals.

Other issues should be reported to your Provider Representative at 1-866-866-3951. The staff is available to address issues with affiliated (contracted) providers and
practitioners.

8.3 Compliance with Regulatory and Accrediting Body Standards

Kaiser Permanente participates in the National Committee for Quality Assurance (NCQA), Centers for Medicare and Medicaid Services, and National Quality Committee (NQC) for the review of activities in order to demonstrate Kaiser Permanente’s compliance to regulatory and accrediting bodies. In addition, KePRO, the designated Quality Improvement Organization (QIO) for Colorado, occasionally conducts quality reviews on Kaiser Permanente Medicare Advantage members*. The Colorado Department of Health Care Policy and Financing conducts reviews on our Medicaid members*. If you receive direct correspondence from either of these agencies, please notify our Regional Quality department so that we can help coordinate and expedite the review for you.

In accordance with these regulations, you are expected to provide to Kaiser Permanente, on an annual basis, measures of clinical quality, appointment access, member (patient) satisfaction survey results, as well as Healthcare Effectiveness Data and Information Set (HEDIS) data collection if applicable via access to your patient’s medical records for HEDIS medical record reviews. Also, in accordance with regulations, physicians are required to cooperate with QI activities. The organization may use Practitioner performance data for quality improvement activities.

Kaiser Permanente expects all of its Participating Providers to have and maintain appropriate accreditation/certification, to be in compliance with all regulatory bodies (i.e. CMS), and to maintain a current Certificate of Liability Insurance. If you receive any recommendations from these organizations, please provide to Kaiser Permanente along with the surveys’ recommendations and the action plan to resolve the identified issue or concern. You may contact our Quality Department at 303-344-7293.

Kaiser Permanente monitors the status of the above listed accreditations, on an annual basis through Kaiser Permanente’s Regional Compliance Department at 303-344-7672.

8.4 Sentinel Events

Some patient events are called “sentinel” because they signal the need for immediate investigation and possible response. Sentinel events can occur any time health care services are provided by Kaiser Permanente and can occur in medical office buildings, KPCO ambulatory surgery centers, skilled nursing facilities, contracted and non-contracted hospitals, etc. Occurrences involving a Kaiser Permanente member defined as a sentinel event are those that result in death, permanent harm, or severe temporary
harm not related to the natural course of the patient’s illness of underlying condition. Sentinel events meet the criteria as defined by the National and Regional Sentinel Event Policy and require IMMEDIATE notification to Kaiser Permanente in accordance with Kaiser Permanente’s policy. A fully copy of the policy and the process for reporting sentinel events is available by contacting Kaiser Permanente’s Regional Risk Management Incident line at 303-344-7298.

All sentinel Event reports are considered confidential and privileged quality/peer review documents.

8.5 Do Not Bill Events (DNBE)

It is Kaiser Permanente’s policy to waive the fees for all or part of the health care services directly related to the occurrence of certain events, referred to as “Do Not Bill” (DNBEs). 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. The “Do Not Bill Event” policy applies to all claims for all KP Members and Patients.

Surgical “Do Not Bill Events” include but may not be limited to 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; and
- Unintended retention of a foreign object after surgery or procedure, except when the risk of removal exceeds the risk of retention (upon retention of a foreign object, the procedure giving rise to the retention is nor a DNBE. However, if medically indicated, the removal of the object may be a DNBE.

Hospital-Acquired Conditions include a condition or event that occurs in a general hospital or acute care setting include but may not be limited to:
- Intravascular air embolism that occurs while being cared for in a health care facility;
- 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 (fractures, dislocations, intracranial injuries, crushing injuries, burns, electric shock);
- Manifestations of poor glycemic control: diabetic ketoacidosis, nonketotic hyperosmolar coma, hyperglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity;
• Surgical site infections following certain elective procedures; including certain orthopedic surgeries (Spine, neck, shoulder, elbow) and bariatric surgery for obesity (Laparoscopic Gastric Bypass, Gastroenterectomy, Laparoscopic Gastric Restrictive Surgery);
• Deep vein thrombosis; or pulmonary embolism following total knee replacement and hip replacement procedures;
• Vascular-catheter associated infection;
• Catheter associated urinary tract infection; and
• Mediastinitis after coronary artery bypass grafting
• Any other HACs added by CMS at a later date will be evaluated for inclusion in the policy.

