KAISER PERMANENTE®

2024 Quality Improvement Work Plan

Kaiser Foundation Health Plan Southern California Region

KFHP Southern California Region
2024 Quality Improvement Work Plan

Tara Harder June 28, 2024

Tara Harder, MBA, CPHQ, CPPS **Date**
Vice President, Quality, Safety & Regulatory Services
Kaiser Foundation Health Plan/Hospital, Southern California & Hawaii
Co-Chair, Southern California Quality Committee

Deepak Sonthalia MD 7/17/2024

Deepak Sonthalia, MD **Date**
Regional Physician Director of Quality, Risk Management, Regulatory & Safety (SCAL)
Co-Chair, Southern California Quality Committee

Approved by Southern California Quality Committee (SCQC) on March 22, 2024

KFHP Southern California Region
2024 Quality Improvement Work Plan

New measures will be marked with an asterisk (*). All other measures are continued from the prior year and were determined to need continuous monitoring for previously identified issues.

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
ACCESS					
Availability of Practitioners: Primary and Specialty Care (NET 1B & NET 1C)					
NCQA	NET 1B: Practitioners Providing Primary Care To evaluate the availability of practitioners who provide primary care services, including general medicine or family practice, internal medicine and pediatrics, the organization: • Establishes measurable standards for the number of each type of practitioner providing primary care. • Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care. • Annually analyzes performance against the standards for the number of each type of practitioner providing primary care. • Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care.	Ratios: 2000:1 for Family Medicine, Internal Medicine, and Pediatrics GeoAccess: 95% of members within 15 miles or 30 minutes of Family Medicine, Internal Medicine, Pediatrics	Q2 2024	• Conduct an annual ratio analysis and an annual Geo Access analysis for primary care and high-volume/high-impact specialties • Identify and address gaps with local areas to meet GeoAccess standards • Report annual findings to the SCAL Regional Access Committee	SCPMG Care Experience (Regional Service and Access) SCAL Regional Access Committee Wadie Marcos, DO Assistant Regional Medical Director, Care Experience (Regional Service and Access) Rebecca Grant, Regional Administrative Leader, Care Experience (Regional Service and Access)
NCQA	NET 1C: Practitioners Providing Specialty Care To evaluate the availability of specialists in its delivery system, the organization: • Defines the types of high-volume and high-impact specialists. • Establishes measurable standards for the number of each type of high- volume specialists. • Establishes measurable standards for the geographic distribution of each type of high-volume specialists.	Ratios: 35,000 members:1 Cardiologist 40,000 members:1 Dermatologist 10,000 members:1 OB/GYN 28,000 members:1 Ophthalmologist 26,000 members:1 Orthopedist	Q2 2024	• Conduct an annual ratio analysis and an annual Geo Access analysis for primary care and high-volume/high-impact specialties • Identify and address gaps with local areas to meet GeoAccess standards • Report annual findings to the SCAL Regional Access Committee	SCPMG Care Experience (Regional Service and Access) SCAL Regional Access Committee Wadie Marcos, DO Assistant Regional Medical Director, Care Experience (Regional Service and Access) Rebecca Grant, Regional Administrative Leader, Care Experience (Regional Service and Access)

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	• Establishes measurable standards for the geographic distribution of each type of high-impact specialist. • Analyzes its performance against the established standards at least annually.	GeoAccess: 80% of members within 15 miles or 30 minutes of High-Volume/High-Impact Specialty Care			
Accessibility of Services: Primary and Specialty Care (NET 2A & NET 2C)					
NCQA	NET 2A: Access to Primary Care Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against its standards for access to: • Regular and routine care appointments • Urgent care appointments • After hours care	80% of non-urgent primary care appointments within 10 bus days 80% of urgent care appointments are within 48 hours KP OnCall Nurse Triage - *Fast Track Abandonment Rate: <5% *Fast Track Service Level: 60% within 60 seconds	Q1 2024 Q1 2024 Q2 2024	• Monitor percent booked in standard performance • Report monthly booked within standard performance to the SCAL Regional Access Committee • Report KP OnCall Nurse Triage performance to the SCAL Regional Access Committee • Regional Senior Leaders to have performance dialogues with each local area as needed	SCPMG Care Experience (Regional Service and Access) SCAL Regional Access Committee Wadie Marcos, DO Assistant Regional Medical Director, Care Experience (Regional Service and Access) Rebecca Grant, Regional Administrative Leader, Care Experience (Regional Service and Access)
NCQA	NET 2C: Access to Specialty Care Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for: • High-volume specialty care	80% of non-urgent specialty care appointments are booked within 15 business days	Q1 2024	• Monitor percent booked within standard performance • Report monthly booked within standard performance to the SCAL Regional Access Committee • Discuss and review action plans developed by the local areas within the SCAL Regional Access Committee	SCPMG Care Experience (Regional Service and Access) SCAL Regional Access Committee Wadie Marcos, DO Assistant Regional Medical Director, Care Experience (Regional Service and Access)

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	• High-impact specialty care	80% of ancillary (radiology) appointments are booked within 15 business days	Q1 2024	• Regional Senior Leaders to have performance dialogues with each local area to ensure action plans are adhered to and yield results	Rebecca Grant, Regional Administrative Leader, Care Experience (Regional Service and Access)
Assessment of Network Adequacy (NET 3A & 3B)					
NCQA	NET 3A: Assessment of Member Experience Accessing the Network The organization annually identifies gaps in networks specific to geographic areas or types of practitioners or providers by: • Using analysis results related to member experience with network adequacy for nonbehavioral healthcare services from ME 7, Element C and Element D. • Compiling and analyzing nonbehavioral requests for and utilization of out-of-network services. NET 3B: Opportunities to Improve Access to Nonbehavioral Healthcare Services The organization annually: • Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements B and C), accessibility (NET 2, Elements A and C), and member experience accessing the network (NET 3, Element A, factors 1 and 3). • Implements interventions on at least one opportunity, if applicable. • Measures the effectiveness of interventions, if applicable	Conduct an assessment of member complaints and appeals, CAHPS surveys, out-of-network requests, network availability, and appointment access data to assess network adequacy and member experience with their care and services.	Q2 2024 Q2 2024	• Report findings to the SCAL Regional Access Committee • Identify opportunities for improvement and implement interventions to address performance gaps	SCPMG Care Experience (Regional Service and Access) SCAL Regional Access Committee Wadie Marcos, DO Assistant Regional Medical Director, Care Experience (Regional Service and Access) Rebecca Grant, Regional Administrative Leader, Care Experience (Regional Service and Access)

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
BEHAVIORAL HEALTH					
Availability of Practitioners: Behavioral Health Care (NET 1D)					
NCQA	NET 1D: Practitioners Providing Behavioral Healthcare To evaluate the availability of high-volume behavioral healthcare practitioners in its delivery system, the organization: Factor 1. Defines the types of high-volume behavioral healthcare practitioners. (see BH Program Description) High volume Behavioral Health Practitioners are grouped into 5 major common types as follows: • **Adult Psychiatrists**: includes Physicians and Physician Extenders whose primary practice is adult patients in Psychiatry • **Child Psychiatrists:** includes Physicians and Physician Extenders whose primary practice is children ages 0-17 in Psychiatry • **Psychiatric Therapists:** includes LCSWs, LMFTs, MSWs, and PhDs who provide therapy services in Psychiatry • **Addiction Medicine Physicians:** includes Physicians and Physician Extenders in Addiction Medicine • **Substance Use Practitioners:** includes LCSWs, LMFTs, MSWs, PhDs, Clinical Nurse Specialists, and substance use counselors in Addiction Medicine	Annual review of definitions as part of the BH Program Description submission	Annual March 2025	Annual review of definitions as part of the BH Program Description submission.	• Lorena Barrio, MD; SCPMG Regional Chief of Psychiatry • Maria I. Villarosa, MD; SCPMG Assistant Regional Medical Director, Behavioral Health Service Line Leader • Ebonie Vazquez, MD; SCPMG Regional Chief of Addiction Medicine • Dawn Gillam; SCPMG Executive Leader, Regional Behavioral Health • Erika Aguirre-Miyamoto, LCSW; SCPMG Regional Operations Director, Regional Behavioral Health • Elizabeth Hamilton, LCSW; SCPMG Regional Clinical Director, Regional Behavioral Health • Carla Hix, PsyD; KFHP Senior Director, Behavioral Health Quality & Regulatory Services • Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)
NCQA	Factor 2. Establishes measurable standards for the number of each type of high-volume behavioral healthcare practitioner. Factor 4. Analyzes performance against the standards annually.		Annual March 2025	Conduct an annual ratio analysis for Behavioral Health high-volume practitioners.	• Lorena Barrio, MD; SCPMG Regional Chief of Psychiatry • Maria I. Villarosa, MD; SCPMG Assistant Regional Medical

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	• **Adult Psychiatrists**: includes Physicians and Physician Extenders whose primary practice is adult patients in Psychiatry • **Child Psychiatrists:** includes Physicians and Physician Extenders whose primary practice is children ages 0-17 in Psychiatry • **Psychiatric Therapists:** includes LCSWs, LMFTs, MSWs, and PhDs who provide therapy services in Psychiatry • **Addiction Medicine Physicians:** includes Physicians and Physician Extenders in Addiction Medicine • **Substance Use Practitioners:** includes LCSWs, LMFTs, MSWs, PhDs, Clinical Nurse Specialists, and substance use counselors in Addiction Medicine	1 budgeted Adult psychiatrist per 18,500 members 1 budgeted Child psychiatrist per 18,500 members 1 budgeted Therapist per 5,900 members 1 budgeted physician per 135,000 members 1 budgeted Substance Use Practitioner per 30,000 members			Director, Behavioral Health Service Line Leader • Ebonie Vazquez, MD; SCPMG Regional Chief of Addiction Medicine • Dawn Gillam; SCPMG Executive Leader, Regional Behavioral Health • Erika Aguirre-Miyamoto, LCSW; SCPMG Regional Operations Director, Regional Behavioral Health • Elizabeth Hamilton, LCSW; SCPMG Regional Clinical Director, Regional Behavioral Health • Carla Hix, PsyD; KFHP Senior Director, Behavioral Health Quality & Regulatory Services • Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)
NCQA	Factor 3. Establishes measurable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner. Factor 4. Analyzes performance against the standards annually. **Mental Health Providers:** • Adult Psychiatrists • Child Psychiatrists • Psychiatric Therapists **Addiction Medicine Program:** • Addiction Medicine Physicians • Substance Use Practitioners	80% of Membership within 15 miles or 30 minutes 80% of Membership within 30 miles or 60 minutes	Annual April 2025	Identify and address gaps with local areas to meet GeoAccess standards.	• Lorena Barrio, MD; SCPMG Regional Chief of Psychiatry • Maria I. Villarosa, MD; SCPMG Assistant Regional Medical Director, Behavioral Health Service Line Leader • Ebonie Vazquez, MD; SCPMG Regional Chief of Addiction Medicine • Dawn Gillam; SCPMG Executive Leader,

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
					Regional Behavioral Health • Erika Aguirre-Miyamoto, LCSW; SCPMG Regional Operations Director, Regional Behavioral Health • Elizabeth Hamilton, LCSW; SCPMG Regional Clinical Director, Regional Behavioral Health • Carla Hix, PsyD; KFHP Senior Director, Behavioral Health Quality & Regulatory Services • Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)
Accessibility of Services: Behavioral Health Care (NET 2B)					
NCQA	NET 2B: Access to Behavioral Healthcare Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for behavioral healthcare for: <u>Factor 1</u>. Care for a Non-Life-Threatening Emergency within 6 hours • Standard = 6 hours • Policy as outlined in 2022 BH Annual Program Description Excerpt from 2024 BH Annual Program Description: *"Our standard for emergent behavioral appointments is immediate. Patients are directed to an emergency department for either life threatening or non-life threatening behavioral health emergency needs.*	See Policy Statement in BH Program Description	Annual March 2025	**BHC Non-Life-Threatening Access** • Review policy as evidenced by statement in Annual BH Program Description	• Lorena Barrio, MD; SCPMG Regional Chief of Psychiatry • Maria I. Villarosa, MD; SCPMG Assistant Regional Medical Director, Behavioral Health Service Line Leader • Ebonie Vazquez, MD; SCPMG Regional Chief of Addiction Medicine • Dawn Gillam; SCPMG Executive Leader, Regional Behavioral Health • Erika Aguirre-Miyamoto, LCSW; SCPMG Regional Operations Director, Regional Behavioral Health

