Kaiser Permanente Colorado Provider Manual

- **Quality Oversight and Improvement**

Section 8: Quality Oversight and Improvement

INTRODUCTION

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 oversight 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 303-587-7056.

TABLE OF CONTENTS

SECTION 8: QUALITY OVERSIGHT AND IMPROVEMENT (QI)

All Colorado Permanente Medical Group (CPMG) and non-CPMG (network/contracted) practitioners, providers, and vendors are expected to participate in Kaiser Permanente's Quality Oversight Program. This includes collaboration and active participation on accreditation metrics, sharing of performance metrics, mitigation of performance through process improvement activities and monitoring for sustainability.

The goal of the Kaiser Permanente Quality Oversight Program is to support seamless care delivery throughout the Colorado region, across Kaiser Permanente and its contracted partners, affiliates, and vendors. The Kaiser Permanente Colorado's (KPCO) Quality Oversight Program meets this goal by providing a structured, thoughtful approach to clinical care delivery and quality oversight across departments, clinics, partners, and the region, resulting in an integrated system of care that is more connected and has safer outcomes. The KPCO Quality Oversight Program oversees the effectiveness of clinical care delivery, including clinical quality, access to services, service quality, and safety.

The ***Clinical*** Quality Oversight Program is a component of the broader KPCO Quality Oversight Program. The Clinical Quality Oversight Program is comprised of quality oversight program specialists, each with a defined portfolio of work spanning both internal and external care delivery services, programs, and venues across the continuum of care. Each portfolio has been carefully designed to provide both depth and breadth of clinical quality oversight coverage across the care continuum. Care delivery partners and affiliates will have a designated quality oversight program specialist assigned to the partnership, based on the type of care being provided to Kaiser Permanente Members. Kaiser Permanente Colorado's Quality Oversight Program and Clinical Quality Oversight Program provides 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.

8.1 QUALITY OVERSIGHT AND IMPROVEMENT PROGRAM OVERVIEW

The purpose of Kaiser Permanente Colorado's Quality Oversight Program is to assure high quality, safe and appropriate health care, delivered in a culturally responsive manner for all Kaiser Permanente Members across all settings of care, whether at a KP or a contracted partner facility. Health care quality access involves care, service, patient safety and cost-effective utilization, as well as business practices that support patient care delivery. The Quality Program requires integration into clinical operations structure, systems, and processes.

Kaiser Permanente's Quality Strategy is guided by the Institute of Medicine's Six Aims for Improvement:

- Safe Care: Prevents harm associated with health care for both patients & providers.
- Effective Care: Provides care based on the best available scientific knowledge.
- Person-Centered Care: Respects Members as partners in care decisions and efforts to improve patient care and experience
- Timely Care: Provides access to care that meets Member needs and ensures the right care at the right time.
- Efficient Care: Achieves top-quality outcomes through evidence-based clinical practices that reduce waste and promote efficiency.
- Equitable Care: Provides personalized and inclusive care for all Members & patients.

The Kaiser Permanente Quality Program's leadership team and organizational structure recognize the importance of walking alongside our contracted partners and developed our program with quality care delivery in mind.

8.1.1 A Leadership Team Focused on Quality

Colorado Permanente Medical Group (CPMG) Vice President and Chief Quality Officer and our VP of Quality and Safety co-chair our Regional Quality Oversight Committee (QOC). The committee is responsible for Kaiser Permanente quality management and improvement activities within the Colorado Region. Together, 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 Kaiser Permanente National Quality Committee (KPNQC) and the Quality and Health Improvement Committee (QHIC), a sub-committee of the Kaiser Foundation Health Plan/Hospitals Boards of Directors.

The Regional QOC oversees clinical quality, service quality, access, and safety across the KPCO region. Committee and sub-committee membership includes those with authority to see that all areas of the organization are taking necessary actions to address all identified areas of concern. This structure of committees and all related activities are commonly called Kaiser Permanente Colorado's Quality Oversight Program.

The purpose of the Quality Oversight Program is the assurance and oversight of high quality and appropriate health care for all Health Plan Members across all care settings, including our affiliates, i.e., contracted practitioners, hospitals, post-acute care facilities, and home health agencies, etc. The Quality Oversight program also provides oversight for vendor partners who provide services and products to KPCO Members.

