

HEALTH PLAN OF SAN JOAQUIN			
Subject: FACILITY SITE REVIEW			
Department: Medical Management			Policy #: QA05
Applies to: Medi-Cal			Scope: QI
Effective Date: 2/96	Revised Date: 6/20/08	Approved by: Chief Executive Officer	

POLICY

- A. The purpose of conducting facility site review audits is to ensure that all primary care provider sites utilized by the Health Plan of San Joaquin (HPSJ) for delivery of services to members have sufficient capacity to:
1. Provide appropriate primary healthcare services;
 2. Carry out processes that support continuity and coordination of care;
 3. Maintain patient safety standards and practices; and
 4. Operate in compliance with all applicable federal, state and local laws and regulations.
- B. HPSJ will provide necessary education and support to primary care providers and their office staff to facilitate successful implementation of the above-mentioned items. In addition, HPSJ will comply with DHS contractual requirements in supporting a system-wide process to minimize site review duplication and support consistency in PCP site reviews.
- C. All primary care provider sites contracted with the HPSJ Medi-Cal Managed Care Program are required by California statute (Title 22, section 56230) to have both initial and periodic site inspections regardless of the status of other accreditation and/or certifications. The Full Scope site review shall be the system-wide standard for conducting the initial and subsequent periodic reviews of PCP sites. Full Scope Review consists of the MMCD Site Review Survey (Attachment A) and Medical Record Review Survey (Attachment B).
1. A Registered Nurse (RN), under the direct supervision of the Director of Medical Management, will perform facility site review audits and medical record review surveys.
- D. If a site receives a non-passing score (<80%) by a reviewer from the HPSJ the site shall be considered to have a non-passing score for all other collaborative health plan partners. The Health Plan will notify its collaborative health plan partners of the non-passing score. The Health Plan will ensure that all non-physician

practitioners will be credentialed according to DHS/MMCD contractual and policy requirements. Facility audit review will require evidence of a written letter of agreement between the non-physician practitioner(s) and the supervising physician, jointly developed standardized guidelines with cited reference materials, and protocols.

E. A proprietary provider who employs physicians or non-physician practitioners is responsible for the quality of care provided by such practitioners and adherence to contractual and policy requirements of the Health Plan regardless of reimbursement arrangements.

F. Initial Full Scope Site Review

1. All new provider sites will undergo initial site review and attain a minimum passing score of 80% on both the Site Review and Medical Record Review surveys. Initial site reviews are to be performed at sites that have not previously had a Full Scope survey, “returning” PCP sites that have not had a Full Scope survey within the past three years, and PCP sites that are returning to Medi-Cal Managed Care and have a passing score but were previously terminated for cause and non-compliance with CAP’s. The initial full scope site review survey can be waived by the HPSJ for a pre-contracted provider site if the provider has documented proof that a current full scope survey with a passing score was completed by another plan with the past three years.
2. Prior to initiating plan operations in a service area an initial full scope survey shall be completed on 5% or 30 PCP sample sites, whichever is greater. The 5% or 30 PCP sample sites shall include a variety of providers from throughout the provider network and/or from each subcontracted entity.
3. If there are 30 or fewer PCP sites in the Network, 100% of sites must be completed prior to HPSJ operations.
4. Initial full scope reviews shall be completed on 100% of the remaining PCP sites within the first 6 months of operation/expansion.

G. Subsequent Periodic Full Scope Site Review

1. After the initial full scope survey, the maximum time period before conduction of the next required full scope site survey shall be three years. The HPSJ may review sites more frequently per local collaborative decision, or when determined necessary based on monitoring, evaluation, or corrective action plan follow-up issues.

2. The Credentialing Specialist will:
 - a) Notify the QI Dept. nurse of pre-contractual providers and network providers in need of a site review audit.

3. The Quality Improvement Nurse will:
 - a) Schedule the facility audit with the provider's Office Manager and will enter the audit date and time in the facility audit spreadsheet.
 - b) Determine the representative sampling of medical records to be pulled for review.
 - c) Pull the most recent facility audit performed and will review previous deficiencies prior to conducting the scheduled facility audit.

