Office Safety
Policy & Procedure Manual

2011

Section H

(Click on the sub-sections to jump to the specific section)

POLICY NUMBER	OS- H100
POLICY TITLE	**Corrective Action Process**
INITIAL EFFECTIVE DATE	07/00
REVISION EFFECTIVE DATE (S)	
DEPARTMENT	Quality Assessment
ORGANIZATION (S)	CCHP, CCHCA
LINES OF BUSINESS	

Policy

Medical Group contracts with each physician require compliance with the Medical Group's Quality Assurance and Utilization/Case Management Programs. A timely response to the office visit onsite review is part of these programs. Non-compliance shall generate the following outcomes.

Procedure

1. Level A. Corrective Action Plan (CAP) not returned after three documented attempts to obtain reply within one month following due date.
   Sanction A. Physician Relations Committee Chair notifies physician by letter no new patients will be assigned to the physician's panel until the corrective action plan is returned.

2. Level B. Office and/or record review score(s) is below 80% indicating substantial deficits.
   Sanction B. Same as for Level A and panel will be frozen until physician receives a passing score of 80% or better on a focused reaudit (within three months). Repeated failures on reaudit are reported to the Physician Relations Committee for further disposition.

3. Level C. Environmental/facility problems that may cause serious harm to patients are noted. Medical record review may indicate the possibility of fraud or abuse.
   Sanction C. Panel is frozen as in Level A. Medical Director is immediately notified of substantial violations regarding patient safety issues. The Medical Director may, at this discretion, further investigate the issue, further immediately suspend the physician from seeing any patients, and reassign the patients to another provider.

4. All actions are reported to the Physician Relations Committee for review and the Committee may determine if further actions are necessary to gain compliance.

Responsibility/Department Linkages

Quality Assessment Department

POLICY NUMBER	OS- H101
POLICY TITLE	**On Site Process**
INITIAL EFFECTIVE DATE	01/01
REVISION EFFECTIVE DATE (S)	08/03
DEPARTMENT	Quality Assessment
ORGANIZATION (S)	CCHP, CCHCA
LINES OF BUSINESS	

Purpose

To ensure that Primary Care, OB/GYN and other high volume specialist offices meet all provider office and medical record keeping standards.

Policy

1) To ensure new CCHCA sites and contracting PCP, OB/GYN and high volume specialist offices meet CCHCA office and medical recordkeeping standards. An on-site review of the site/office will be conducted prior to being accepted as a CCHCA provider for managed care patients. Any deficiencies found will be reported to the Membership Committee and to the provider. The provider will have the opportunity to submit documentation of corrective action.
2) To ensure that CCHCA office and medical recordkeeping standards are consistently being met. An on-site review of all PCP, OB/GYN and high volume specialist offices will be done every 3 years.

Procedure

1) The auditor will inform the doctors, in advance, of the time of the audit.
2) Medical office audits of all PCP, OB/GYN and high volume specialists will be conducted as part of the initial credentialing process and then at least every 3 years as part of the recredentialing process.
3) Medical record audits of all PCP, OB/GYN and high volume specialists will be conducted as part of the initial credentialing process and then at least every 3 years as part of the recredentialing process. A minimum of 5 charts per doctor will be picked at random and will be reviewed.
4) If an initial review was done within one year of credentialing a provider, an abbreviated audit is used.
5) Documentation of these reviews and any corrective action instituted will be kept by the Quality Management Department.
6) Results of these reviews will be reported to the Membership Committee on a regular basis and should be reflected in the Membership Committee meeting minutes (as part of the recredentialing peer review process).

Responsibility/Department Linkages

CCHCA QM and/or designated Department / Quality Assessment Department

POLICY NUMBER	OS- H102
POLICY TITLE	**Pre-Review Procedure**
INITIAL EFFECTIVE DATE	07/00
REVISION EFFECTIVE DATE (S)	
DEPARTMENT	Quality Assessment
ORGANIZATION (S)	CCHP, CCHCA
LINES OF BUSINESS	

Policy

Medical Group contracts with each physician require compliance with the Medical Group's Quality Assurance and Utilization/Case Management Programs. A timely office visit onsite review is part of these programs. Non-compliance shall generate the following outcomes.

Procedure

1. Level A. After one month and three documented failed attempts by staff to establish an appointment for a site visit.
   Sanction A. Medical Department notifies physician by letter that if visit is not completed within one month from the date of the letter, no new patients will be assigned to the physician's panel until the visit is completed.
2. Level B. Time for visit is established, but cancelled with less than 24 hours notice twice.
   Sanction B. After cancellation of second visit without good cause, patient panel is frozen as for level A sanction. If the late cancellation resulted in a financial cost to the Plan, the physician shall be liable for the cost. A letter stating that the cost will be sent to the physician, and must be paid to the Plan prior to the rescheduled visit.
3. Level C. Surveyor is at the office for the review and office/physician cancels visit without good cause.
   Sanction C. Patient panel is frozen as in Level A. sanction Physician shall be liable for the costs of the aborted visit and subsequent office review. Cost for the two visits shall be paid prior to the visit.
4. All actions are reported to the Physician Relations Committee for review and the Committee may determine if further actions are necessary to gain compliance.