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	Emergent – Sudden, unforeseen illness or injury that requires immediate medical attention – or which if left untreated could result in serious disability or death. The following clarifying statements were added for our behavioral health departments: • ***Psychiatry:*** *A behavioral health life threatening or non-life threatening crisis that may result in a danger to self or others or concern of further decompensation (e.g. intra-psychic or environmental)* • ***Addiction Medicine:*** *May include components of a medical or psychiatric emergency."*				• Elizabeth Hamilton, LCSW; SCPMG Regional Clinical Director, Regional Behavioral Health • Carla Hix, PsyD; KFHP Senior Director, Behavioral Health Quality & Regulatory Services • Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)
NCQA	Factor 2. Urgent care within 48 hours.	Physician and Non-Physician >= 80% Booked within 48 hours	Quarterly Review March 2025	**BHC Urgent Appointment Access** • Review access data on a minimum of quarterly basis • Ensure Access Corrective Action Plans are requested of Departments in a timely manner • Oversight of Access CAP's until resolved • Identify opportunities for access improvement	• Lorena Barrio, MD; SCPMG Regional Chief of Psychiatry • Maria I. Villarosa, MD; SCPMG Assistant Regional Medical Director, Behavioral Health Service Line Leader • Ebonie Vazquez, MD; SCPMG Regional Chief of Addiction Medicine • Dawn Gillam; SCPMG Executive Leader, Regional Behavioral Health • Erika Aguirre-Miyamoto, LCSW; SCPMG Regional Operations Director, Regional Behavioral Health • Elizabeth Hamilton, LCSW; SCPMG Regional Clinical Director, Regional Behavioral Health • Carla Hix, PsyD; KFHP Senior Director, Behavioral Health

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
					Quality & Regulatory Services • Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)
NCQA	Factor 3. Initial visit for routine care within 10 business days.	Physician and Non-Physician >= 80% Booked within 10 Business Days	Quarterly Review March 2025	**BHC Routine Appointment Access** • Review access data on a minimum of quarterly basis • Ensure Access Corrective Action Plans are requested of Departments in a timely manner • Oversight of Access CAP's until resolved • Identify opportunities for access improvement	• Lorena Barrio, MD; SCPMG Regional Chief of Psychiatry • Maria I. Villarosa, MD; SCPMG Assistant Regional Medical Director, Behavioral Health Service Line Leader • Ebonie Vazquez, MD; SCPMG Regional Chief of Addiction Medicine • Dawn Gillam; SCPMG Executive Leader, Regional Behavioral Health • Erika Aguirre-Miyamoto, LCSW; SCPMG Regional Operations Director, Regional Behavioral Health • Elizabeth Hamilton, LCSW; SCPMG Regional Clinical Director, Regional Behavioral Health • Carla Hix, PsyD; KFHP Senior Director, Behavioral Health Quality & Regulatory Services • Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
NCQA	Factor 4. Follow up routine care. Follow Up visit within 5 business days	Physician and Non-Physician >= 80% Booked within 5 Business Days	Quarterly Review March 2025	**Follow-up Routine Appointment Access** • Review access data on a minimum of quarterly basis • Behavioral Health Quality Oversight Committee (BHQOC) to determine appropriate action for access that is out of standard • Review of the Follow-Up standard conducted and will align with the DMHC Follow-Up standard • Ensure Access Corrective Action Plans are requested of Departments in a timely manner when not meeting DMHC Follow-Up standards	• Lorena Barrio, MD; SCPMG Regional Chief of Psychiatry • Maria I. Villarosa, MD; SCPMG Assistant Regional Medical Director, Behavioral Health Service Line Leader • Ebonie Vazquez, MD; SCPMG Regional Chief of Addiction Medicine • Dawn Gillam; SCPMG Executive Leader, Regional Behavioral Health • Erika Aguirre-Miyamoto, LCSW; SCPMG Regional Operations Director, Regional Behavioral Health • Elizabeth Hamilton, LCSW; SCPMG Regional Clinical Director, Regional Behavioral Health • Carla Hix, PsyD; KFHP Senior Director, Behavioral Health Quality & Regulatory Services • Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)
Assessment of Network Adequacy (NET 3A & 3C)					
NCQA	The organization provides members adequate network access for needed healthcare services: **Element A:** Assessment of Member Experience Accessing the Network **Factor 2:** Using analysis results related to member experience with network adequacy for	Analysis of BH availability, accessibility, complaints, and appeals, and the BH Member Experience survey to identify opportunities for improvement. Review to	Annual March 2025	Prioritizes improvement opportunities. Implement interventions on at least one opportunity, if applicable.	• Lorena Barrio, MD; SCPMG Regional Chief of Psychiatry • Maria I. Villarosa, MD; SCPMG Assistant Regional Medical Director, Behavioral

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	behavioral healthcare services from ME 7, Element E **Factor 4:** Compiling and analyzing behavioral healthcare requests for and utilization of out-of-network services **Element C:** Opportunities to Improve Access to Behavioral Healthcare Services **Factor 1:** Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements A&D), accessibility (NET 2, Element B), and member experience accessing the network (NET 3, Element A, factor 2 and 4). **Factor 2:** Implements interventions on at least one opportunity, if applicable **Factor 3:** Measures the effectiveness of the interventions, if applicable	identify if opportunities are geographic specific. Grievances and Appeals related to Access to Care and Access Appointments by Area. Physician and non-physician staffing by area.			Health Service Line Leader • Ebonie Vazquez, MD; SCPMG Regional Chief of Addiction Medicine • Dawn Gillam; SCPMG Executive Leader, Regional Behavioral Health • Erika Aguirre-Miyamoto, LCSW; SCPMG Regional Operations Director, Regional Behavioral Health • Elizabeth Hamilton, LCSW; SCPMG Regional Clinical Director, Regional Behavioral Health • Carla Hix, PsyD; KFHP Senior Director, Behavioral Health Quality & Regulatory Services • Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)
Member Experience (ME 7E & 7F)					
NCQA	**Element E:** Using valid methodology, the organization annually: **Factor 1:** Evaluates behavioral healthcare member complaints and appeals for each of the five required categories: • quality of care • access • attitude and service • billing and financial issues • quality of practitioner office sites **Factor 2:** Conducts a member experience survey	Analysis of Behavioral Health grievances and appeals Survey of patient experiences including some who have accessed	Annual Review March 2025	If not meeting goal, provide analysis and target systemic issues; develop appropriate interventions and action plans.	• Lorena Barrio, MD; SCPMG Regional Chief of Psychiatry • Maria I. Villarosa, MD; SCPMG Assistant Regional Medical Director, Behavioral Health Service Line Leader • Ebonie Vazquez, MD; SCPMG Regional Chief of Addiction Medicine • Dawn Gillam; SCPMG Executive Leader,

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	Analysis must be conducted separately for each product line	BH services both internally and externally			Regional Behavioral Health • Erika Aguirre-Miyamoto, LCSW; SCPMG Regional Operations Director, Regional Behavioral Health • Elizabeth Hamilton, LCSW; SCPMG Regional Clinical Director, Regional Behavioral Health • Carla Hix, PsyD; KFHP Senior Director, Behavioral Health Quality & Regulatory Services • Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)
NCQA	**Element F:** The organization works to improve members' experience with behavioral healthcare and service by annually: **Factor 1:** Assessing data from complaints and appeals or from member experience surveys **Factor 2:** Identifying opportunities for improvement **Factor 3:** Implementing interventions, if applicable **Factor 4:** Measuring effectiveness of interventions if applicable *Analysis must be conducted separately for each product line*	Identification of opportunities Documentation of interventions Measure progress over time	Annual March 2025	If not meeting goal, provide analysis and target systemic issues; develop appropriate interventions and action plans.	• Lorena Barrio, MD; SCPMG Regional Chief of Psychiatry • Maria I. Villarosa, MD; SCPMG Assistant Regional Medical Director, Behavioral Health Service Line Leader • Ebonie Vazquez, MD; SCPMG Regional Chief of Addiction Medicine • Dawn Gillam; SCPMG Executive Leader, Regional Behavioral Health • Erika Aguirre-Miyamoto, LCSW; SCPMG Regional Operations Director, Regional Behavioral Health • Elizabeth Hamilton, LCSW; SCPMG

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
					Regional Clinical Director, Regional Behavioral Health • Carla Hix, PsyD; KFHP Senior Director, Behavioral Health Quality & Regulatory Services • Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)
Continuity and Coordination Between Medical Care and Behavioral Healthcare (QI 4)					
NCQA	The organization collaborates with behavioral healthcare practitioners to monitor and improve coordination between medical care and behavioral healthcare. The organization collaborates with behavioral healthcare practitioners and uses information at its disposal to coordinate medical care and behavioral healthcare. **Element A:** The organization annually collects data about opportunities for collaboration between medical care and behavioral healthcare in the following areas: **Factor 1:** Exchange of information	HealthConnect access review to ensure information allowed by Federal & State laws is available to all practitioners	Annual March 2025	If not meeting standard, investigate HealthConnect functionality issues and develop action plan. On-going sharing of HealthConnect successful practices to maximize sharing of information between BHC and medical care departments.	• Lorena Barrio, MD; SCPMG Regional Chief of Psychiatry • Maria I. Villarosa, MD; SCPMG Assistant Regional Medical Director, Behavioral Health Service Line Leader • Ebonie Vazquez, MD; SCPMG Regional Chief of Addiction Medicine • Dawn Gillam; SCPMG Executive Leader, Regional Behavioral Health • Erika Aguirre-Miyamoto, LCSW; SCPMG Regional Operations Director, Regional Behavioral Health • Elizabeth Hamilton, LCSW; SCPMG Regional Clinical Director, Regional Behavioral Health • Carla Hix, PsyD; KFHP Senior Director, Behavioral Health Quality & Regulatory Services

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
					• Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)
NCQA	**Factor 2:** Appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care **Factor 3:** Appropriate uses of psychotropic medications	Documentation of collaboration with BH practitioners Identifying & selecting opportunities: **Factor 2:** Improve performance with patients being diagnosed with an SUD diagnosis using: HEDIS ADD and KPSC (CSG) ADD Initiation Measure for follow-up contact within 14 days or less. Taking collaborative actions & interventions **Factor 3:** Improving antidepressant medication management care using HEDIS AMM and KPSC (CSG) AMM measures to monitor performance. Taking collaborative actions and interventions	Annual March 2025	Review HEDIS and CSG ADD results and if not meeting goals implements interventions to improve performance. Review HEDIS and CSG AMM performance and initiate collaborative actions if not meeting goals.	• Lorena Barrio, MD; SCPMG Regional Chief of Psychiatry • Maria I. Villarosa, MD; SCPMG Assistant Regional Medical Director, Behavioral Health Service Line Leader • Ebonie Vazquez, MD; SCPMG Regional Chief of Addiction Medicine • Dawn Gillam; SCPMG Executive Leader, Regional Behavioral Health • Erika Aguirre-Miyamoto, LCSW; SCPMG Regional Operations Director, Regional Behavioral Health • Elizabeth Hamilton, LCSW; SCPMG Regional Clinical Director, Regional Behavioral Health • Carla Hix, PsyD; KFHP Senior Director, Behavioral Health Quality & Regulatory Services • Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)
NCQA	**Factor 4:** Management of treatment access and follow-up for members with coexisting medical and behavioral disorders	Improve follow-up care for patients discharged from the Emergency	Annual March 2025	Review HEDIS and CSG FUA results and if not meeting goals implements interventions to improve performance.	• Lorena Barrio, MD; SCPMG Regional Chief of Psychiatry

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
		Department with an SUD diagnosis using: **Factor 4:** HEDIS and KPSC (CSG) Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) Measure reports to monitor performance			• Maria I. Villarosa, MD; SCPMG Assistant Regional Medical Director, Behavioral Health Service Line Leader • Ebonie Vazquez, MD; SCPMG Regional Chief of Addiction Medicine • Dawn Gillam; SCPMG Executive Leader, Regional Behavioral Health • Erika Aguirre-Miyamoto, LCSW; SCPMG Regional Operations Director, Regional Behavioral Health • Elizabeth Hamilton, LCSW; SCPMG Regional Clinical Director, Regional Behavioral Health • Carla Hix, PsyD; KFHP Senior Director, Behavioral Health Quality & Regulatory Services • Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)
NCQA	**Factor 5:** Primary or secondary preventive behavioral health program implementation	HEDIS and KPSC (CSG) measures: **Factor 5:** Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS): The percentage of members 12 years of age and older with a diagnosis of major depression or	Annual March 2025	Review PHQ9 collection rates for members newly diagnosed with depression and take collaborative actions if not meeting goal.	• Lorena Barrio, MD; SCPMG Regional Chief of Psychiatry • Maria I. Villarosa, MD; SCPMG Assistant Regional Medical Director, Behavioral Health Service Line Leader • Ebonie Vazquez, MD; SCPMG Regional Chief of Addiction Medicine