8.5.1 Notification of Adverse Event to Kaiser Permanente

Providers should notify the Health Plan when an adverse event, “Do Not Bill Event” or unexpected condition adversely impacting a Member is discovered by contacting the Kaiser Permanente Risk Management Incident line at 303-344-7298. This number is not intended for member use. Kaiser Permanente members should be directed to contact the Member Services Call Center at 303-338-3800 or 1-800-632-9700.

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

A participating Hospital/Facility must include “Present on Admission” indicators on all Member claims. Providers should ensure that their billing staff is aware when a “Do Not Bill Event” involving a Member’s care has occurred prior to submitting the claim to Kaiser Permanente for processing.

When a “Do Not Bill Event” is recognized prior to 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)
➢ Additionally, the UB-04 or CMS 1500 form should reflect all service 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 impacted Member may not be balanced billed for any services related to a “Do Not Bill Event”.

Kaiser Permanente Colorado Provider Manual - 2019
8.6 Quality Reports

For Kaiser Permanente and the participating provider to be in compliance with accrediting and regulatory bodies, various reports must be generated to track any quality issues. Prior to report generation, investigations into the quality of care in specific individual cases, called Peer Review Event review, can be generated by a variety of sources including, but not limited to, the following:

- Allegations of professional negligence (formal or informal)
- Member complaints/grievances related to quality of care
- Risk Management referral (Significant Events, Potentially Compensable Events or Do Not Bill Events)
- Physician concern (Colleague, Specialty consultant, Primary care, Affiliated provider, External (non-plan)
- Staff concern
  - Infection Control
  - Other Quality Monitoring
  - Infection Control
  - Ambulatory Surgery Occurrence Review
  - Patient Safety Review
  - Other occurrence review (e.g. contract hospital)
- Regulatory Concern
- Hospital concerns

8.7 Practitioner/Provider Credentialing

To ensure the quality of practitioners/providers who treat Kaiser Permanente Members, Kaiser Permanente Colorado (KPCO)/Colorado Permanente Medical Group (CPMG) credentials or provides oversight of the credentialing function for all participating practitioners/providers and ensures that credentialing is conducted in a non-discriminatory manner. All participating practitioners/providers must be fully credentialed and “approved to participate” before treating Kaiser Permanente Members.

Practitioners

The credentialing process is a formal system designed to query, verify, investigate, track and report all information regarding the competency of any preferred practitioner. Preferred practitioners are those health care practitioners who have contracts with KPCO to provide health care services to Kaiser Foundation Health Plan members. The credentialing system is designed to ensure that all preferred practitioners and all licensed independent practitioners or other professional health care practitioners under
contract with KPCO/CPMG are qualified, appropriately educated, trained and competent practitioners and are able to deliver health care according to KPCO prevailing standards of care and all appropriate applicable state and Federal regulatory agency guidelines to ensure high quality of care and patient safety. The credentialing process follows applicable accreditation agency guidelines, such as those set forth by the National Committee for Quality Assurance (NCQA).

Providers
Preferred providers are those institutions (hospitals, skilled nursing facilities, home health agencies, freestanding ambulatory surgery centers and behavioral healthcare centers, etc.) that are contracted with CPMG and/or KFHP to provide services to members. Kaiser Permanente Colorado (KPCO) region evaluates its preferred providers by the same high standards of care and service and expects the same level of care and service that its own medical offices and network of CPMG practitioners provide.

KPCO maintains policies and procedures for the initial/recredentialing and ongoing assessment of these providers. This process includes at a minimum, confirmation that the provider is in good standing with both state and Federal regulatory bodies. The Federal sanctioned and debarred/opt out list is checked routinely and prior to credentialing or re-credentialing any provider or practitioner. This is to ensure that a provider or practitioner that has opted out, been debarred, or sanctioned by a government health program, e.g. Medicare, does not provide clinical services to members or patients. The process also includes that the provider has been reviewed and approved by an accrediting body surveyed by the Centers for Medicare and Medicaid (CMS) or the Colorado Department of Public Health and Environment at least every 36 months. In situations where the provider has not been reviewed and approved by an accrediting body, or surveyed by CMS or the State of Colorado, Kaiser Permanente (KP) conducts a site visit to credential or re-credential the provider. If a site visit is required, the site visit should be scheduled at least three (3) months in advance of the re-credentialing date to allow time for any necessary corrective action. KPCO staff and clinicians conduct the site visit based on specific guidelines outlined below.