Responsibility/Department Linkages
Quality Assessment Department

POLICY NUMBER	OS- H103
POLICY TITLE	**Office Review Standards**
INITIAL EFFECTIVE DATE	01/00
REVISION EFFECTIVE DATE (S)	
DEPARTMENT	Quality Assessment
ORGANIZATION (S)	CCHP, CCHCA
LINES OF BUSINESS	

Purpose

To ensure that the contracted medical office environments are consistent with state, federal and other accrediting agency standards and regulations; and to assure appropriate access to quality patient care.

Policy

It is the policy to ensure that PCPs and OB/GYNs meet all established medical office standards and related policies and procedures as part of the credentialing/recredentialing process. It is the policy to ensure that PCPs with more than *50* MCO members meet all established medical office standards and related policies and procedures as part of the recredentialing process.

Procedure

Compliance with the following standards:

1. Access
    a. Entrance for handicapped equipment with a ramp with handrails on both sides
    b. Access to an elevator if facility is a multi-story building
    c. Bathroom is handicapped accessible
    d. Adequate regular and designated handicapped parking available
    e. Facility is easily recognizable with clearly marked address and name
    f. Waiting and Exam rooms (2 exam rooms/physician on duty) are of adequate size and seating
    g. Exits and Evacuation Plan are clearly indicated
    h. Office hours and after hours are posted

2. Cleanliness and Safety
    a. Corridors, hallways, and doorways are free of obstruction
    b. Exits are visible and clear of obstruction
    c. There are no noxious odors
    d. Fire extinguisher(s) are visible and conveniently located
    e. Fire inspections are current

f. Emergency/Disaster Plan for earthquake, fire, etc.
g. All patient areas including floor/carpet, walls and furniture are neat, clean and well maintained.
h. Restrooms are clean and contain appropriate sanitary supplies.

3. Medical and Lab Equipment
   a. Medical equipment is clean, functioning properly and maintained in operational condition.
   b. Written documentation demonstrates the appropriate maintenance of all specialized medical equipment according to equipment manufacturer's guidelines.

4. Appropriate Storage of Supplies, Instruments, Trash and Infection Control
   a. Containers for disposal of syringes and needles are located in every room
   b. Hazardous and toxic materials are centrally stored away from treatment areas
   c. There is compliance with a written OSHA Exposure Control Plan and Policy and Procedure
   d. There is compliance with a written Sterilization Policy and Procedure
   e. Medical instruments are sterilized after each use, or disposed of if disposable
   f. No needles or syringes are stored in exam rooms or within patient access
   g. No prescription pads are stored in the exam rooms or within patient access
   h. Trash is contained and properly stored
   i. All clean patient supplies are stored above floor level

5. Appropriate Storage of Drugs and Medical Records
   a. Medical Records are stored in a secure area with no patient access
   b. Drugs are current and routinely checked for outdates
   c. There is a procedure for dispensing samples
   d. Refrigerated drugs are properly maintained
   e. Controlled drugs are locked with restricted access and log
   f. Drug administration is done by a licensed staff member or practitioner
   g. There is compliance with a written Policy and Procedure for Storage of Drugs and Medical Records

6. Imaging (if applicable)
   a. Equipment is appropriately inspected by the state and licensed
   b. Equipment and staff licenses are current and posted
   c. There is compliance with a written Imaging Policy and Procedure

7. Lab (if applicable)
   On-site lab is CLIA certified, or if meets requirements has a certificate of waiver.

8. Emergencies
    a. Staff is trained in emergency procedures (CPR or 911)
    b. Emergency equipment/supplies/drugs are available and routinely checked
    c. There is compliance with a written Emergency Policy and Procedure
    d. There is compliance with a written Fire/Safety/Disaster Policy and Procedure

9. Written Risk Management Policies and Procedures (staff are familiar and in compliance with):
    a. Advance Directive
    b. Confidentiality
    c. Medical Office Standards
    d. Medical Record Standards
    e. Medical Office and Record keeping On-site Audit Tool and Reviewer Guidelines
    f. Member's Rights and Responsibilities
    g. Member and Practitioner Complaint process
    h. Missed Appointments
    i. Notification of Test Results
    j. Referral/Authorization/Eligibility/Benefits/Co-pay process
    k. Reporting Abuse/Neglect for Children, Elder/Dependent, Domestic Violence
    l. Risk Management
    m. Treatment Consent

10. Intake System
    a. Office staffs are professional and courteous
    b. Office staffs speak language of member population
    c. There is provision for 24-hour care coverage
    d. Office waiting room wait time is within 30 minutes
    e. Office telephone wait time is within 30 seconds
    f. Appointment schedule wait time is
        1) immediate for emergent,
        2) 24 hours for urgent,
        3) 7 days for PCP non-urgent,
        4) 14 days for SCP non-urgent referral,
        5) 30 calendar days for routine physical.
    g. There is an Access Policy and Procedure
    h. There is an After Hours Calls Policy and Procedure

11. Health Educational Promotion
    a. Practice and Preventive Care Guidelines are followed

b. Written Practice Guidelines
c. Written Preventive Care Guidelines
d. Information and services are made available to members

Responsibility/Department Linkages

Physician and office staff. / Quality Assessment Department