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
		dysthymia who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter. <u>Depression Remission or Response for Adolescents and Adults (DRR):</u> The percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4-8 months of the elevated score.			• Dawn Gillam; SCPMG Executive Leader, Regional Behavioral Health • Erika Aguirre-Miyamoto, LCSW; SCPMG Regional Operations Director, Regional Behavioral Health • Elizabeth Hamilton, LCSW; SCPMG Regional Clinical Director, Regional Behavioral Health • Carla Hix, PsyD; KFHP Senior Director, Behavioral Health Quality & Regulatory Services • Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)
NCQA	**Factor 6:** Special Needs of Members with Severe & Persistent Mental Illness	**Factor 6:** Continue to track ED Referrals from the 24/7 KPSC Behavioral Health Helpline to ensure they follow through on initial treatment plan. **Factor 6:** HEDIS IET performance (Commercial & Medicare) • Initiation Phase – 90th Percentile • Engagement Phase – 90th Percentile	Annual March 2025	Review definition of Severe Mental Illness. Obtain KPSC ED referral report to determine metrics related to completing the initial assessment and triaging to an appropriate level of care for those with acute and persistent mental illness. Review HEDIS and CSG IET results and if not meeting goals implements interventions to improve performance.	• Lorena Barrio, MD; SCPMG Regional Chief of Psychiatry • Maria I. Villarosa, MD; SCPMG Assistant Regional Medical Director, Behavioral Health Service Line Leader • Ebonie Vazquez, MD; SCPMG Regional Chief of Addiction Medicine • Dawn Gillam; SCPMG Executive Leader, Regional Behavioral Health • Erika Aguirre-Miyamoto, LCSW; SCPMG Regional Operations Director, Regional Behavioral Health

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
					• Elizabeth Hamilton, LCSW; SCPMG Regional Clinical Director, Regional Behavioral Health • Carla Hix, PsyD; KFHP Senior Director, Behavioral Health Quality & Regulatory Services • Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)
NCQA	**Element B:** The organization annually conducts activities to improve the coordination of behavioral healthcare and general medical care, including: **Factor 1:** Collaborating with behavioral healthcare practitioners **Factor 2:** Quantitative and causal analysis of data to identify improvement opportunities **Factor 3:** Identifying and selecting one opportunity for improvement from Element A **Factor 4:** Identifying and selecting a second opportunity for improvement from Element A **Factor 5:** Taking collaborative action to address identified opportunity for improvement from Element A **Factor 6:** Taking collaborative action to address a second identified opportunity for improvement from Element A	**Factor 1:** HealthConnect access review to ensure information allowed by Federal & State laws is available to all practitioners **Factor 2:** HEDIS ADD performance (Commercial & Medicare) • Initiation Phase – 90th percentile • Engagement Phase – 90th percentile **Factor 3:** HEDIS AMM performance • Acute Phase – 90th percentile • Continuation Phase – 90th percentile **Factor 4:** HEDIS FUA Performance • Within 7 Days – 95th percentile • Within 30 Days – 95th percentile	Annual March 2025	If not meeting standard, investigate HealthConnect functionality issues and develop action plan. On-going sharing of HealthConnect successful practices to maximize sharing of information between BHC and medical care departments. Review HEDIS and CSG ADD results and if not meeting goals implements interventions to improve performance. Review HEDIS and CSG AMM performance and initiate collaborative actions if not meeting goals. Review HEDIS and CSG FUA results and if not meeting goals implements interventions to improve performance. Review PHQ9 collection rates for members newly diagnosed with depression and take collaborative actions if not meeting goal. Review definition of Severe Mental Illness. Obtain KPSC ED referral report to determine metrics related to completing the initial assessment and triaging to an appropriate level of care for those with acute and persistent mental illness. Review HEDIS and CSG IET results and if not meeting goals implements interventions to improve performance.	• Lorena Barrio, MD; SCPMG Regional Chief of Psychiatry • Maria I. Villarosa, MD; SCPMG Assistant Regional Medical Director, Behavioral Health Service Line Leader • Ebonie Vazquez, MD; SCPMG Regional Chief of Addiction Medicine • Dawn Gillam; SCPMG Executive Leader, Regional Behavioral Health • Erika Aguirre-Miyamoto, LCSW; SCPMG Regional Operations Director, Regional Behavioral Health • Elizabeth Hamilton, LCSW; SCPMG Regional Clinical Director, Regional Behavioral Health • Carla Hix, PsyD; KFHP Senior Director, Behavioral Health

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
		Factor 5: CSG DMS & DRR Performance • DMS – 60% • DRR – 24.0% Initial & Follow-up (Ages 12-17) • DRR – 51% Initial and Follow-up (Ages 18+) **Factor 6:** Continue to track ED referrals from the 24/7 KPSC Behavioral Health Helpline to ensure they follow through on their treatment plan. **Factor 6:** HEDIS IET performance (Commercial & Medicare) • Initiation Phase – 90th percentile • Engagement Phase – 90th percentile			Quality & Regulatory Services • Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)
NCQA	**Element C:** The organization annually measures the effectiveness of improvement actions taken for: **Factor 1:** The first opportunity identified in Element B **Factor 2:** The second opportunity identified in Element B	Areas of opportunity to be determined based on assessment of Element B: Factors 1-6.	Annual March 2025	Prioritizes improvement opportunities.	• Lorena Barrio, MD; SCPMG Regional Chief of Psychiatry • Maria I. Villarosa, MD; SCPMG Assistant Regional Medical Director, Behavioral Health Service Line Leader • Ebonie Vazquez, MD; SCPMG Regional Chief of Addiction Medicine • Dawn Gillam; SCPMG Executive Leader, Regional Behavioral Health

KFHP Southern California Region
2023 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
					• Erika Aguirre-Miyamoto, LCSW; SCPMG Regional Operations Director, Regional Behavioral Health • Elizabeth Hamilton, LCSW; SCPMG Regional Clinical Director, Regional Behavioral Health • Carla Hix, PsyD; KFHP Senior Director, Behavioral Health Quality & Regulatory Services • Regional Behavioral Health • Behavioral Health Quality Oversight Committee (BHQOC)

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
CLINICAL PRACTICE GUIDELINES					
Clinical Practice Guidelines					
	Update two (2) evidence-based Clinical Practice Guidelines (CPGs) for chronic conditions (Diabetes, Obesity) and two (2) for behavioral health (ADHD, Depression) at least every two (2) years Distribute revised CPGs for these conditions to practitioners via email, if substantive changes have been made since the previous update	Timely completion of updates for Diabetes, Obesity, Depression and ADHD guidelines, as needed, based on 2-year review cycle Distribute revised CPGs with substantive changes	Q4 2024	Work with KP National Guideline Program (CMI) to ensure timely updating of guidelines	Benjamin Broder, MD Marguerite Koster Yerado Abrahamian SCPMG Evidence-Based Medicine Services

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
OUTPATIENT CLINICAL QUALITY KEY MEASURES					
Outpatient Clinical Quality Key Measures					
KP	**2024 Key Clinical Quality Goals:** To address the growing challenge of publicly reported data, the Southern California Health Plan and Medical Group leaders identify clinical quality goals as areas of focused improvement. These are "Clinical Quality of Care Key Measures", which include several HEDIS-like measures as well as other performance measures which are only for internal monitoring. The Ambulatory Quality Composite summarizes performance across 70+ measures of clinical quality. 2024 Clinical Quality Key Measures: <u>Ambulatory Quality Composite</u> Proportion of Areas meeting AQC <u>Care Coordination</u> • Plan All-Cause Readmissions O/E ratio (Medicare members) <u>Staying Healthy</u> • HbA1c < 8.0% Non-Latino population (18-64 y/o) • HbA1c < 8.0% Latino Population (18-64 y/o) • Childhood Vaccinations: Combo 10 – Non-AA/Black Population • Childhood Vaccinations: Combo 10 – AA/Black Population • Proportion of Days Covered: Statins (18-85)	Targets: 100.0 13/13 1.03 69.0% 61.0% 61.0% 43.0% 84.0%	Achieve targets by the measurement period ending 10/31/2024	The 2024 Clinical Quality of Care Key measures reports are updated monthly and are available in the SCAL Clinical Strategic Goals (CSG) Sharepoint website: https://sp-cloud.kp.org/sites/teams-sccaa/CSG/CSG%20Report%20Library/CSG%20Current%20Monthly%20Reports Complete Care Initiatives with strategic plans are available at: https://sp-cloud.kp.org/sites/teams-scpmgcc-secure/complete%20care/SitePages/Home.aspx	Clinical Strategic Goals Planning & Measurement Group Timothy S Ho, MD, SCPMG Regional Assistant Medical Director, Quality & Complete Care Tracy Imley, MD, SCPMG Regional Assistant Medical Director, Quality & Clinical Analysis Nancy Gin, MD, SCPMG Medical Director of Quality and Clinical Analysis Giselle Willick, PharmD, SCPMG Chief Officer, Quality and Systems of Care Tania Tang, PhD, Executive Leader, SCPMG Clinical Analysis Ralph Vogel, PhD, Director, SCPMG Clinical Analysis Tara Harder, KFH/HP VP, Quality, Safety & Regulatory Services

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
HEDIS/CSG					
HEDIS					
NCQA	Report SCAL HEDIS MY 2023 data to NCQA, IHA, and HSAG	Data submission to NCQA and other agencies once a year for more than 70 measures	End of Q2 2024	• Review HEDIS specifications for changes and new metrics • Seek NCQA ASCR Measure Certification for all reported measures • Participate in audits by external agencies • Submit data to NCQA via IDSS, IHA via Onpoint, and Medi-Cal MCAS via IDSS/HSAG	Timothy Ho, MD Tania Tang, PhD Ralph Vogel, PhD Veronica Corrales Nick Alcivar
SCPMG KP HP	Report HEDIS-like and other metrics in monthly Clinical Strategic Goals (CSG) reporting	Report results for over 70 measures as part of CSG monthly reporting	Monthly, approx. six weeks after the end of each monthly measurement period	• Report monthly data in CSG reports https://sp-cloud.kp.org/sites/teams-sccaa/CSG/CSG%20Report%20Library/CSG%20Current%20Monthly%20Reports • Complete Care Initiatives https://sp-cloud.kp.org/sites/teams-scpmgcc-secure/complete%20care/SitePages/Home.aspx	Timothy Ho, MD Tania Tang, PhD Ralph Vogel, PhD Veronica Corrales

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
CONTINUITY AND COORDINATION OF CARE					
Continuity and Coordination of Care (QI 3)					
NCQA	The organization monitors and takes actions, as necessary, to improve continuity and coordination of care across the health care network. **Ambulatory POSH Post Discharge Visit Evaluation (POSH Timeliness)** The performance goals are as follows: 1. A Scheduled POSH physician visit within 7 days of discharge: ≥ 90% (2020) 2. A Completed POSH physician visit within 7 days of discharge: ≥ 80% (2020) **Ambulatory Visit Medications Reconciliation Assessment (Med-Adherence)** The target goal for successful medication reconciliation is defined as > 60% of visits have successful medication reconciliations. **Comprehensive Diabetes Care – Eye Exams** The performance target is 87% (for all lines of business) of the eligible population where	**POSH Timeliness** – Timely visit within 7 days of discharge for members identified as having a high LACE score and discharging from the medicine service **Med Adherence** – Percent of medications documented in KPHC on the patient's medication list at the beginning of the office visit that have a check mark as "member taking" by the end of the visit after the medication review (measure of medication concordance). Successful medication reconciliation occurs when >75% of the medications on the list at the beginning of the visit have a check mark by the end of the visit (medication concordance). **Comprehensive Diabetes Care – Eye Exams**	Q4 2023	**Ambulatory POSH Post Discharge Visit Evaluation** 1. Aggregate and member-specific data are distributed weekly at the member level and reviewed by each of the Medical Center's readmission teams: physicians, nurses, managers, unit-based teams, etc. 2. Daily call lists are generated and reviewed by a core team at each of the Medical Centers, with a monthly dashboard review of performance by Medical Center Leaders, Medical Center Improvement Advisors, and Medical Center Initiative Leads. 3. Monthly HEDIS OE performance is generated and includes each of the metrics in the Readmission Reduction Program in addition to other intermediate process measures to monitor operations. 4. All reports and statistics, by Medical Center and in aggregate, are posted and accessible in a secure shared document library available to Leadership and members of the Care teams. 5. Reports are also reviewed monthly by the Medical Center Leadership and Regional Leadership through the monthly Readmission Steering Committee and monthly Readmission Improvement Advisor webinar and the bi-monthly Readmission Reduction Champion meetings. 6. Regional oversight and ongoing monitoring are also conducted by the Hospital Clinical Improvement Team (HCIT) and the Medicare 5-Star workgroup. 7. Regional Leadership is responsible to ensure outcomes are achieved as well as providing feedback and strategies to address performance gaps. 8. Annually an evaluation and strategic plan is developed to assess the impact of the program and improve effectiveness in reducing readmissions. **Medication Reconciliation** 1. Engagement of Medical Center champions, as well as determining priority areas and activities	**POSH Timeliness** • Dan Huynh, MD • Michelle Pruitt • Fredy Medina **Med Adherence** • Steven Steinberg, MD • Jose Becerra • SCAL Medication Adherence and Reconciliation Committee **Comprehensive Diabetes Care – Eye Exams** • John Martin, MD • Tim Hsieh, MD • Bobeck Modjtahedi, MD • Diane Simon • Shalini Rao • Jennifer Tran **Total Joint Replacement and Recovery** • Ronald Navarro, MD • Nithin Reddy, MD • P. Martin Yuson, PT, DPT, JD