H. Medical Record Review

1. Ten medical records shall be reviewed initially for each provider as part of the medical record review. Medical records of new providers shall be reviewed within 90 calendar days of the date on which members are first assigned to the provider. An additional extension of 90 calendar days may be allowed only if the new provider does not have sufficient assigned Medi-Cal members to complete a review of 10 medical records. If there are still fewer than 10 assigned member records at the end of six months, a medical record review shall be completed on the total number of records available, and the scoring shall be adjusted according to the number of records reviewed.

2. Sites where documentation of patient care by multiple PCP's occurs in the same record shall be reviewed as a "shared medical record system". Shared medical records shall be considered those that are not identifiable as separate records belonging to any specific PCP. A minimum of 10 records shall be reviewed if two to three PCP's share records; 20 records for 4-6 PCP's, and 30 records for 7 or more PCP's.

I. Scoring

1. The minimum passing score for both the site review survey and the medical record survey is 80%. If one of the scores is below 80%, the site fails the facility site review. Facility sites that receive an Exempted Pass (90% or above, without critical element deficiencies and/or deficiencies in pharmacy, infection control) will not be required to complete a corrective action plan (CAP), unless required by the HPSJ or local plan collaborative. All sites that receive a Conditional Pass (80-89%, or 90% or

above with critical element deficiencies) will be required to establish a CAP that addresses each of the noted deficiencies. The compliance categories for both the facility site review and medical record review are the same as listed below:

- a) Exempted Pass: 90% or above
 - b) Conditional Pass: 80-89%
 - c) Not Pass: below 80%
2. Facility sites that receive an Exempted Pass (90% or above) for medical record review will not be required to complete a CAP. On-site CAP follow-up visits are intended to verify that processes are in place to remedy deficiencies.
 3. A full point shall be given if the scored element meets the applicable criterion. Partial points shall not be given for any scored element that is considered only partially met by the reviewer. Zero points shall be given if an element does not meet criteria. The reviewer shall determine the “not applicable” (N/A) status of each criterion based on site-specific assessment. The reviewer must explain all criteria scored as zero points or assessed as N/A.
 4. If a site receives a non-passing score by one plan, the site shall be considered to have a non-passing score by all other Medi-Cal managed care plans. The HPSJ shall use the local collaborative process to identify shared providers and to define methodology and determine systems for sharing survey information.

J. Critical Elements

1. Nine critical survey elements related to the potential for adverse effect on patient health or safety have a scored weight of two points. All other survey elements are weighted at one point. All critical element deficiencies found during a full scope site survey, focused survey, or monitoring visit shall be corrected by the provider within 10 business days of the survey date, and verified as corrected by the reviewer within 30 days. Sites found deficient in any critical element during a Full scope Site Review Survey shall be required to correct 100% of the deficiencies regardless of survey score. Critical elements include the following nine criteria:
 - a) Exit doors and aisles are unobstructed and escape accessible
 - b) Airway management equipment, appropriate to practice and populations served are present on site.

- c) Only qualified/trained personnel retrieve, prepare or administer medications.
- d) Office practice procedures are utilized on site that provide timely physician review and follow-up of referrals/consultation reports and diagnostic test results.
- e) Only lawfully authorized persons dispense drugs to patients.
- f) Personal Protective Equipment is readily available for staff use.
- g) Needle stick safety precautions are practiced on site.
- h) Blood, other potentially infectious materials (specimens) and regulated wastes (Sharps/Biohazardous non-sharps) are placed in appropriate leak-proof, labeled containers for collection, handling, processing, storage, transport or shipping.
- i) Spore testing of autoclave/steam sterilizer is completed at least monthly, with documented results.

K. Corrective Action Plans

- 1. All sites that receive an Exempted Pass (90% or above, without critical element deficiencies) shall not be required to complete a CAP unless determined necessary by the HPSJ. All sites that receive a Conditional Pass (80-89%, or 90% and above with critical element deficiencies and/or deficiencies in pharmacy, infection control) shall be required to establish a CAP that addresses each of the noted deficiencies. CAP documentation shall identify the specific deficiency, corrective action(s) needed, re-evaluation timelines/dates, responsible person(s), problems in completing corrective actions, education and/or technical assistance provided by the Health Plan, evidence of the correction(s), completion/closure dates, and name/title of reviewer. The CAP steps shall be as follows:

L. Providers with Conditional Pass Score (80% or above)

- 1. At the time of the survey: reviewers shall inform providers of non-passing survey scores, critical element deficiencies, other deficiencies determined by the reviewer or HPSJ to require immediate corrective action, and the CAP requirements for these deficiencies.
- 2. Within 10 business days of the survey date:
 - a) Providers shall submit a completed CAP with verification for all critical element deficiencies and/or other survey criteria requiring immediate correction.
 - b) The Plan shall provide a report of survey findings and a formal written request for a CAP for all other non-critical deficiencies to providers within 5 business days following the survey.