Activities that support the Region's Quality Oversight Program include, but are not limited to, the review of:

- Regional Clinical Quality and/or Safety initiatives
- Process improvement activities related to clinical care delivery
- Continuum of Care improvement
- Patient and Provider Safety
- Behavioral and Mental Health
- Complications
- Review and cause mapping of adverse events
- Medication errors
- Morbidity and mortality
- Member service and satisfaction
- Credentialing/re-credentialing (both practitioners and health delivery organizations)
- 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

8.1.2 Business Practices

All our affiliate providers are expected to participate in Kaiser Permanente's Colorado Affiliate Collaborative visits and share performance metrics. These are to transform affiliate relations from a payer to one of partnership by maintaining a regular dialog to establish true alignment and collaboration throughout the care continuum. The Affiliate Collaborative is also intended to satisfy compliance with CMSFDR (First tier, Downstream and Related Entities) annual reporting and attestation requirements.

The meeting objectives are as follows:

- Maintaining an open line of communication to solidify the relationship between the

affiliate partner and Kaiser Permanente
- Establishing alignment with regards to patient clinical quality, safety, access, and service outcomes
- Ensuring KP Members cared for in affiliate practices have a favorable care experience
- Providing a forum to share best practices, successes, and opportunities for improvement.

Also, 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: **Quality Department 303-587-7056**

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. Your report will be investigated and appropriately publicized.

The results of these activities will be included, as appropriate, in the credentialing and re-credentialing/re-negotiations process.

8.2 CONTACT INFORMATION

Colorado Quality Leaders			
Name/Title	**Office Address**	**Office Phone**	**E-Mail**
Wendee Gozansky, MD VP and Chief Quality Officer	Regional Office 10350 East Dakota Avenue Denver, CO 80247	303-344-525	Wendolyn.S.Gozansky@kp.org
Susan Schreiner, RN MS CPHQ Regional Quality/Safety Leader (Interim)	Regional Office 10350 East Dakota Avenue Denver, CO 80247	303-501-0596	Susan.Schreiner@kp.org
Deanna McQuillan, Sr. Director of Quality CPMG	Regional Office 10350 East Dakota Avenue Denver, CO 80247	303-283-2511	Deanna.B.McQuillan@kp.org
Brant Odland, DO Physician Director of Quality and Peer Review	Regional Office 10350 East Dakota Avenue Denver, CO 80247	303-344-7867	Brant.x.Odland@kp.org
Denise Braegger Sr. Director, Risk & Integrated Safety	Regional Office 10350 East Dakota Avenue Denver, CO 80247	720-491-8923	Denise.E.Braegger@kp.org
Robin Beagle Director, Accreditation,	Regional Office 10350 East Dakota Avenue	206-327-2431	Robin.E.Beagle@kp.org

Regulatory & Licensure	Denver, CO 80247		
Mary Jo Strobel Director, Clinical Quality Oversight	Regional Office 10350 East Dakota Avenue Denver, CO 80247	303-344-7540	MaryJo.Strobel@kp.org
Beth Champlin Director of Regional Credentialing	Regional Office 10350 East Dakota Avenue Denver, CO 80247	303-519-8508	Beth.A.Champlin@kp.org

If you have questions about the structure of our quality management activities or wish to provide comments about our program, then 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 individuals above.

Other issues should be reported to your Provider Representative on 1-866-866-3951, who will be able 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 (CMS), and Kaiser Permanente National Quality Committee (KPNQC) for the review of activities 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 or more often as applicable/necessary, 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 its Participating Providers to have and maintain appropriate accreditation/certification, to comply 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 them 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 303-587-7056.

Kaiser Permanente monitors the status of the above-listed accreditations, on an annual basis through Kaiser Permanente's Regional Compliance Department at CO-ComplianceDepartment@kp.org.

8.4. SENTIMENTAL AND ADVERSE EVENTS

The Kaiser Foundation Health Plan of Colorado, Inc. (KPCO) is committed to improving care through continuous learning. Incident and sentinel event reporting is an important part of error prevention. KPCO learns from patient safety events to promote system education, initiate process improvement, and prevent and mitigate healthcare errors. This provision outlines the tenets of the KPCO incident and sentinel event reporting criteria that will result in the best patient outcomes.