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	members with retinopathy have a qualifying eye exam in the calendar year and those without diabetic retinopathy have a qualifying eye exam in the calendar year or year prior or bilateral eye enucleation any time up to the measurement year end. **Total Join Replacement and Recovery** The overarching objective of the same-day Total Joint program is to reduce length of stay while maintaining or improving quality compared to inpatient Total Joint patient cases. The specific goals of the same-day Total Joint program include: • Length of stay (LOS) goal – at least 80% same-day surgery, 5% or less 2-midnight stay, and the remainder (approx. 15%) 1-midnight stay. • Quality balancing measures – 8% or less return to Urgent Care or Emergency Department within 7 days and 3% or less hospital readmissions within 30 days. **QI 3A. The organization annually identifies opportunities to improve coordination of medical care by:** 1. Collecting data on member movement between practitioners. 2. Collecting data on member movement across settings. 3. Conducting quantitative and causal analysis of data to identify improvement opportunities. 4. Identifying and selecting one opportunity for improvement.	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) and where members with retinopathy have a qualifying eye exam in the calendar year and those without diabetic retinopathy have a qualifying eye exam in the calendar year or year prior. **Total Joint Replacement and Recovery** 8% or less return to Urgent Care or Emergency Department within 7 days and 3% or less hospital readmissions within 30 days.		2. Development of workflow with input and agreement from physicians, RNs, pharmacy, and collaboration among other disciplines including hospital champions 3. Development of a training "tool kit" that promotes consistency and offers sufficient flexibility to accommodate differences that maybe unique to a particular clinic or sub-specialty 4. Access to real-time data and information so that staff are effectively monitoring fulfillment of the program protocols; and 5. Development and dissemination of physician level reports as well as analysis that calculates performance rates for each specialty or clinic type, including each Medical Center. **Comprehensive Diabetes Care – Eye Exams** The Diabetic Retinal Screening (DRS) Work Group will evaluate performance on retinal screening and plan quality improvement initiatives as appropriate. Primary care providers capture digital retinal photos within the primary care setting and send to optometry to review and share findings. Photos illustrating eye complications elicit an outreach from the eye care professional to the patient to come in for further evaluation; and those follow-up results and subsequent care plan are shared with the primary care provider. **Total Joint Replacement and Recovery** Key activities for Total Joint Replacement and Recovery take place in the following three general areas: 1. Pre-op – The "Pre-op" process begins when the orthopedic surgeon and patient agree that surgery is the appropriate option and ends when the patient presents for surgery. 2. In the hospital – The "In the Hospital" process begins when the patient presents for surgery and ends when the patient is discharged to home or a skilled nursing facility. This process also applies to patients who may have surgery in an ambulatory surgery facility. 3. At home – The "At Home" process encapsulates all care provided at the patient's home after discharge from the hospital.	

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	5. Identifying and selecting a second opportunity for improvement. 6. Identifying and selecting a third opportunity for improvement. 7. Identifying and selecting a fourth opportunity for improvement.				
NCQA	**QI 3B. The organization annually acts to improve coordination of medical care by:** 1. Acting on a first opportunity for improvement identified in Element A, factors 4-7. 2. Acting on a second opportunity for improvement identified in Element A, factors 4-7. 3. Acting on a third opportunity for improvement identified in Element A, factors 4-7.	If opportunities are identified in QI 3A, then actions will be taken, at which point the metric will be: Met or Not Met	Q4 2023	Opportunities will be identified throughout the year and action plans will be developed if necessary	**POSH Timeliness** • Dan Huynh, MD • Michelle Pruitt • Fredy Medina **Med Adherence** • Steven Steinberg, MD • Jose Becerra • SCAL Medication Adherence and Reconciliation Committee **Comprehensive Diabetes Care – Eye Exams** • John Martin, MD • Tim Hsieh, MD • Bobeck Modjtahedi, MD • Diane Simon • Shalini Rao • Jennifer Tran **Total Joint Replacement and Recovery** • Ronald Navarro, MD • Nithin Reddy, MD • P. Martin Yuson, PT, DPT, JD
NCQA	**QI 3C. The organization annually measures the effectiveness of improvement actions taken for:** 1. The first opportunity identified in Element B. 2. The second opportunity identified in Element B.	If opportunities are identified in QI 3B, then the effectiveness of the actions will be measured, at which point the metric will be: Met or Not Met	Q4 2023	For opportunities identified throughout the year, improvement actions will be evaluated on at least 3 related key opportunities.	**POSH Timeliness** • Dan Huynh, MD • Michelle Pruitt • Fredy Medina **Med Adherence** • Steven Steinberg, MD • Jose Becerra

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	3. The third opportunity identified in Element B.				• SCAL Medication Adherence and Reconciliation Committee **Comprehensive Diabetes Care – Eye Exams** • John Martin, MD • Tim Hsieh, MD • Bobeck Modjtahedi, MD • Diane Simon • Shalini Rao • Jennifer Tran **Total Joint Replacement and Recovery** • Ronald Navarro, MD • Nithin Reddy, MD • P. Martin Yuson, PT, DPT, JD

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
CONTRACT OVERSIGHT & CONTRACTED PROVIDERS					
Contract Oversight & Contracted Providers					
NCQA DMHC CMS KP-SCAL Goal	Ensure safety of patients in contracted facilities. Meet 100% of required elements by NCQA re: Health Services Contracting on an ongoing basis.	Met/Not through evidence of reports on an annual basis to RCC and SCQC	Q4 2024	Continuing leveraging the quality oversight repository to capture ongoing quality metrics and evaluations for contracted providers and incorporate new In-Scope providers. Participate in JOC meetings for Delta Dental and ASH. Perform Annual Audits and report to SCQC,	Paula Kraft Regional Director Quality Oversight
NCQA DMHC CMS KP-SCAL Goal	Ensure safety of patients in contracted facilities. Meet 100% of required elements by NCQA re: Health Services Contracting on an ongoing basis.	100% review of all KP contracted providers	Ongoing Reports on an annual basis to RCC and SCQC & QHIC	Ongoing monitoring of quality oversight process as evidenced by Executive Summaries to Regional Credentialing, SCQC and QHIC. Continue development of site visit tools and protocols to ensure quality and standardized approach. Clearly define Site Visit Requirements and Recommendations for key stakeholders.	Paula Kraft Regional Director Quality Oversight
NCQA DMHC CMS KP-SCAL Goal	Continue to widen scope of the ongoing partnership between KFH and other plan facilities' quality, patient safety and infection control program.	Implementation of action items as outlined	Q4 2024	Joint Operations meeting between KP Leaders and Affiliated Hospitals to reflect quality oversight dialogue. Quality Reporting for Affiliated Hospital key metrics within SharePoint. Ongoing monitoring of goals and reporting to SCQC and KPAHC. Continue Affiliated Hospital Quality Subcommittee revised structure to focus on improvement opportunities through collaborative efforts and the sharing successful strategies focused on key quality metrics.	Paula Kraft Regional Director Quality Oversight

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
CREDENTIALING					
Credentialing					
NCQA KP	• 100% of practitioners are credentialed prior to providing services to our members • 100% of practitioners are re-credentialed at least every 24 months for hospital practitioners • and every 36 months for ambulatory practitioners • As applicable, 100% of practitioners are re privileged at least every 24 months • All privileged files are reviewed by Regional Credentialing personnel prior to action by C&P • Credentialing errors are corrected prior to C&P Committee action as required per regulatory standards/requirements.	100% Goal Monitored Quarterly	Ongoing	2024 Action Plans and Next Steps: • Re-evaluate monitoring program and implement process improvement opportunities to ensure 100% compliance in privilege adherence and reappointment timeliness. Continue to monitor through Tableau and MSO reports. • Regional monthly reports will communicate any noncompliance and action plans will be required if improvement plans are not successful. • A new standardized process will be developed to monitor, track and communicate compliance and or areas of improvement for errors being corrected prior to C& P Committee.	Monique Ferguson SCAL Regional Credentials Director Regional Credentials Committee Christopher Distasio, MD and Margie Harrier, SVP

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
KFHP Care Coordination and Case Management					
Outreach Requirements – Population Health Management and Whole Child Model					
DHCS	Perform Health Risk Assessment (HRA) for the following PHM and WCM populations per regulatory requirements: 1. WCM 2. SPD 3. CSHCN 4. LTSS	KFHP case managers outreach to PHM and WCM members to complete the required assessment.:	December 31, 2024	Health Risk Assessment (HRA): 1. KFHP case managers utilize the WCM enrollment worklist to outreach to WCM members 2. KFHP case managers utilize Compass Rose target tasks to guide outreach to SPD members 3. Department manager to monitor completion performance of the HRA 4. HRA chart reviews	Sloane Petrillo, Director of Care Coordination / Case Management
DHCS	1. For WCM a. initial HRA completed within 90-days of enrollment in CCS for members stratified as high risk b. Initial HRA completed within 120 days of enrollment in CCS for members stratified as low risk c. Reassessment within 365 days from the last assessment	1. 100% Outreach to the newly enrolled WCM 2. Timeliness of outreach to WCM population >90%	December 31, 2024	Health Risk Assessment (HRA): 5. KFHP case managers utilize the WCM enrollment worklist to outreach to WCM members 6. KFHP case managers utilize Compass Rose target tasks to guide outreach to SPD members 7. Department manager to monitor completion performance of the HRA 8. HRA chart reviews	Sloane Petrillo, Director of Care Coordination / Case Management
DHCS	2. For SPD a. Initial HRA for members stratified as High Risk started within 30 days of risk stratification and completed within 60 days of risk stratification	1. 100% Outreach to the newly enrolled High Risk SPD members 2. Timeliness of outreach to High Risk SPD population >90%	December 31, 2024	Health Risk Assessment (HRA): 9. KFHP case managers utilize the WCM enrollment worklist to outreach to WCM members 10. KFHP case managers utilize Compass Rose target tasks to guide outreach to SPD members 11. Department manager to monitor completion performance of the HRA 12. HRA chart reviews	Sloane Petrillo, Director of Care Coordination / Case Management
DHCS	3. For CSHCN a. Complete HRA outreach for members identified as CSCHN-assessment to begin	1. 100% outreach to CSHCN members	December 31, 2024	Health Risk Assessment (HRA): 13. KFHP case managers utilize the WCM enrollment worklist to outreach to WCM members	Sloane Petrillo, Director of Care Coordination / Case Management

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	within 30 days of risk stratification and complete HRA within 60 days of risk stratification. *New measure for 2024	2. Timeliness of outreach to CSHCN population >90%		14. KFHP case managers utilize Compass Rose target tasks to guide outreach to SPD members 15. Department manager to monitor completion performance of the HRA 16. HRA chart reviews	
DHCS	4. For LTSS a. Complete Outreach for all members identified with LTSS needs within 2024 *New measure for 2024	1. 100% outreach to members identified with LTSS needs 2. Timeliness of outreach to LTSS population >90%	December 31, 2024	Health Risk Assessment (HRA): 17. KFHP case managers utilize the WCM enrollment worklist to outreach to WCM members 18. KFHP case managers utilize Compass Rose target tasks to guide outreach to SPD members 19. Department manager to monitor completion performance of the HRA 20. HRA chart reviews	Sloane Petrillo, Director of Care Coordination / Case Management
KFHP Complex Case Management (CCM), Community-Based Adult Services (CBAS) and Transitional Care Services (TCS)					
NCQA	CCM: Comply with NCQA PHM 5 Standards	CCM: Achieve >90% on department chart audits for 2024	December 31, 2024	CCM: 1. Targeted CCM chart reviews (5 or 5%) 2. Follow up education for case managers, as needed.	Sloane Petrillo, Director of Care Coordination / Case Management
DHCS	CBAS: 1. Compliance with CBAS Referral Process and Turn Around Time (TAT) 2. Improve CBAS workflow process and ensure using the correct HCPC codes.	CBAS Process and TAT: 1. CBAS CEDT TAT Goal: 100% 2. CBAS Authorization TAT Goal: 98%	December 31, 2024	CBAS Process and TAT: 1. Complete CEDT with RN signatures within thirty (30) calendar days from receipt of benefit inquiry. 2. CBAS Authorization TAT to approve, modify or deny must be completed within 5 business days upon receipt of authorization request 3. Reinforce with continuous education on CBAS program and process TAT to staff 4. Department manager monitors and reviews CBAS TAT quarterly.	Sloane Petrillo, Director of Care Coordination / Case Management
DHCS	TCS:	TCS:		TCS: Outreach to TCS high-risk members:	Sloane Petrillo, Director of Care Coordination / Case Management