- c) Within 30 days of the survey date, plans shall re-evaluate and verify corrections of critical element and other survey deficiencies requiring immediate correction.
- d) Within 45 calendar days of receiving the report of survey findings and written CAP request, PCP's shall submit a completed CAP to HPSJ. The HPSJ shall review/revise/approve CAP and timelines within 45 calendar days of receiving the CAP from the provider.
- e) Within 90 calendar days from the date of the written CAP request providers shall complete all other corrective actions; and the HPSJ shall provide educational support and technical assistance as needed, re-evaluate/verify corrections, and close the CAP. Beyond 90 calendar days of the date of written CAP request:
- f) Providers may receive an additional 30 day extension to complete corrections if extenuating circumstances that prevented completion of corrections can be clearly be demonstrated, and if agreed to by the HPSJ.
- g) The HPSJ shall re-survey any provider site in 12 months that required an extension period beyond 120 calendar days to complete corrections prior to closing the CAP.

M. Non-Passing Pre-contractual Provider

- 1. A pre-contractual provider who scores below 80% on the full scope site review survey shall not be counted as a network provider. Prior to being contracted with the Health Plan, a non-passing provider must be re-surveyed and pass the Full Scope Site Review Survey at 80% or higher. After achieving a score of 80% or higher, a CAP shall be completed as specified under CAP steps. The Health Plan reserves the right not to contract with any provider who does not pass the pre-contractual Site Review Survey.

N. Non-Passing Contracted Provider

- 1. Non-passing providers shall be notified of the survey score, all cited deficiencies and CAP requirements at the time of the non-passed survey. The HPSJ shall have the right to remove any provider with a non-passing score from the provider network. However, if a provider with a non-passing score is allowed to remain in the provider network, survey deficiencies must be corrected by the provider and verified by the plan within the CAP timelines established within MMCD policy letter 02-02. Enrollment of new members shall not be assigned to providers that score below 80% on a subsequent full scope site review survey, until corrections are verified and the CAP is closed. If the corrections are appropriately made and the Health Plan closes the completed CAP the

provider shall remain in the network and new member assignments shall resume.

O. Non-Compliant Provider

1. Providers that do not correct survey deficiencies within the established CAP timelines shall not be assigned new members, until such time as corrections are verified and the CAP is closed. Any network provider who does not come into compliance with survey criteria within the established timelines shall be removed from the network and plan members shall be appropriately re-assigned to other network providers. The HPSJ shall provide affected members with a 30-day notice that the non-compliant provider is being removed from the network.

P. Provider Appeal Process

1. Providers removed from the network, shall have the right to appeal the decision with the Plan. Appeals shall be in writing and submitted within 7 working days of notice of deletion from the Plan network. The Medical Director will put the appeal request on the agenda of the next scheduled QIUM and Peer Review Committee meeting. If documented evidence of corrections is accepted by the Plan and the decision is reversed, the Plan shall allow the site review survey and CAP to stand as completed. However, if the decision is not reversed, the Medical Director will present the audit results and CAP findings along with recommendations of the Peer Review and QIUM Committees at the next scheduled QI sub-committee of the Health Commission, in a closed session.
2. The Commission shall take final action, with immediate notification, by certified letter from the HPSJ Medical Director to the provider. A provider may re-apply in 12 months to become a plan provider via the provider application processes established by the Plan. All providers returning to the network shall be re-surveyed.

Q. Monitoring

1. HPSJ shall systematically monitor all PCP sites between each regularly scheduled full scope site review survey. Monitoring methods may include site visits. Monitoring sites between audits shall include the use of both internal information such as member complaints, and telephone access studies and external sources of information from our collaborative Health Plan partners and Public Health.
2. Evaluation of the nine critical elements shall be monitored on all sites between full scope site surveys. When problems are identified through monitoring processes, HPSJ shall determine the appropriate course of action to assure that problems are fully investigated and corrective action plans are submitted in a timely manner.