8.4.1 Types of Disputes – Definitions

Adverse Event: A patient safety event that resulted in harm to a patient. A subcategory of Adverse Events is a Patient Safety Event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- Death
- Permanent Harm
- Severe Temporary Harm

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

Sentinel Event: A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe temporary harm.

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

- Suicide of any patient receiving care, treatment, or services in a staffed around-the-clock care setting or within 72 hours of discharge, including rom the organization's emergency department;

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

Procedure to Report:

- Timely and comprehensive event reporting is key to driving a just patient culture. Organizations are expected to report all events within 48 hours of knowledge.
- All adverse events, patient safety events, and sentinel events shall be phoned to the KPCO Risk Management Patient Safety Department. The telephone number is (303) 344-7298.

Response to Events:

- Equipment involved in a Patient Safety Event shall be tagged and sequestered.

Tubing or disposable products shall be kept with the equipment. Until a joint decision is made to release the equipment, the equipment involved shall not be used, cleaned, or disturbed.

- Any event that involves criminal behavior, police or security investigation should be immediately phoned to Patient Safety and Risk Management.

Sentinel Event/Significant Event Root Cause Analysis Framework:

- Site leadership will provide a risk management contact.
- A cause analysis team shall first review the event within three working days of its notification. A thorough and credible root cause analysis and action plan should be completed within 45 calendar days of the event or of becoming aware of the event.
- The team shall use a mutually agreed upon tool or use the "Framework for Conducting a Root Cause Analysis and Corrective Actions" format found at the Joint Commission Website:

https://www.jointcommission.org/framework_for_conducting_a_root_cause_analysis_and_action_plan/

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

8.5. DO NOT BILL EVENTS

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 Events" (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.

Should you need assistance or have questions regarding a possible DNBE, please contact the KPCO Risk Management Patient Safety Department. The telephone number is (303) 344-7298.

8.6. QUALITY REPORTS

8.6.1 Types of Disputes – Definitions

Provider Reconsideration / Appeal

A provider is challenging the initial organization determination by the plan.

- For claims for Medicare Members: Applies only to non-contracted providers*
- Claim denied 100%
- Partially paid claims with Post Stabilization (CRD12) denials
- Partially paid claims with Not Authorized (AUDxx) denials
- Partially paid claims with denials assigning financial responsibility to the Member (Not copay/coinsurance/deductible)

*Note – for claims for Medicare Members:

Per CMS Guidelines: Provider Disputes involving payment amounts are governed by the dispute resolution provisions in the provider contract. Thus, a reconsideration / appeal request cannot be filed for fully and partially paid claims by contracted providers.

Provider Dispute

A provider is challenging the initial organization determination by the plan.

- Contracted providers – Medicare and non-Medicare
- Non-Contracted providers – non-Medicare
- Includes any other determination not defined as a reconsideration (above)

6.6.2 Provider Disputes – Timely Submission

Provider Claims Dispute

- In writing
- Within 90 calendar days of the last plan determination
- Failure to request the dispute within 90 days shall result in the appeal request being denied

6.6.3 Provider Reconsiderations/Appeals - Timely Submission

Provider Reconsideration / Appeal

- In writing
- Must be filed within 60 calendar days from the date of the notice of the initial determination
- Waiver of Liability (WOL) must be filed with the appeal
- Failure to request the reconsideration within 60 days or no WOL will result in a dismissal

6.6.4 Submission Instructions

For Kaiser Permanente Colorado and the participating provider to comply with accrediting and regulatory bodies, various reports must be generated to track quality issues. Prior to report generation, investigations into the potential quality of care in specific individual cases, can be initiated from 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
- Quality monitoring
- Ambulatory Surgery occurrence review
- Patient Safety Review
- Other occurrences (e.g., contract hospital)
- Regulatory concern
- Hospital concerns

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

- Member Satisfaction Measures
- Quality Measures
- Member Complaints and Grievances
- Referral Measures
- Utilization Measures
- HEDIS/NCQA

The reporting of quality metrics may be required on a regular cadence. As opportunities for improvement are identified, action plans for improvement may also be required.