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	1. Outreach high-risk members identified through data mining for TCS per regulatory requirements: a. Assign member to a TCS care manager upon enrollment b. Conduct outreach to members enrolled in TCS through data mining. 2. Ensure TCS members have a post-discharge, follow-up appointment with their provider scheduled. *New measure for 2024	Document outreach of TCS high-risk members: • 100% of TCS members have a care manager assigned within 24-hours of admission notification. • 100% of TCS high-risk members have outreach conducted within 7 days of discharge. 2. Document TCS member post-discharge, follow-up provider appointment scheduled: • 100% of TCS high-risk members have a follow-up provider appointment scheduled within 7 days of discharge. • 100% of TCS low-risk members have a follow-up provider appointment scheduled within 30 days of discharge.		1. TCS care managers utilize member admissions, discharge, and transfer (ADT) file to outreach and assess transitioning members 2. Department manager to monitor completion of outreach 3. Conduct chart review for random sample of TCS outreach quarterly Post-discharge, follow-up provider appointment for TCS member scheduled: 1. TCS care managers conduct chart review to identify missing post-discharge, follow-up provider appointments 2. TCS care managers have access to schedule post-discharge, follow-up provider appointments as needed 3. Department manager to conduct quarterly chart review for random sample of TCS members to ensure post-discharge, follow-up provider appointments are scheduled	

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
Special Needs Plan (SNP) Regulatory Requirements					
CMS, DHCS and NCQA	A. SNP Care Management Measure: 1. Complete initial Health Risk Assessment (HRA) within 90 days (before or after) of the most current enrollment effective date 2. Complete the annual HRA within 365 days of the initial assessment/1 year of the previous HRA date	A. SNP Care Management Measure: The annual target for the completion of initial and annual SNP HRAs in 2024 is: 5-Star minimum cut point to 100%	December 31, 2024	1. Care managers will outreach to all members who are due for the initial and annual HRA within compliance timeframes 2. Care managers will accurately document in KPHC the outreach outcomes to easily identify the number of Reached/Completed, Unable to Reach, Refused, Hospice/Home Based Palliative Care and Other 3. Region will provide education to care managers on the HRA process, and best practices 4. Region will monitor and track the number of "overdue" assessments weekly 5. Care managers will outreach to all members who are due for the initial and annual HRA and will perform functional status, pain screening, medication review and advocate for life care planning during the HRA 6. Performance data will be monitored monthly	Sloane Petrillo, Director of Care Coordination / Case Management Kim Kaiser, Regional Quality Administrator
CMS, DHCS, and NCQA	B. Care of Older Adults Measures: 1. Completion of SNP member medication review during the measurement year 2. Completion of SNP member functional status during the measurement year 3. Completion of SNP member pain screening during the measurement year	B. Meet KFHP set benchmarks for Care of Older Adult measures: 1. Medication Review = 95% 2. Functional Status = 93% 3. Pain Screening = 94%	December 31, 2024	1. SNP Care Managers are not the only drivers for this measure. 2. Performance data will be monitored monthly 3. Care managers will outreach to all members who are due for the initial and annual HRA and will perform functional status, pain screening, medication review and advocate for life care planning during the HRA	Sloane Petrillo, Director of Care Coordination / Case Management Kim Kaiser, Regional Quality Administrator
DHCS and NCQA	C. Follow-Up After ED Visit for Mental Illness (2 Rates): The percentage of Medicare Advantage Special Needs Plan members assessed after an emergency department (ED) visit, includes adults and children 6 years of age and older with a diagnosis of mental illness and who received a follow-up visit for mental illness	C. Follow-Up After ED Visit For Mental Illness: Rate 1 - Within 30 days = 76% Rate 2 - Within 7 days= 63%	December 31, 2024	C. Follow-Up After ED Visit For Mental Illness: 1. SNP Care Managers are not the only drivers for this measure 2. Performance data will be monitored monthly	Sloane Petrillo, Director of Care Coordination / Case Management Kim Kaiser, Regional Quality Administrator

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	*New measure for 2024				
CMS, and NCQA	D. SNP Member Satisfaction with the care coordination and SNP case management program by conducting quarterly analysis on Member Satisfaction survey results and receive 80% or better on the question "Do you think this case management program is helpful for you in achieving your goals?" *New measure for 2024	D. Do you think this case management program is helpful for you in achieving your goals? = ≥ 80%	December 31, 2024	D. SNP Member Satisfaction: 1. Perform member satisfaction survey via interactive voice recognition weekly on sample population. 2. Collect and report results annually	Sloane Petrillo, Director of Care Coordination / Case Management Kim Kaiser, Regional Quality Administrator
CMS, and NCQA	E. 30-Day Readmissions: The percentage of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days to ensure affordability and appropriate utilization of services for preventative health and chronic conditions. *New measure for 2024	E. 30-Day Readmissions = 0.86	December 31, 2024	E. 30-Day Readmission: 1. Provide education to care managers on post discharge protocols 2. Post discharge and readmission reports provided regularly for transitional care management 3. Performance data will be monitored monthly	Sloane Petrillo, Director of Care Coordination / Case Management Kim Kaiser, Regional Quality Administrator
Special Needs Plan (SNP) Quality and Process Measure Compliance					
DHCS, CMS and NCQA	A. Receive 90% or better on quarterly SNP Medicare Monitoring Metrics targeted at care coordination elements of the SNP Model of Care: 1. Timely Initial Health Risk Assessment (HRA) 2. Timely Re-assessment 3. Care Plan Completion 4. Care Plan Implementation	A. Reach 90% or better on the following SNP Metrics: 1. Timely Initial Assessment 2. Timely Re-assessment 3. Care Plan Completion 4. Care Plan Implementation	December 31, 2024	A. Medicare Monitoring Metrics: 1. Continue to address and provide training to care managers on all elements of care coordination and care management per the SCAL SNP Model of Care 2. Hold quarterly care manager meetings and/or trainings to share SCAL region best practices and care coordination topics 3. Provide trainings focused specifically on proper care plan development, implementation and documentation 4. Care managers will have knowledge of community-based services for referral and to provide coordination of care as appropriate 5. Care managers will accurately document outreach outcomes in KPHC by required	Sloane Petrillo, Director of Care Coordination / Case Management Kim Kaiser, Regional Quality Administrator

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
				timeframes to easily identify the number of Reached/Completed, Unable to Reach, Refused, Hospice/Home Based Palliative Care and Other 6. Conduct chart reviews for random sample of SNP membership quarterly	
DHCS, CMS and NCQA	B. Care Transitions: 1. Outreach and health risk assessment will be performed for post-acute discharges within 72-hours of discharge notification	B. Care Transitions: 1. 90% call completion rate	December 31, 2024	B. Care Transitions: 1. Provide education to care managers on post discharge protocols 2. Post discharge and readmission reports provided regularly for transitional care management	Sloane Petrillo, Director of Care Coordination / Case Management Kim Kaiser, Regional Quality Administrator
	C. Reduce the Health Risk Assessment (HRA) Overdue Rate	C. Reduce the number of overdue (unable to reach, refused, hospice, HBPC, and others) from the SNP population. Target is ≤ 8%	December 31, 2024	C. Reduce HRA Overdue Rate: 1. Care manages will outreach to all members who are due for the initial and annual HRA within compliance timeframes 2. Care managers will accurately document outreach outcomes in KPHC by required timeframes to easily identify the number of Reached/Completed, Unable to Reach, Refused, Hospice/Home Based Palliative Care and Other 3. Region will provide education to care managers on the HRA process and best practices	Sloane Petrillo, Director of Care Coordination / Case Management Kim Kaiser, Regional Quality Administrator
	D. Increase the number of Health Care Decision Makers identified and documented in the Life Care Planning Tab in HealthConnect during Initial and Annual SNP Assessment Process	D. Target is ≥ 45% that a Health Care Decision Maker was identified on or before the encounter date	December 31, 2024	D. Life Care Planning: 1. Care managers will outreach to all members who are due for the initial and annual HRA and will advocate and document life care planning conversations during the HRA 2. Data will be monitored and reported monthly	Sloane Petrillo, Director of Care Coordination / Case Management Kim Kaiser, Regional Quality Administrator

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
Medicare Advantage Chronic Care Improvement Program (CCIP) – new project pending					
CMS and NCQA	Diabetes control and disparity reduction for Hispanic/Latino Members	Exceed the national 90th percentile for HbA1c control (HbA1c < 8 mg/dL) in the overall Medicare population and close the disparity gap for Medicare SNP Hispanic Latino enrollees with diabetes	December 31, 2024	1. In-reach interventions to increase the percentage of members who have their HbA1c tested regularly 2. Provision of language services to Hispanic/Latino enrollees with diabetes, including diabetes education classes and online education materials available in Spanish	Sloane Petrillo, Director of Care Coordination / Case Management Kim Kaiser, Regional Quality Administrator
Enhanced Case Management (ECM) and Community Supports (CS) Regulatory Requirements					
DHCS	1. Process authorizations for ECM and Community Supports services	1. ECM referrals processed upon receipt of information from NLE 2. Community Supports Referrals processed timely: • Community Supports Referral Process and 5-day Turn Around Time (TAT) target = 100%	December 31, 2024	ECM: 1. KFHP case managers utilize RTF and internal referrals to process authorizations in Tapestry 2. Monitor completion of authorizations via log, reports, and chart review Community Supports: 1. Manager to monitor queue and inbox daily 2. Quarterly CS education 3. Development of team to process CS referrals	Sloane Petrillo, Director of Care Coordination / Case Management

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
HOME HEALTH AND HOSPICE					
Access					
CMS CMS KP	Home Health 48-hour admission timeliness (Adjusted – 48 hours/per patient request with an MD order) (BPQI – source) Palliative Care 48-hour admission timeliness (Adjusted – 48 hours/per patient request with an MD order) (BPQI – source) Hospice 24-hour admission timeliness (Adjusted – 48 hours/per patient request with an MD order) (BPQI – source) **Source of timeliness, may change*	Target: 90% Target: 90% Target: Min: 85% Max: 95%	Jan-Dec 2024	1. Optimized Referral Process & Risk Stratification 2. Improved Productivity and Capacity** (Technology dependent & Operational Standardization Structure dependent for accelerated improvement) 3. Supervisory oversight of schedules Monitoring Monthly and Quarterly	**Della Williams –** *Quality Director Continuing Care* **Angel Vargas –** *Vice President, Care at Home* **Odylin Bundalian –** *Sr. Director, Clinical Excellence and Chief Clinical Officer*
Experience					
CMS/KP	Re-hospitalization Rate within 30 days from discharge from the hospital (SHP – source)	**SCAL Target:** Min: <= SHP State % for same period Max: <5% 2023 SCAL avg was 10.5% (SHP State <13%) **HI Target:** Min: <= SHP State % for same period Max: <5% 2023 HI Avg was 17.4% (Hi State was 15.5%)	Jan-Dec 2024	1. Use of SHP program to identify patients at high risk for readmission 2. Development of care plan to include frequency and duration to prevent re-admission and interventions to address high risk patients based on SHP high risk alert 3. Multi-disciplinary conference for high-risk patients 4. Monthly readmission meeting to review audit findings and action plans 5. Utilization of readmission drivers – CHEFF to prevent readmission a. Chart Review b. Head to toe assessment c. Escalation d. Front load e. Follow up with family, caregiver, provider Monitoring Monthly and Quarterly	**Della Williams –** *Quality Director Continuing Care* **Angel Vargas –** *Vice President, Care at Home* **Odylin Bundalian –** *Sr. Director, Clinical Excellence and Chief Clinical Officer*
Service					
CMS	Home Health – Summary Star Rating (HHCAHPS NCEA – source)	Target: Minimum: 3.5 star (3 to 3.5) Maximum: 5 star (4.5 or higher)	Rolling 12 months Oct 2024	1. Continue improvement strategies: AIDET, AHEART Service Recovery, Golden Minute, ALWAYS TELL, Direct Report Rounding and Patient Rounding 2. Regional Service education for new staff, Supervisors and Quality staff	**Della Williams –** *Quality Director Continuing Care* **Angel Vargas –** *Vice President,*

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
				3. Improve service excellence by reward and recognition with DAISY and Rose award 4. Provide QR code to patients to obtain real time feedback 5. Present Thank you cards to patient upon discharge 6. Monitor and present SHP comments during staff meetings 7. Incorporate care experience initiative within UBTs to drive improvement Monitoring Monthly and Quarterly	*Care at Home* **Odylin Bundalian –** *Sr. Director,* *Clinical Excellence and Chief Clinical Officer*
CMS	Hospice – Rate of Agency (NCEA HOCAHPS – source)	Target: Minimum: 3.25 star (3 to 3.5) Maximum: 5 star (4.5 or higher)	Rolling 12 months Oct 2023-Sept 2024	1. Implement Performance Improvement strategies to improve after hours service and patient and caregiver communication 2. Identify opportunities for service improvement from feedback on returned surveys 3. Incorporate care experience initiative within UBTs to drive improvement Monitoring Quarterly	**Della Williams –** *Quality Director* *Continuing Care* **Angel Vargas –** *Vice President,* *Care at Home* **Odylin Bundalian –** *Sr. Director,* *Clinical Excellence and Chief Clinical Officer*