R. Focused Review

1. The focused review is a “targeted” audit of one or more specific site or medical record review survey areas, and shall not be substituted for the full scope survey. Focused reviews may be used to monitor providers between full scope site review surveys, to investigate problems identified through monitoring activities, or to follow-up on corrective actions.
2. Reviewers may use the appropriate section(s) of site review and/or medical record review survey tools for the focused review, and/or other methods to investigate identified problems or situations. All deficiencies found in a focused review shall require the completion and verification of corrective actions according to CAP timelines established in MMCD policy letter 02-02. See QI05B

S. Local Collaboration

1. The HPSJ shall collaborate locally within each Medi-Cal managed care county, to establish systems and implement procedures for the coordination and consolidation of site audits for mutually shared primary care providers. All contracting plans within a county have equal responsibility and accountability for participation in the local site review collaborative process.
2. An initial written description and periodic update reports, as requested by MMCD, shall be submitted to the MMCD Medical Monitoring Unit Nurse describing the local collaborative processes, which may include but are not limited to the following information:
 - a) Names and titles of participating personnel from each plan
 - b) Work plan that includes goals, objectives, activities, and timelines
 - c) Scheduled meeting dates/times/locations, meeting processes and outcomes
 - d) Communication and information sharing processes
 - e) Roles and responsibilities of each plan
 - f) Delegated activities, and use of delegated and/or sub delegated entities/agencies; and
 - g) Memoranda of Agreement (MOA) requirements established for plans and providers.
3. Policies and procedures shall be also established to define local collaborative methodology for the following:
 - a) Confidentiality, disclosure and release of shared provider survey information;

- b) Oversight and monitoring of survey processes;
- c) Site review personnel and training processes;
- d) Collection and maintenance of a local survey information database system;
- e) Evaluation processes;
- f) How to deal with problematic providers; and
- g) Focus visits.
- h) Participation in the DHS scheduled Site Review work groups.

T. Review Personnel

1. The Medical Director is ultimately responsible for site review activities implemented by HPSJ personnel and/or contracted agency or entity. The HPSJ shall retain site review program oversight responsibility whether survey functions are maintained within the plan, delegated to another plan, or subcontracted to a third agency or entity. The HPSJ shall identify designated registered nurse (RN) personnel to become certified Master Trainers by MMCD. Master trainers shall have the overall responsibility for training and supervising reviewers, certifying reviewers, monitoring reviews and evaluating reviewers for inter-rater reliability. The Plan will be responsible for notifying DHS when a master trainer resigns.
2. The Plan will identify other trainers as necessary to assist the master trainer in providing training and supervision of staff responsible for conducting site reviews. The master trainer shall certify these trainers.
3. The Plan shall identify RNs who will be responsible for each site review and who shall sign the site review and/or the medical record survey as required in MMCD policy letter 02-02. The plan shall ensure a master or other designated plan trainer certifies the RN site reviewer.
4. The Plan shall determine the composition of the review teams performing site review surveys.
5. The Plan shall adhere to the Inter-rater Reliability Health Plans Collaborative Process policy and procedure for certification and re-certification of reviewers and trainers.

U. Site Review Training and Certification

1. Site Review trainers shall be certified as trainers, and re-certified every three years thereafter. All site reviewers shall complete site review training prior to conducting surveys, and periodically thereafter as

established in the site review training program curriculum and site review certification process.

V. Site Review Submission Procedures

1. The plan shall submit site review data to the MMCD Medical Monitoring Unit nurse evaluator every six months, by June 30 and December 31 of each calendar year, or as specified by the MMCD. The master trainer, or the QI Manager will submit the data to the MMCD Medical Monitoring Unit nurse as directed. Data will be submitted secured centralized web-based system, share point application.

REFERENCES

- A. DHS Contract, Exhibit A, Attachment 4
- B. Title 22, CCR, Section 56230DHS MMCD Policy Letter 02-02, Site Review
- C. DHS MMCD Policy Letter 02-04, Certification of Managed Care Plan Staff Responsible for the Conduct of Primary Care Provider Site Reviews

Created by/Date	Revised by/Date	Revised by/Date	Revised by/Date	Revised by/Date	Revised by/Date
2/96	QIUM 1/02	S. Steely 07/31/03	S.Steely 8/24/04	S. Steely 4/12/05	Trinchera, 6/20/08
	Reviewed by J. Scott 9/08				