Evaluation for the site visit is accomplished using systematic methodology to measure current levels of care and service, identify opportunities for improvement and establish accountability for implementation of needed changes. Components of care and service may include (but are not limited to):

- Leadership/Governance
- Facility/office structure and safety
- Quality improvement systems and processes
- Resource stewardship/utilization management, systems, and processes
• Risk Management
• Patient Safety
• Infection Control policies/procedures
• Credentials management
• Medical record keeping practices
• Effectiveness and continuity of care
• Availability
• Customer satisfaction, including member complaints
• Committee participation
• Data and data systems, regulatory compliance as appropriate

When all documentation, verifications, and site visit results are obtained, the designated KFHP and CPMG management leaders determine if the organization meets KPCO standards for participation as an organizational provider. If the practitioner office site or provider scores less than 85 percent on their site review, a corrective action plan may be requested (with response within 30 days), a re-audit is done in 60 days for compliance or the re-audit is performed every six (6) months until the practitioner office site or provider achieves or exceeds this goal.

8.7.1 Credentialing and Re-credentialing Processes

Initial credentialing and recredentialing are part of the preferred practitioner/provider contract process. Recredentialing of a preferred practitioner occurs at least every 36 months. Kaiser Permanente Colorado/Colorado Permanente Medical Group requires all preferred practitioners to be board certified in the specialty listed as primary specialty. At least every 36 months, each practitioner completes, signs, and dates a recredentialing application including an attestation of its correctness and completeness. The recredentialing process includes the collection and/or reverification of the credentialing information originally verified, as applicable. The information is again verified from primary sources. Kaiser Permanente Colorado/Colorado Permanente Medical Group Credentials Committee oversees all credentialing and/or recredentialing activities and ensures that credentialing is conducted in a non-discriminatory manner.

Any physician or professional health care practitioner who joins an existing contracted medical service group will be credentialed and recredentialed according to the credentialing policies set forth by KPCO/CPMG before they render services to Kaiser Foundation Health Plan members. All credentialing policies and procedures are available upon request by calling the Credentialing Department at 303-344-7543.
8.7.2  **Practitioner Notification of Status of Credentialing Application**

A practitioner has the right, upon request, to be informed of the status of his/her application. Please contact the Credentialing Department at 303-344-7543 should you need to receive a status update on your application.

8.7.3  **Practitioner Right to Review and Correct Erroneous Information**

The preferred practitioner must produce information for an adequate evaluation of the practitioner’s qualifications and suitability and must resolve any reasonable doubts about clinical or character matters by satisfying requests for further information. Such information is considered confidential. The preferred practitioner’s failure to provide this information within 30 calendar days of the date of notification, may be grounds for discontinuing contract negotiations or termination of contract privileges. Credentialing information containing misrepresentations or omissions may be grounds for discontinuing contract negotiations or termination of contract privileges. Where permitted by law, the practitioner may review, and authorized persons may have access to the application, with the exception of references or other information determined to be inaccessible to the practitioner. Also, where appropriate, the practitioner may correct erroneous information.

8.7.4  **Practitioners on Corrective Action Plan Status**

The Federal sanctioned and debarred/opt out list is checked routinely and prior to credentialing or re-credentialing any practitioner/provider. This is to ensure that a practitioner/provider that has opted out, been debarred, or sanctioned by a government health program does not provide clinical services to members. Additionally, at the time of re-credentialing, member complaints and peer review events pertaining to the practitioner/provider are reviewed. Any sanctions, debarred, quality of care or complaints that render a quality issue may be grounds for corrective action or termination.

8.7.5  **Confidentiality of Credentialing Information**

The credentialing database is password protected, and passwords are only issued to personnel who have signed a confidentiality agreement.

8.8  **Peer Review**

Kaiser Permanente maintains a peer review process to promote and monitor credentialing, quality patient care, member satisfaction, member complaints and administrative compliance with policies, procedures, rule and practices for all
Participating Practitioners.