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
LONG TERM CARE / SKILLED NURSING FACILITY					
Access					
KP	**SNF to Home Readmissions** % of patients discharged from SNF to home (including home with home health) and has a hospital readmission within 30 days of SNF discharge (KP Insight)	Target: 11 % (lower is better) or 1% Reduction	Jan-Dec 2024	1. Standardize best practices for readmission strategies. 2. Drill down by Medical Center and spread best practices from areas meeting the target. 3. The importance of 7-day POSH appointments and 3-day call backs will be emphasized locally. 4. Quality oversight of contracted facilities will be standardized regionally and locally to ensure patient safety. 5. Understand readmission variation across core and non-core facilities.	**Della Williams –** *Senior Director Quality & Safety -Continuum Quality* **Jose John –** *Executive Director Care Coordination and Continuum* **Deepa Savani, MD –** *SNF Physician Champion* **Vacant –** *Regional Program Director for LTC Services* **Karen Sielbeck** *Vice President, Care Coordination and Continuum*
Quality					
KP	**Completion of Annual Review** % of annual site visits completed of all skilled contracted facilities within 12 months of the previous review. Includes the desktop review of LTC/Custodial facilities. (KP Regional Long Term Care Tracker) **Flu Vaccine Penetration Rate in Core SNFs** % of Members who receive flu vaccinations from KP or outside of KP and have their flu vaccines documented in HealthConnect out of Members who have at least 1 custodial encounter or 2 SNF encounters in core facilities with physicians, residents and APPs. Patients are homed to either their first custodial visit or second SNF visit whichever comes first. (Business Systems and Reporting) *New measure for 2024	Target: 100% (higher is better) Site Visit Completion Target: Greater than or equal to 82% or 5% Improvement (higher is better) Target: 80% (higher is	Jan-Dec 2024	1. Continue to track completion regionally and update the local medical centers to ensure compliance. 2. Collaborate with Hospice for the visits. 3. Using the new tool to track the quality site visits. 4. Clearly delineate distribution of responsibility between local and regional quality teams. Drill down metric to each accountable team. 5. Partner with SNF on vaccination procedures. 6. Hardwire documentation workflows to capture vaccinations completed outside of KP. 7. Use the Serious Illness flag to identify high risk members. 8. Hardwire workflows to ensure high quality LCP shared decision making.	**Della Williams –** *Senior Director Quality & Safety -Continuum Quality* **Jose John –** *Executive Director Care Coordination and Continuum* **Deepa Savani, MD –** *SNF Physician Champion* **Vacant –** *Regional Program Director for LTC Services* **Karen Sielbeck** *Vice President, Care Coordination and Continuum*

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	Life Care Planning Discussions Documented (Core SNFs) % of skilled patients in a Core SNF with use of serious illness or wellness smartphrase by any member of the team out of referrals to SNF (core, skilled only) with any encounter during the stay. (Business Systems and Reporting) *New measure for 2024	better)			
Satisfaction					
KP	**7-Day POSH Scheduling** % of SNF discharges to home who had a Post-Hospital (POSH) visit booked appointment with within 7 days post-discharge from SNF (KP Insight) **3-Day Call Backs** % of SNF discharges to home who had a Post-Discharge Follow-up Phone Call within 3 days post-discharge from SNF (KP Insight)	Target: 85% or 5% Improvement (higher is better) POSH Scheduling Target: TBD for 2024 (2023 Target: 78%) 3-Day Call Backs	Jan-Dec 2024	1. Revisit POSH and Call Back workflows for opportunities for improvement and re-implement with local medical center teams. 2. Root-cause analysis with areas with the greatest and consistent opportunity and spread best practices from areas meeting the target. 3. LTC Coordinators will ensure patients received POSH appointments prior to discharge. 4. 3-day call back completion calls will ensure members are aware of their appointments. 5. Monitor statuses on a quarterly basis.	**Della Williams –** *Senior Director Quality & Safety -Continuum Quality* **Jose John –** *Executive Director Care Coordination and Continuum* **Deepa Savani, MD –** *SNF Physician Champion* **Vacant –** *Regional Program Director for LTC Services* **Karen Sielbeck** *Vice President, Care Coordination and Continuum*

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
MEDI-CAL QUALITY IMPROVEMENT & HEALTH EQUITY TRANSFORMATION PLAN (QIHETP)					
2023-2026 Kaiser Permanente Statewide DHCS Clinical Performance Improvement Project (PIP): W30-6					
DHCS	Improve Well Child Visits in the First 30 Months of Life - Well Child Visits in the First 15 Months of Life - Six or More Well-Child Visits (W30-6) measure among Black/African American Medi-Cal Members. **Health Disparity** Improve the health of Black/African American Medi-Cal Members 0-30 months of age. **Goal:** Conduct required PIP in accordance with the DHCS contract and HSAG guidelines and meet 2024 deliverables a timeline. HSAG/DHCS Deliverable Timeline: **2024** – Submit baseline data to HSAG/DHCS for CY 2023 for Well Care Visits in the first 30-months of Life 0-15 months: 6 or more well child visits (W30-6). Update Steps 1-6, if needed, complete Step 7 with baseline data, and Step 8 with QI activities completed to date. 2025 – Submit baseline to remeasurement data for CY2024 and narrative to HSAG/ DHCS, complete Step 8 with QI activities completed to date. 2026 – Meet the target established in 2024. Submit final baseline to remeasurement data for CY2025, narrative, and PIP report to HSAG/DHCS. *New measure	HSAG/DHCS Submission timeline met and achieved validation requirements. Increase W30-6 rate among Black/African Americans from the MY2023 baseline. **Baseline** (KP California GMC + Plan Partners): MY2023 TBD MY2022: 69.08%. **Target**: TBD based on MY2023 baseline, but to exceed MY2022 and MY2023 performance. **Outcome measure**: W30-6 rate among Black/African American Medi-Cal members. **Process measure**: Pediatrics access to care.	MY 2024 ending December 31, 2024/RY 2025	Submit 2024 deliverables to HSAG and DHCS within the required timeframes and achieve validation requirements. Establish a Stakeholder group. Request necessary data to track both outcome and process measures. Validate the data and break it down by service area and county. Conduct a needs assessment to identify additional barriers. Develop specific PDSAs (Plan Do Study Act) with the Stakeholder workgroup to address Well-Care Visit disparity among Black/African American Medi-Cal Members 0-30 months of age. Track and evaluate progress following various PDSAs. Report progress and goal status to stakeholders and committees for review, support, recommendations, and approval. .	• Vice President, Associate Chief Medical Officer, National Medicaid and State Programs • Executive Director, Chief Health Equity Officer, National Medicaid and State Programs • Regional Assistant Medical Director, Quality & Complete Care • Regional Director Quality & Safety Southern California Medi-Cal Quality • Quality & Safety Improvement Consultant, Clinical Quality Consulting
2023-2026 Kaiser Permanente Statewide DHCS Non-Clinical Performance Improvement Project (PIP)					
DHCS	Improve % of provider notifications for Members with Substance Use Disorder (SUD) and Specialty Mental Health (SMH) diagnoses following or within 7-days of E.D. visit. Goal: Conduct required PIP in accordance with the DHCS contract and HSAG guidelines and meet the 2024 deliverable timeline.	HSAG/DHCS Submission timeline met and achieved validation requirements. Improve % of provider notifications care for Members with	MY 2024 ending December 31, 2024/RY 2025	Submit 2024 deliverables to HSAG and DHCS within the required timeframes and achieve validation requirements. Establish a Stakeholder group. Request and validate necessary data.	• Vice President, Associate Chief Medical Officer, National Medicaid and State Programs • Executive Director, Chief Health Equity Officer,

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	HSAG/DHCS Deliverable Timeline: 2024 – Submit to DHCS baseline data to HSAG/DHCS for CY2023 for % of provider notifications care for Members with SUD/SMH following or within 7-days of Emergency Department (ED) visit. Update Steps 1-6, if needed, complete Step 7 with baseline data, and Step 8 with QI activities completed to date. 2025 – Submit baseline to remeasurement data for CY2024 and narrative to HSAG/ DHCS, complete Step 8 with QI activities completed to date. 2026 – Meet the target established in 2024. Submit final baseline to remeasurement data for CY2025, narrative, and PIP report to HSAG/ DHCS. *New measure	SUD/SMH following or within 7-days of Emergency Department (ED) visit from the MY 2023 baseline to the target established in 2024. **Baseline** (KP California GMC + Plan Partners): SMH - CY2023 TBD. (CY2022 54.62%) SUD - CY2023 TBD (CY2022 37.69%) TOTAL – CY2023 TBD (CY2022 47.78%) **Target**: TBD in 2024 based on MY2023 baseline, but to exceed MY2022 and MY2023 performance. **Process measure**: N/A		Develop specific PDSAs (Plan Do Study Act) with the Stakeholder workgroup to improve % of provider notifications for Members with Substance Use Disorder (SUD) and Specialty Mental Health (SMH) diagnoses following or within 7-days of E.D. visit. Identify and implement IT solutions for notification of KP PCPs about qualifying encounters at non-KP and KP facilities. Report progress and goal status to stakeholders and committees for review, support, recommendations, and approval	National Medicaid and State Programs • Regional Assistant Medical Director, Quality & Complete Care • Regional Director Quality & Safety Southern California Medi-Cal Quality • Quality & Safety Improvement Consultant, Clinical Quality Consulting
DHCS Managed Care Accountability Set (MCAS) Measure Performance: Child and Adolescent Well Care Visits (WCV)					
DHCS	Improve Child and Adolescent Well-Care Visit rates among Medi-Cal members in Kaiser Permanente Southern California Region. **<u>Goal</u>**: Meet or exceed the 2024 Minimum Performance Level (MPL) for Child and Adolescent Well-Care Visits. *New measure	Increase the percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. **Baseline** (KP SCAL – San Diego): MY 2023 48.33% **Target**: 2024 MPL 2022 MPL was 48.93% 2023 MPL was 48.07% **Stretch Goal**: 50%	MY 2024 ending December 31, 2024/ RY 2025	Conduct applicable DHCS required Accountability Project (e.g., A3, DHCS Child Health Sprint). Establish a Stakeholder group. Request and validate necessary data to track both outcome and process measures. Validate the data and break it down by service area and county. Conduct a needs assessment to identify additional barriers. Develop specific PDSAs (Plan Do Study Act) with the Stakeholder workgroup to address Well-Care Visit disparity among young Medi-Cal Members in northern California.	• Vice President, Associate Chief Medical Officer, National Medicaid and State Programs • Executive Director, Chief Health Equity Officer, National Medicaid and State Programs • Regional Assistant Medical Director, Quality & Complete Care • Regional Director Quality & Safety Southern California Medi-Cal Quality • Quality & Safety Improvement Consultant, Clinical Quality Consulting

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
		Outcome Measures: WCV rate **Process Measures**: Pediatrics, Adult Family Medicine and OB/GYN Access to care.		Track and evaluate progress following various PDSAs. Report progress and goal status to stakeholders and committees for review, support, recommendations, and approval.	
DHCS Managed Care Accountability Set (MCAS) Measure Lead Screening in Children (LSC)					
DHCS	Improve lead screening rates among Kaiser Permanente Medi-Cal Members by their second birthday in Kaiser Permanente Southern California Region. **Goal**: Meet or exceed the 2024 Minimum Performance Level (MPL) for Lead Screening in Children. *New measure	Increase the percentage of children who turn 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday. **Baseline** (KP SCAL – GMC San Diego): MY 2023 49.61% **Target**: 2024 MPL 2022 MPL was 63.99% 2023 MPL was 62.79% **Stretch Goal**: 65% **Outcome measures**: Lead Screening in Children (LSC) rate **Process measures**: Lab orders for lead screening in children between 6-months to 2 years of age.	MY 2024 ending December 31, 2024/ RY 2025	Partner with Pediatrics and Adult Family Medicine. Establish a Stakeholder group. Request necessary data to track both outcome and process measures. Validate the data and break it down by service area and county. Develop specific PDSAs (Plan Do Study Act) with the Stakeholder workgroup to address lead screening rates among Medi-Cal Members between 6-months to 2 years of age during Periodic Health Assessment (PHA). Track and evaluate progress following various PDSAs. Report progress and goal status to stakeholders and committees for review, support, recommendations, and approval.	• Vice President, Associate Chief Medical Officer, National Medicaid and State Programs • Executive Director, Chief Health Equity Officer, National Medicaid and State Programs • Regional Assistant Medical Director, Quality & Complete Care • Regional Director Quality & Safety Southern California Medi-Cal Quality • Quality & Safety Improvement Consultant, Clinical Quality Consulting
DHCS Comprehensive Quality Strategy Bold Goals 50 x 2025 Initiative					
DHCS	Goal: Close the gap in baseline MY2021 performance for Bold Goal Specific Measures to exceed the MPL by 2025 to help achieve DHCS' vision of eliminating health care disparities. **Bold Goals and Specific Measures:**	**Baseline**: MY2021 performance (KP SCAL – GMC San Diego)	MY 2024 ending December 31, 2024/RY 2025	Implement focused initiatives around children's health, preventive care, behavioral health integration, and maternity care, focusing on health equity to improve applicable measure performance. (i.e.: DHCS required actions; actions identified by KP stakeholders)	• Vice President, Associate Chief Medical Officer, National Medicaid and State Programs • Executive Director, Chief Health Equity Officer,

