This policy applies to: ☑ *Stanford Health Care* ☑ *Lucile Packard Children's Hospital Stanford*	**Date Written or Last Revision: January 2019**
Name of Policy: Site Visit	**Page 1 of 3**
Departments Affected: All Departments	

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I. PURPOSE

Stanford Health Care and Lucile Packard Children's Hospital Stanford establishes the following standards for office site quality and medical record-keeping practices, and thresholds for office site visits. 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 for site visit and medical record keeping.

II. POLICY STATEMENT

To protect the health and safety of Physician Network patients by outlining a process for evaluations of office sites of physicians for whom the Physician Network receives patient 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 (see definition of Performance Thresholds III.C below) 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. Patient Complaints about Practitioner Offices

Patient 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 received is 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.

3. The Physician Network will conduct a follow-up site visit of a previously deficient office if the practice site meets the practice standards by correcting the deficiencies. Follow-up site visits must be conducted within 60 days of the practice standards 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 QPSEC 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 Industry Collaboration Effort (ICE) Audit tool and requirements. Following are the requirements of staff who conduct these visits:

1. The auditing staff member should be an employee of the Quality Department who has:
    a. Reviewed all the policies and procedures related to conducting an onsite audit.
    b. 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. 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%.

The performance threshold for the medical/treatment record-keeping criteria is a score of 85%

IV. DOCUMENT INFORMATION

A. Legal Authority/References
    1. NCQA Standards

B. Author/Original Date
This Policy was authored by the Manager, Medical Staff Services in November 2010.

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.

F. Review and Revision History
Revision – 11/10, 8/15, 1/19

G. Local Approvals
Credentials Committee
Medical Board

H. Board Approvals

Direct inquiries to:
Director, Medical Staff Services, (650) 497-8920
SHC and LPCH