

<p>This policy applies to:</p> <p><input checked="" type="checkbox"/> <i>Stanford Hospital and Clinics</i></p> <p><input checked="" type="checkbox"/> <i>Lucile Packard Children's Hospital</i></p>	<p>Date Written or Last Revision: March 2009</p>
<p>Name of Policy: Site Visit</p>	<p style="text-align: center;">Page 1 of 4</p>
<p>Departments Affected: All Departments</p>	

I. PURPOSE

Stanford Hospital and Clinics and Lucile Packard Children's Hospital establishes the following standards and thresholds for office site criteria and medical record-keeping practices. This policy applies to all practitioners within the scope of credentialing. The Physician Network will use the California Shared Commercial and Medicare Site Review Survey and Corrective Action Plan form.

II. POLICY STATEMENT

To protect the health and safety of Physician Network members by outlining a process for evaluations of Physician care sites for whom the Physician Network receives member complaints concerning the accessibility, appearance, lack of space, availability of appointments, medical/treatment records or adequacy of equipment (applicable to Medicare only).

III. PROCEDURE

The site visit review process will include standards and thresholds for each of these elements:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space
- Availability of appointments
- Adequacy of medical/treatment record keeping
- Adequacy of equipment

A. Member Complaints of Practitioner Offices

Member complaints related to the quality of all practitioner office sites will be monitored and investigated when received. The Physician Network has established a threshold of three complaints regardless of severity that must be received before conducting an office-site visit. When the complaint has been received related to physical accessibility, physical appearance, adequacy of waiting and examining room space and adequacy of equipment, a site visit will be performed within 60 days of the threshold being met to assess these elements. (*Appointment availability and Medical Record Keeping will not be included. These are addressed under the Quality Improvement Program.*)

1. When it has been verified that an office site does not meet the Physician Network's performance thresholds, the office site must develop an action plan for improvement.
2. The Physician Network will revisit the office site at least every six months until the performance standards are met. Documentation of the revisit will be included in the practitioner's file.

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3. The Physician Network will conduct a follow-up site visit of a previously deficient office if the practice site meets the reasonable complaint threshold subsequent to correcting the deficiencies. Follow-up site visits must be conducted within 60 days of the reasonable complaint threshold being met. If the site still does not meet the Physician Network's performance thresholds, the Physician Network or the site must develop and implement an action plan for improvement which will then be presented to the Physician Network's QIC for review and any additional action or recommendation taken that they deem appropriate.

B. The staff member who conducts the site visits must be trained on the use of the ICE Audit tool and requirements. Following are the requirements of staff who conduct these visits:

1. The auditing staff member needs to be an employee of the QI/Credentialing Department who have:
 - a. Reviewed all the policies and procedures related to conducting an onsite audit.
 - b. Have been supervised during two onsite audits and signed off by a staff member (or QI/Credentialing Manager) with experience in conducting site audit utilizing the ICE Audit tool.
 - c. Have been trained to document such activity in the QI Activity Logs and complete the Site Audits Outcome Log.

C. Performance Thresholds:

The performance threshold for the Office Site Visit is a score of 85%.

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IV. DOCUMENT INFORMATION

- A. Legal Authority/References
 1. NCQA Standards
- B. Author/Original Date
This Policy was authored by the Director, Medical Staff Services in March 2009.
- C. Gatekeeper of Original Document
The Director, Medical Staff Services (or designee), who will be responsible for initiating its review and revision. The Policy will reside in the Credentials Policy and Procedure Online Manual.
- D. Distribution and Training Requirements
The distribution and training requirements for this Policy will be handled through the Credentials Department.
- E. Review and Renewal Requirements
This Policy will be reviewed and/or revised every three years or as required by change of law or practice.

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- F. Review and Revision History
Revision – March 2009

- G. Local Approvals
Credentials Committee (2) – 3/09
Medical Board (2) 4/09

- H. Board Approvals 4/09

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Direct inquiries to:
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SHC and LPCH