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	State Level Bold Goal: Close racial and ethnic disparities in well-child visits and immunizations Close gap in baseline MY 2021 performance to achieve MPL by 2025. Measures: - Infant, child, and adolescent well-child visits - Childhood adolescent vaccinations State Level Bold Goal: Close maternity care disparity for Black and Native American persons by 50%. Measures: - Prenatal and postpartum visits - C-section rates State Level Bold Goal: Improve maternal and adolescent depression by 50%. Measures: - Prenatal and postpartum depression screening - Adolescent depression screening and follow-up State Level Bold Goal: Improve follow-up for mental health and substance use disorder by 50%. Measures: - Follow-up after ED visits for SUD within 30 days - Depression screening and follow-up for adults - Initiation and engagement of alcohol and SUD treatment Health Plan Level Bold Goal: Ensure all health plans exceed the 50th percentile for all children's preventive care measures. Measures: - Infant, child, and adolescent well-child visits - Childhood and adolescent vaccinations - Blood lead and developmental screening - Chlamydia screening for adolescents *New measure	**Target**: Pending DHCS MY 2024 goals and targets		Report progress and goal status to stakeholders and committees for review, support, recommendations, and approval. Partner and participate in the county local health jurisdiction collaborative committees on 2024 Population Health Management (PHM) Strategy Deliverable.	National Medicaid and State Programs • Regional Assistant Medical Director, Quality & Complete Care • Regional Director Quality & Safety Southern California Medi-Cal Quality • Quality & Safety Improvement Consultant, Clinical Quality Consulting

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
MY 2024 DHCS MCAS Measure Set Performance					
DHCS	The 18 MY2024 MCAS measures held to Minimum Performance Level (MPL) Performance meet or exceed the NCQA Quality Compass Medicaid 50th Percentile Minimum Performance Level (MPL) benchmark in Kaiser Permanente Southern California Region. **Goal**: Meet or exceed the 2024 Minimum Performance Level (MPL) 1. FUA - Follow-up After ED Visit for Substance Abuse - 30 days (MPL 36.34%) 2. FUM - Follow-up After ED Visit for Mental Illness - 30 days (MPL 54.87%) 3. WCV - Child and Adolescent Well-Care Visits: ages 3-21 (MPL 48.07%; KP stretch goal 50%) 4. CIS-10 - Childhood Immunization Status: Combination 10 (MPL 30.90%) 5. Dev - Developmental Screening in the First Three Years of Life (MPL34.70%) 6. IMA-2 - Immunizations for Adolescents: Combo 2 (MPL 34.31%) 7. LSC - Lead Screening in Children (MPL 62.79%; KP stretch goal 65%) 8. TFL-CH - Topical Fluoride for Children (MPL 19.30%) 9. W30-2+ - Well-Child Visits in the First 30 Months of Life - for Age 15 Months -30 Months (2 or more well-child visits) (MPL 66.76%) 10. W30-6+ - Well-Child Visits in the First 30 Months of Life -in the first 15 months (6 or more well-child visits) (MPL 58.38%) 11. AMR - Asthma Medication Ratio (Ages 5-64) (MPL 65.61%) 12. CBP - Controlling High Blood Pressure (age 18-85) (MPL 61.31%) 13. GSD -Glycemic Status Assessment for Patients with Diabetes (>9%). (New Measure -MPL pending) 14. CHL - Chlamydia Screening in Women (Ages 16-24) (MPL 56.04%)	**Baseline** (KP SCAL – GMC San Diego): MY 2022: Above MPL for 13 of 15 measures held to MPL Below MPL: WCV and LSC MY 2023: Eighteen measures held to MPL (added: AMR, DEV, and TFL-CH) MY2023 November YTD – Above MPL: 14 of 18 measures. Below MPL: WCV, LSC, DEV. Projected below MPL: TFL-CH (based on MY2022 annual performance) **Target**: 2024 MPL and KP stretch goals for WCV and LSC **Outcome measures**: Measure performance rates	MY 2024 ending December 31, 2024/RY2025	Monitor KP internal Medi-Cal MCAS performance reports and annual DHCS MCAS Public Rate Sheet trends to 1) track MCAS measure performance above High-Performance level (HPL), MPL, below MPL, and 2) proactively identify improved and declining measure performance. Keep stakeholders informed of measure performance through committee reports, published scorecards, and individual communication. Facilitate stakeholder engagement to • Implement and/or continue initiatives that achieve and maintain high performance levels (HPLs) • Take action to address measures performing below the MPL and measures with declining performance. This includes 1) conduct DHCS required PIPs and Quality Accountability Projects., b) identify Regional and Local Service Area initiatives in place/planned c) work with stakeholders to initiate new interventions, and d) facilitate implementation of KP initiated performance improvement projects.	• Vice President, Associate Chief Medical Officer, National Medicaid and State Programs • Executive Director, Chief Health Equity Officer, National Medicaid and State Programs • Regional Assistant Medical Director, Quality & Complete Care • Regional Director Quality & Safety Southern California Medi-Cal Quality • Quality & Safety Improvement Consultant, Clinical Quality Consulting

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	15. PPC-P0st - Prenatal & Postpartum Care - Postpartum Care (MPL 78.10%) 16. PPC-Pre - Prenatal & Postpartum Care - Timeliness of Prenatal Care (MPL 84.23%) 17. BCS-E – Breast Cancer Screening (MPL 52.60%) 18. CCS – Cervical Cancer Screening (MPL 57.11%) *New measure				

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
MEMBER EXPERIENCE					
Member Experience					
NCQA and DMHC	Conduct an annual assessment of complaints and grievances to identify opportunities for improvement per ME7, Elements C and D; NET3, Element A, Factor 1; NET4, Element C) Conduct an annual assessment of publicly reported member experience results (Commercial CAHPS, Medicare CAHPS, and QHP Enrollee Experience Survey) to identify opportunities for improvement per ME7, Elements C and D Conduct an annual assessment of enrollee satisfaction with access to care (as measured in CAHPS) to meet DMHC Timely Access Standards	Commercial CAHPS Medicare CAHPS QHP Enrollee Experience Survey Complaints and Grievances data	4Q 2024	1. a) Conduct an annual assessment of complaints and appeals of all members and by: • Commercial • Medicare • Exchange • Medi-Cal b) Conduct an annual assessment of network adequacy complaints and appeals of all members and by: • Commercial • Medicare • Exchange • Medi-Cal 2. Conduct an annual analysis of Commercial CAHPS results against external benchmarks from Quality Compass and CAHPS accreditation index. 3. Conduct an annual analysis of Medicare CAHPS results. 4. Conduct an annual analysis of Qualified Health Plan (QHP) Enrollee Experience Survey. 5. Per DMHC Timely Access Standards, conduct an annual analysis of the enrollee survey (CAHPS Getting Care Quickly and Getting Needed Care Composites) against the organizational goal using the external benchmarks from Quality Compass; communicate analyses and key findings to the Access Committee. 6. Communicate analyses and key findings to the Member Concerns Committee and SCQC.	Rochelle A. McCauley, SCPMG Performance Assessment Paul Choe, Member Relations Ashley Mehrabi, HPSA & Consumer Experience Member Concerns Committee, Access Committee, SCQC
NCQA	Continue to close the gap to external benchmarks on measures that predict member rating of overall health care: 1. Personal doctor communication (close the gap to the Health Plan CAHPS Pacific 90th %ile) 2. Getting care quickly composite (close the gap to the Health Plan CAHPS Pacific 75th percentile) 3. Getting needed care (close the gap to the Health Plan CAHPS Pacific 75th percentile)	CAHPS Patient Assessment Survey (PAS) of California medical groups	4Q 2024	1. Use the annual KPSC Commercial CAHPS results to monitor and report performance on #1-4 and compare against the Pacific benchmarks. 2. Use the annual SCPMG PAS results to monitor and report performance on #5 and compare against the California benchmarks. Both reports are posted on the SCPMG Performance Assessment website and shared with the Care Experience and Access Leaders.	Rochelle A. McCauley, SCPMG Performance Assessment Dr. Wadie Marcos, Rebecca Grant, Anthony Encinas, SCPMG Service and Access Member Concerns Committee

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	4. Overall rating of specialist (maintain Health Plan CAHPS Pacific 75th percentile) 5. Helpful, courteous office staff composite (close the gap to the PAS California 90th percentile)				
NCQA	Enhance member care experience by targeted member experience improvement projects	n/a	4Q 2024	Develop and implement member experience improvement projects to address areas of opportunities identified in the 2023 complaint and grievance and CAHPS results analysis for ME 7, Elements C and D, which include Access and Care Coordination. To address areas of opportunity found within the Access to Care composite, improvement projects have ramped up as shifts in focus related to managing the COVID-19 pandemic have allowed for newer interventions: 1. Addition of new clinical positions to increase capacity for patient appointments 2. Addition of enhancements to kp.org to promote online scheduling of appointments 3. Increasing in person visit volume to meet patient demand 4. Enhancing patient experience when waiting for Urgent Care visits by improving communication about wait times through digital displays and mobile text notifications 5. Providing offerings such as E-visits, an online self-directed care option, as well as "Get Care Now" appointments, which are a more efficient way to speak to a physician about urgent needs To address areas of opportunity found within the Care Coordination composite, specifically regarding the Medicare population, improvement projects include: 1. Expansion of implementation of text notifications to patients ages 18+ to alert them that their lab results are ready, allowing for timelier follow up of test results. 2. Continued development of clinician training materials (e.g., playbooks, videos) geared towards improving care coordination-related best practices and communication strategies. In 2024, training materials will highlight best practices learned from 2023-2024 Deep Dives.	Rochelle A. McCauley, SCPMG Performance Assessment Dr. Wadie Marcos, Rebecca Grant, Anthony Encinas, Donna Bolotaulo, SCPMG Service and Access Dr. Timothy Ho, Michelle Pruitt, Shalini Rao, Krystle Amezcua, SCPMG Complete Care Member Concerns Committee

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
				By the end of 2024, clinician training materials such as playbooks and videos will be developed to enhance communication strategies and best practices in care coordination, incorporating the lessons learned from Deep Dives in 2023-2024. Deep Dives focus on specific topics with each medical center to gain insight into their current process, suggestions, strategies, and barriers. This information is synthesized into an actionable document for local medical centers to use as a resource. 3. Regular assembly of the Care Coordination Plus Leadership Collaborative to spread best practices by highlighting high-performing areas to adopt their strategies.	

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
MEMBER-PRACTITIONER COMMUNICATIONS					
Member-Practitioner Communications					
NCQA KP-Goal	Member-Practitioner Communications: KP-SCAL annually makes information about its QI program available to our Members and our Practitioners Publication and distribution of Annual Letters	Met/Not Met	Complete all by End of Q4 2024 Ongoing (website) Q4 2024	Maintain a log of all communications and how they are distributed as the organization gets 'greener'. Ensure involvement from all standard owners and content experts for Annual Letters	Farnaz Meybodi, Regional Director, Quality and Regulatory Services

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
Patient-Centered Medical Home (PCMH)					
NCQA PCMH (Patient-Centered Medical Home) Recognition					
F / G	Maintain PCMH recognition status for 106 practice sites MOBs that offer primary care (family medicine, internal medicine and/or primary pediatric care) under NCQA's PCMH Program. Finalize achievement of PCMH recognition for Chino Medical Offices; carried over from 2023 transition effort.	Maintenance of PCMH recognition requires meeting 12 core criteria per practice site.	Last quarter 2024	Q1-2024: • Finalize 2023 new site recognition efforts for Chino Medical Offices and participate in NCQA virtual session. • Chino Medical Offices formally NCQA PCMH recognized in January 2024. • Communicate PCMH recognition performance throughout the Region. • Evaluate the timeline for 2024 PCMH annual renewal effort for 106 practice sites. • Gather appropriate PCMH evidence (reports, policies, documented processes, etc.). • PCMH Leads will attend training(s) as needed. Q2-2024: • Determine KPSC practice site structure for 2024 PCMH Submission. • Pay NCQA fees for PCMH Recognition. • Continue to gather appropriate PCMH evidence (reports, policies, documented processes, etc.). • PCMH Leads continue to attend training as needed. Q3-2024: • Prepare practice site evidence for 106 renewing practice sites. • Continue to gather appropriate PCMH evidence (reports, policies, documented processes, etc.). • PCMH Content Expert certification examination for Consultant V. Q4-2024: • Continue to gather appropriate PCMH evidence (reports, policies, documented processes, etc.). • Complete submission of evidence for 106 renewing practice sites. • Receive PCMH re-recognition decisions back from NCQA. • Communicate PCMH recognition performance throughout the Region.	**Executive Sponsor:** *Nancy E. Gin, MD, FACP* Executive Vice President and Chief Quality Officer, The Permanente Federation Regional Medical Director of Quality & Clinical Analysis, SCPMG **Leads:** Baleria Berumen, SCPMG Consultant V Nicole Ives, SCPMG Consulting Manager Mimi Hugh, SCPMG Director