Kaiser Permanente has established thresholds for performance measures which include but are not limited to the following key areas:

1. Member Satisfaction Measures  
2. Quality Measures  
3. Member Complaints and Grievances  
4. Referral Measures  
5. Utilization Measures  
6. HEDIS/NCQA  

Peer Review is a confidential, statute protected process by which health care professionals evaluate each other’s clinical performance to improve the quality and safety of care. The peer review process determines whether the standard of care was met and identifies opportunities for improvement at the practitioner and system level. All potential quality of care concerns are reviewed by Quality Review Coordinators (Registered Nurses) and if met established criteria they are forwarded to the Colorado Permanente Medical Group (CPMG) Physician Director of Quality and Peer Review. They may be sent for additional peer review to a CPMG primary care or specialty care peer review committee. If an opportunity for improvement is identified, the practitioner and their supervisor are notified. The entire peer review process and its conclusions are confidential, but trended information may be used in credentialing and annual performance review.

Physicians who have a contract with CPMG and disagree with a peer review finding may request a second review and can appeal the decision through this review process. Kaiser Permanente is committed to fairness in the implementation of these processes if an adverse action is imposed.

An Executive Leadership Team of CPMG, may conduct professional reviews of any credentialed practitioner pursuant to Colorado law. There is a review process to assess whether the practitioner in question is lacking in qualifications, has any Medicare or Medicaid sanctions or limitations on licensure, has complaints or provided substandard or inappropriate patient care identified through adverse events, or has exhibited inappropriate professional conduct. Restrictions of the practitioner’s privileges, up to temporary suspension and including termination of such contract are possible consequences. Any terminations with cause related to quality of care issues will be reported to the Colorado Medical Board (CMB) and the National Practitioners Data Bank (NPDB), as required by Federal and State laws. Any reportable adverse action for quality may be appealed as described in Section 8.8.

Subject to disclosure required by law, such proceedings shall be confidential.
Notification of final findings is communicated to the effected practitioner, including the appeal process.

In addition, the CPMG Board of Directors has defined an impaired physician as a physician whose professional performance has become unreliable by reason of substance abuse (alcohol or drugs) or mental impairment. Pursuant to Colorado law, CPMG has the following policy (5.11 in the Staff Manual) that includes four elements relating to impaired physicians:

- Reporting
- Action
- Merit
- Treatment

Failure to comply with any part of the prescribed treatment in such a program may result in the contract physician’s termination. CPMG encourages physicians to seek help if needed and to report any potential problem. For more details about these subjects, please contact our Quality Department at 303-344-7293.

8.8.1 Fair Hearing Process

CPMG extends those affiliate providers that it credentials the same fair hearing rights as extended to CPMG providers in the case of an adverse action for quality of care that may be reportable to the NPDB. These fair hearing rights are described in the “CPMG Staff Manual Policy 4.04 - Professional Review” which can be accessed through the below link.

http://www.providers.kaiserpermanente.org/html/cpp_cod/providerinfotoc.html?

8.9 Monitoring of Practitioner Office Site Complaints

The quality of practitioner office sites is measured by environmental patient safety complaint criteria. Practitioner offices which exceed the threshold of three complaints in any one category will trigger a review of the individual environmental complaint and a subsequent site visit. The required site visit will address physical accessibility, physical appearance, and adequacy of waiting and exam room spaces and be performed within 60 calendar days of the complaint threshold being met.

8.10 Compliance with Medical Record Requirements

Medical record documentation is developed and maintained for the primary purpose of fostering continuity of patient care and is a means of communication among health care practitioners treating the patient now and in the future.
Providers and other health care practitioners are expected to comply with Article 6 (Records and Confidentiality) and Exhibit 6 (Federal Program Compliance) of their Agreements with Kaiser Permanente. Integrity and security need to be documented and in practice to ensure compliance with applicable laws, regulations and standards. In addition, annual training of staff concerning the confidentiality and handling of patient information is expected.

Integrity and security need to be documented and in practice to ensure compliance with applicable laws, regulations and standards. In addition, annual training of staff concerning the confidentiality and handling of patient information is expected.

### 8.11 Accessibility Standards

Kaiser Permanente assesses Primary Care and selected Specialty Care physician appointment availability annually to ensure timely access to our practitioners. In summary, appointment availability is assessed for the following:

<table>
<thead>
<tr>
<th>Access Requirements</th>
<th>Standards</th>
<th>2018 Goals</th>
<th>Methods of Measurement</th>
<th>Dates of Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Regular and Routine Care Appointments** | Regional: *Average Days Wait (ADW) for NEW visit types (excludes follow-up visits, physicals and procedures): less than or equal to 3 days*  
                      |           | Integrated Group Model: *Average Days Wait (ADW) for NEW visit types: less than or equal to 3 days*  
                      |           | KPCO Internal Goal: *Routine appointments within 3 calendar days 70% of the time*  
                      |           | Affiliated Network Model: *90% of regular/routine care appointments are within 7 calendar days*  
                      |           |                        | Affiliated Network Model: Survey incorporating self-reported data from the practitioners  
                      |           |                        | Integrated Group Model: Clarity Reports (EPIC relational database)  
                      |           |                        | Patient Satisfaction Survey: Patient Satisfaction with appointment access and scheduling. Time from call to seen is also measured.  
                      |           |                        | Affiliated Network Model and Integrated Group Model: Analysis of complaints in Access category  
                      |           |                        | Affiliated Network Model: Monitored annually  
                      |           | Integrated Group Model: *All patients presenting to Urgent Care are seen same-day (i.e. within 24 hours).*  
                      |           | Affiliated Network Model: Analysis of Complaints  
                      |           | Affiliated Network Model: Monitored at least annually  
| **Urgent Care**      | Regional: *100% of walk-in patients seen during hours of operation*  
                      | Integrated Group Model: *100 percent*  
                      | Affiliated Network Model: *100 percent within 24 hrs*  
|                      | Integrated Group Model: *All patients presenting to Urgent Care are seen same-day (i.e. within 24 hours).*  
                      | Affiliated Network Model: Analysis of Complaints  
<p>|                      | Affiliated Network Model: Monitored at least annually  |</p>
<table>
<thead>
<tr>
<th>Access Requirements</th>
<th>Standards</th>
<th>2018 Goals</th>
<th>Methods of Measurement</th>
<th>Dates of Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>After-Hours Care</td>
<td>Integrated Group Model: Availability of RN and MD providers for advice</td>
<td>Integrated Group Model: Maintain an average speed of answer for urgent incoming calls at 60 seconds or less, 80 % of time and an abandonment rate of less than 5%. Nurse Advice Line (NAL) availability 24/7 hours per day.</td>
<td>Integrated Group Model: Genesys Call Management System – service level, average speed of answer, abandonment rate.</td>
<td>Integrated Group Model: Continuously Monitored – daily, weekly and monthly performance reports.</td>
</tr>
<tr>
<td></td>
<td>and/or triage 24/7 at the Appointment and Advice Contact Center.</td>
<td></td>
<td>Nice recording system – monitor quality of processes and outcomes.</td>
<td>Affiliated Network Model: Monitored continuously through member complaints.</td>
</tr>
<tr>
<td></td>
<td>Affiliated Network Model: Availability of practitioners 24 hours, seven</td>
<td>Affiliated Network Model: 100% available immediately.</td>
<td>Affiliated Network Model: Analysis of Complaints Survey incorporating self-reported data from the practitioners.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>days a week via telephone access.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member Services Telephone Lines</td>
<td>Regional: 80 percent of calls answered within 120 seconds &lt; 3 percent</td>
<td>Regional: Genesys Call Management System – measures call volume, service level, average speed of answer, abandonment rate.</td>
<td></td>
<td>Regional: Monitored Continuously</td>
</tr>
<tr>
<td>Member Services Department</td>
<td>abandonment rate.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Regional: % of calls answered within 120 seconds &lt; 3 percent abandonment</td>
<td>Regional: Genesys Call Management System – measures call volume, service level, average speed of answer, abandonment rate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>rate.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>Life Threatening and Non-Life-Threatening Emergencies: NCQA: Within 6</td>
<td>Denver/Boulder Service Area Study that measures the difference between the time the member calls and the time the member has access to a behavioral health clinician. Sample of 4-week timeframe.</td>
<td>Denver/Boulder Service Area: Delegated arrangement with Beacon Health Options (BHO), an NCQA accredited MBHO.</td>
<td>Denver/Boulder Service Area: Delegated arrangement with BHO, an NCQA accredited MBHO.</td>
</tr>
<tr>
<td></td>
<td>hours.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Southern, Northern, and Mountain Colorado Service Area: Delegated</td>