8.7. PRACTITIONER/PROVIDER ASSISTANCE

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.

8.7.1 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's 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).

8.7.2 Health Delivery Organizations (Providers)

Preferred providers are institutions (hospitals, skilled nursing facilities, home health agencies, freestanding ambulatory surgery centers, and behavioral healthcare centers, etc.) that contract with CPMG and/or KFHP (Kaiser Foundation Health Plan) to provide services to Members. 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/re-credentialing 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 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 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, KPCO conducts a site visit to credential or re-credential the provider. If a site visit is required, then it can be conducted on-site or virtually, and scheduled at least three (3) months in advance of the re-credentialing expiration 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 a systematic methodology to measure current levels of care and service, identify opportunities for improvement, and establish accountability for the 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.

8.7.3 Credentialling 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.

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. KPCO/CPMG Credentials Committee oversees all credentialing and 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 emailing the Credentialing Department at KP-Colorado-Credentialing@kp.org.

8.7.4 Practitioner Notification of Status of Credentialing Application

A practitioner has the right, upon request, to be informed of his/her application's status. Please contact the Credentialing Department at KP-Colorado-Credentialing@kp.org should you need to receive a status update on your application.

8.7.5 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, except references or other information determined to be inaccessible to the practitioner. Also, where appropriate, the practitioner may correct erroneous information.

8.7.6 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. Also, at 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.

6.7.7 Disclosure of Quality and Performance Indicators

Kaiser Permanente conducts ongoing studies and surveys of Member satisfaction and health outcomes. The provider must participate in these studies and surveys as requested by Kaiser Permanente pursuant to CMS standards.

8.7.8 Confidentiality of Credentialing Information

Credentialing documents and data are stored in a credentialing database which is secured with multi-factor authentication. Any individual or department allowed access to the credentialing files will treat the content with strict confidentiality. The electronic

credentialing database is password protected and passwords are only issued to personnel on a need-to-know basis.

8.8. PEER REVIEW

KPCO maintains a peer review process to promote and monitor credentialing, patient care quality, Member satisfaction, Member complaints, and administrative compliance with policies, procedures, rules, and practices for all participating practitioners.

Peer Review is a confidential, statute protected process by which health care professionals evaluate the clinical performance of similarly trained practitioners to improve the quality and safety of patient care. The peer review process determines whether the standard of care was met and identifies opportunities for improvement at the practitioner and system levels. All potential quality of care concerns are reviewed by Registered Nurses and if established criteria is met, they are forwarded to the CPMG Physician Director of Quality and Peer Review. The Director or designee then determines if a case should be reviewed by the clinically appropriate CPMG 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 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 Colorado is committed to fairness in the implementation of these processes if an adverse action is imposed.

Separate from the peer review process, a CPMG Executive Leadership Team 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 ofcare events may be appealed as described in the Centers for Medicare and Medicaid Services (CMS) Bylaws Index VI(a) or the NPDB Guidebook, Chapter F.

Subject to disclosure required by law, such proceedings shall be confidential. Notification of final findings is communicated to the affected 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 (HR.002 in the CPMG 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 303-587-7056.

8.8.1 Fair Hearing Process

KPCO extends those affiliate providers that it credentials the same fair hearing rights as extended to its practitioners in the case of an adverse action for quality of care that may be reportable to the NPDB. Fair Hearing Rights Policy and Procedure available upon request.

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 may trigger a review of the individual environmental complaint and a determination of a subsequent site visit. At a minimum, 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 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 confidentiality and handling of patient information is expected.

8.11. ASSESIBILITY STANDARDS

Kaiser Permanente assesses Primary Care and selected Specialty Care physician appointment availability to ensure timely access to our practitioners.

Performance is continuously measured against established standards and goals to identify opportunities for improvement. When an opportunity for improvement is identified, KPCO will implement an action plan to correct any deficiencies.

For Medicare Members, the minimum standards for appointment wait times for primary care and behavioral health service appointments are:

- Emergency or urgently needed services – immediately
- Non-urgent/emergent, but enrollee requires medical attention – Seven (7) business days
- Routine and Preventive care – 30 business days.