<td>Southern, Northern and Mountain Colorado Service Area: Delegated arrangement with Beacon Health Options (BHO), an NCQA accredited MBHO.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>arrangement with Beacon Health Options (BHO), an NCQA accredited MBHO.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access Requirements</td>
<td>Standards</td>
<td>2018 Goals</td>
<td>Methods of Measurement</td>
<td>Dates of Measurement</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------</td>
<td>------------</td>
<td>------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Routine Office Visit</td>
<td>NCQA;</td>
<td>Denver/Boulder Service Area: Average number of days for a routine initial appointment w/ therapist or psychiatrist is 14 calendar days (10 business days) or less.</td>
<td>Denver/Boulder Service Area: Computerized Appointment System – measured as the average number days from date of appt request to the date of appointment. Changes in the accessibility measure are also compared with patient satisfaction with accessibility to services and complaint data. Northern Colorado: BHO measures patient access to the same NCQA standard through both survey results for access and validates that data through patient satisfaction and complain and appeals data. This practice meets NCQA standards. South and Mountain Colorado Service Area: Delegated arrangement with BHO, an NCQA accredited MBHO.</td>
<td>Denver/Boulder Service Area: Monitored Monthly Northern Colorado: Data is gathered on an ongoing bases and evaluated quarterly as reported to NCQA. Southern and Mountain Colorado Service Area: Delegated arrangement with BHO, an NCQA accredited MBHO.</td>
</tr>
<tr>
<td>Access Requirements</td>
<td>Standards</td>
<td>2018 Goals</td>
<td>Methods of Measurement</td>
<td>Dates of Measurement</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------</td>
<td>------------</td>
<td>------------------------</td>
<td>----------------------</td>
</tr>
</tbody>
</table>
| **Follow-Up Routine Care** | NCQA Requirement, Organization Sets the Timeframes:  
Southern Colorado Service Area:  
Beacon Health Options Mental Health 30 days 100% of the time. Psychiatry 90 days 100% of the time. | Denver/Boulder Service area:  
Chemical Dependency 14 days 75% of the time. Mental Health 21 days 70% of the time. Psychiatry 40 days 65% of the time.  
Southern and Mountain Colorado Service Area:  
Delegated arrangement with BHO, an NCQA accredited MBHO. | Denver/Boulder Service Area:  
Computerized Appointment System – measured as the average number days from date of appt request to the date of appointment.  
Changes in the accessibility measure are also compared with patient satisfaction with accessibility to services and complaint data.  
Northern Colorado service area:  
Routine follow-up rates are based on claims. The denominator includes all members with a claim for an intake appointment. The numerator includes members who had a claim for a follow-up service within 90 days of the intake for prescribers and within 30 days of the intake for non-prescribers. | Denver/Boulder Service Area:  
Monitored Monthly  
Northern Colorado: Data is gathered on an ongoing basis and evaluated quarterly as reported to NCQA.  
Southern and Mountain Colorado Service Area:  
Delegated arrangement with BHO, an NCQA accredited MBHO. |
| **Telephone Service for Screening and Triage** | NCQA: Telephones answered within 30 seconds with < 5 percent abandonment rate.  
Southern and Mountain Colorado Service Area:  
Delegated arrangement with BHO, an NCQA accredited MBHO. | Denver/Boulder and Northern Service Area:  
Currently does not have Centralized Screening and Triage.  
Southern and Mountain Colorado Service Area:  
Delegated arrangement with BHO, an NCQA accredited MBHO. | Denver/Boulder and Northern Service Area:  
Currently does not have Centralized Screening and Triage.  
Southern and Mountain Colorado Service Area:  
Delegated arrangement with BHO, an NCQA accredited MBHO. | Denver/Boulder and Northern Service Area:  
Currently does not have Centralized Screening and Triage.  
Southern and Mountain Colorado Service Area:  
Delegated arrangement with BHO, an NCQA accredited MBHO. |
### Specialty Care: Medical and Surgical specialties

<table>
<thead>
<tr>
<th>Access Requirements</th>
<th>Standards</th>
<th>2018 Goals</th>
<th>Methods of Measurement</th>
<th>Dates of Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Urgent Office Visit</td>
<td>Regional: Within 14 days</td>
<td>Regional: 90% of patients booked within 14 days.</td>
<td>Integrated Group Model: Computerized Appointment System – calculated using the booked date and the appointment date.</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Affiliated Network Model: 90% of patients booked within 14 days.</td>
<td>Affiliated Network Model: Survey incorporating self-reported data from high-volume practitioners. Analysis of complaints.</td>
<td>Annually</td>
</tr>
</tbody>
</table>

#### 8.12 Non-Compliance Accessibility Standards

Kaiser Permanente Colorado continuously measures its performance against the established standards and goals to identify opportunities for improvement. When an opportunity for improvement has been identified, Kaiser Permanente Colorado will implement an action plan to correct any deficiency.