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
				• Reassess 2025 timeline for transition of 2 new sites, Watts Medical Offices and Wildomar Medical Offices. *Ongoing work throughout 2024* • Ongoing communication with KFHP SCAL and support of NCQA Health Plan Accreditation activities. • PCMH leads will continue to provide NCQA with an update of clinicians attributed to our practice sites who have PCMH Recognition. Physicians are eligible to apply for a Maintenance of Certification (MOC) benefit though their respective boards (Family Medicine, Internal Medicine, Pediatrics) because of being affiliated with a NCQA PCMH recognized practice site. • Ongoing communication of PCMH updates will be maintained through the PCMH SharePoint site to assist physicians with completing Maintenance of Certification board credit; https://sp-cloud.kp.org/sites/SCPMG-PA/SitePages/PCMH.aspx?kp_shortcut_referrer=kp.org/scal/pcmh	

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
POPULATION HEALTH MANAGEMENT (PHM)					
Strategy Description (PHM 1A)					
NCQA	Annual review of the PHM Strategic Program Summary that describes: 1. Goals and populations targeted for each of the four areas of focus. a. Keeping members healthy b. Managing members with emerging risk c. Patient safety or outcomes across settings d. Managing multiple chronic illnesses 2. Programs or services offered to members. 3. Activities that are not direct member interventions. 4. How member programs are coordinated. 5. How members are informed about available PHM programs. 6. How the organization promotes health equity.	Met/Not Met	Q1 2025	Review and update the PHM Strategic Program Summary to ensure appropriate scope, leadership, structure, and adequacy of function for members in all lines of business (Commercial, Exchange, Medicare, and Medicaid).	Timothy Ho, MD Regional Assistant Medical Director, Quality & Complete Care Michelle Pruitt, RN Director, Clinical Quality SCPMG Complete Care Support Programs Krystle Amezcua Clinical Quality Consultant IV, SCPMG Complete Care Support Programs
Informing Members (PHM 1B)					
NCQA	Inform members eligible for programs that include interactive contact: 1. How members become eligible to participate. 2. How to use program services. 3. How to opt in or opt out of the program.	Met/Not Met	Q1 2025	Provide eligible members with information on specific programs with interactive contact.	Timothy Ho, MD Regional Assistant Medical Director, Quality & Complete Care Michelle Pruitt, RN Director, Clinical Quality SCPMG Complete Care Support Programs Krystle Amezcua Clinical Quality Consultant IV, SCPMG Complete Care Support Programs
Segmentation (PHM 2D)					
NCQA	Annually collect, integrate, and assess member data to review and update the population health management programs, as needed.	Met/Not Met	Q1 2025	1. Segment or stratify the member population into subsets for targeted intervention.	Timothy Ho, MD

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	1. Segment or stratify the member population into subsets for targeted intervention. 2. Assess for racial bias in its segmentation or stratification methodology.			2. Assess for racial bias in its segmentation or stratification methodology.	Regional Assistant Medical Director, Quality & Complete Care Michelle Pruitt, RN Director, Clinical Quality SCPMG Complete Care Support Programs Krystle Amezcua Clinical Quality Consultant IV, SCPMG Complete Care Support Programs
Population Health Management Impact (PHM 6A & 6B)					
NCQA	Annually measure the effectiveness of PHM strategy by: A. Measuring Effectiveness – conducting a comprehensive analysis of the impact of the PHM strategy that includes the following: 1. Quantitative results for clinical, cost/utilization and experience measures. 2. Comparison of results with a benchmark or goal. 3. Interpretation of results. B. Improvement and Action – Using results from the PHM impact analysis to: 1. Identify opportunities for improvement. 2. Act on one opportunity for improvement.	Met/Not Met	Q1 2025	Administer a member survey to assess for each line of business (Commercial, Exchange, and Medicare) the impact of PHM strategy and efforts, identify opportunities, and act on one opportunity.	Timothy Ho, MD Regional Assistant Medical Director, Quality & Complete Care Michelle Pruitt, RN Director, Clinical Quality SCPMG Complete Care Support Programs Krystle Amezcua Clinical Quality Consultant IV, SCPMG Complete Care Support Programs

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
PRACTITIONER AVAILABILITY – CULTURAL NEEDS & PREFERENCES					
Practitioner Availability: Cultural Needs & Preferences					
NCQA	Assesses the cultural, ethnic, racial, SOGI, and linguistic needs of our members.	Complete Annual Assessment	Q4 2024	Analyze the demographic needs of our members to identify opportunities for improvement.	Rachel Sandoval, Director, Equity, Inclusion & Diversity
NCQA	Provide Cultural and Linguistic training to KP workforce to ensure the delivery of culturally competent care and linguistically appropriate services.	Increase the cultural sensitivity of our workforce to include how to provide appropriate language assistance services.	Q4 2024	Develop training introducing how to apply the "Health Equity Toolkit" and resources to advocate an Equity Centered Mindset that helps to increase People Pulse scores on Influence and Fairness and conduct train-the-trainer session with at least 75% participation of SCAL UBT Consultants. Develop DEI training for the Department of Health Care Services (DHCS) by December 31, 2024 to meet the requirements of APL 23-025.	Rachel Sandoval, Director, Equity, Inclusion & Diversity
NCQA	Ensure Inpatient Units have the appropriate tools and training to offer and document the use/refusal of language assistance services.	Language Services training for Inpatient Departments	Q4 2024	Ensure all units have access to information regarding language assistance services, do rounding in hospital to cross-check awareness by Q1 or before TJC. Complete 100% of language assessments for Inpatient Units and establish a training plan for the 2025 year by Q4 2024.	Rachel Sandoval, Director, Equity, Inclusion & Diversity

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
QUALITY MANAGEMENT					
Quality Management					
NCQA DMHC DHCS	• Review and revision of 2024 KFHP Quality Program Description • Evaluation of 2023 KFHP Quality Work Plan • Development and implementation 2024 KFHP Quality Work Plan and goals	Met/Not Met	April 2024	1. Review and update the 2024 Quality Program Description, 2024 Work Plan and 2023 Work Plan Evaluation to ensure appropriate scope, leadership, structure, adequacy of issues and function for both Medical and Behavioral Healthcare aspects. 2. Acquire approval of 2024 Quality Program Description and Work Plan and 2023 Evaluation of the Quality program. This Work Plan is reviewed, evaluated, and revised mid-year as needed and annually at a minimum. The results of the evaluation will be documented in the Quality Program Evaluation document, which will address results of focused reviews, strengths, barriers and limitations and opportunities for improvement for consideration to be included in the following year's work plan.	**Farnaz Meybodi**, Regional Director, Quality and Regulatory Services Southern California Quality Committee (SCQC)

KFHP Southern California Region
2024 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
SAFETY AND RISK MANAGEMENT					
I. Primary Driver: Accountability					
Leadership Safety Culture	1.1 Communicate safety events that have a high risk of happening across other medical centers and/or across the program.	Met/Not Met	Ongoing	1.1 Monthly Safety Learning Huddle Calls. Cause Map and Action Plans discussed. Creating a Safety Call SBAR each time. Refresh process with Medical Center rotation and gap analysis structure 1.1.1 Focus on psychological safety and near misses. Rework Good Catch Submission to include SBAR format & spreadable learnings/close loop feedback 1.1.2 Refresh Quarterly Newsletter with trends/analysis & program overview 1.1.3 SVP Escalation vs SE notification process clarity for Directors with updated crosswalk tool; in alignment with revised National Sentinel Event policy.	Regional Safety & Risk Deepak Sonthalia, MD *Regional Physician Lead- Patient Safety* Robin Sustayta, *Sr. Director, Safety and Risk Management* Jonell Adams, *Regional Director Risk Management* Medical Center RM/PS/WPS Teams
Oversight and Metrics: Compre-hensive System Analysis (CSA)	1.2 Oversight and review of all Risk Focus Study events, emphasis on Events required to conduct a CSA	Met/Not Met	Ongoing	1.2 Validate that the CSA was completed with cause map, executive summary, action items and measures of success included. 1.2.1CSA and reporting timeframes were met according to policy. 1.2.2Cause Maps are done correctly answering the "why's" to get to the causal factors of the incident. 1.2.3Taxonomy and General Contributing Factor alignments for National reporting	Regional Safety & Risk Medical Center Risk
Regulatory Reporting of Adverse Events	1.3 Working in collaboration with AR&L, monitor workflow developed in 2023 to ensure that all Adverse Events meet the reporting criteria from date of event to time of notification to AR&L.	Met/Not Met	Ongoing	1.3.1Reconciliation of adverse events reported through MIDAS validated against CALHeart with AR&L. 1.3.2 Build out visualizations of the workstreams not associated with high-risk and/or Sentinel Events, such as Medical Board Reporting and Death Associated with Restraints	Regional Risk Regional AR&L Medical Center Risk Medical Center AR&L
II. Primary Driver: Resilience					
Individual: Good Catch Awards	2.1 Continue the regional Good Catch program, based on the TeamSTEPPS© domains of Leadership, Communication, Mutual Support, and Situational Monitoring for all Safety events.	Met/Not Met	Ongoing	1.1 Continue the Regional Good Catch program. Rework Good Catch submissions from the Medical Centers to include SBAR format & spreadable learnings/close loop feedback 2.1.1Involve members in selection process for quarterly award 2.1.2Continue to work with Risk Managers to distribute and acknowledge local award winners	Jonell Adams, *Regional Director Risk Management* Brooke Jones-Pavon

KFHP Southern California Region
2024 Quality Improvement Work Plan Evaluation

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
				2.1.3Publish winners in the Regional Risk Pt Safety Newsletter.	
Leadership Safe Culture	2.2 Team STEPPS	Met/Not Met	Ongoing	2.2 Continue to teach the dynamics around the Just Culture methodology by using the pillars of Team STEPPS 2.2.1Use the same methodology to review CSAs to learn from and spread actions taken to promote a Speak Up culture 2.2.2 Build repository for Regional TeamSTEPPS program graduates' story boards	Christine Pak, *Regional Patient Safety Officer* Charles Hummel, *Regional Physician for Safety*
III. Primary Driver: Reliability					
People: High Reliability Teams Med Safety	3.1 Participate on Medication Safety Oversight Committee	Met/Not Met	Ongoing	3.1 Collaborate with Pharmacy and Medicine to define, discuss and mitigate medication harm	Christine Pak, *Regional Patient Safety Officer* Inpatient Pharmacy
People: High Reliability Teams PPSP	3.2 Reinforce the standardized work of Perinatal Patient Safety Program	Met/Not Met	Ongoing	3.2 Work with subject matter experts to continue & improve the multidisciplinary perinatal case review process at Med Centers. 3.2.1Support the National Community of Practice 3.2.2Track and trend MCH Perinatal case reviews 3.2.3Continue participation in National SMM Workgroup & National PPSP.	*Perinatal Physicians;* *MCH Nursing;* Jonell Adams, *Regional Director Risk Management* Brooke Jones-Pavon
People: High Reliability Teams SAHFE	3.3 Facilitate Regional SAHFE Committee	Met/Not Met	Ongoing	3.3 Oversight of the SAHFE (Safety and Human Factor Education) program for the SCAL and HI region	Christine Pak, *Regional Patient Safety Officer* Charles Hummel, *Regional Physician for Safety*

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
SCPMG EQUITY, INCLUSION & DIVERSITY					
Reporting Stratified Measures (HE 6A)					
NCQA	Annually report HEDIS measures and determine if health care disparities exist for each HEDIS measure, stratified by race/ethnicity: 1. Colorectal Cancer Screening (COL) 2. Controlling High Blood Pressure (CBP) 3. Hemoglobin A1c Control for Patients with Diabetes (HBD) 4. Prenatal and Postpartum Care (PPC) 5. Child and Adolescent Well Care Visits (WCV) *New measure	Met/Not Met	Nov 2024	For each measure and by product line (Commercial, Exchange, Medicare, and Medicaid), analyze the performance of race/ethnicity subgroups by comparing them against a reference group.	SCPMG Clinical Analysis Ralph Vogal, Director Robert Arevalo, Consultant *(HEDIS Performance Reports: 'Interactive Data Submission System (IDSS)')*
Use of Data to Assess Disparities (HE 6B)					
NCQA	Annually use race/ethnicity, language, gender identity and/or sexual orientation data and the following methods to determine if health care disparities exist: 1. Analyze one or more valid measures of clinical performance, such as HEDIS, by preferred language. 2. Analyze one or more valid measures of clinical performance, such as HEDIS, by gender identity and/or sexual orientation. *New measure	Met/Not Met	Nov 2024	For each measure and by product line (Commercial, Exchange, Medicare, and Medicaid), stratify data to identify individuals by self-identified preferred language, gender identity, and sexual orientation. Address any opportunities for improvement.	SCPMG Clinical Analysis Ralph Vogal, Director Julley Jung, Consultant *(ECHO used in past; SCAL data available? HEDIS Measure by Language and by Product)*
Use of Data to Measure Inequities (HE 6D)					
NCQA	Based on the results of health care inequities, annually: 1. Identify and prioritize opportunities to reduce health care inequities.	Met/Not Met	Nov 2024 p	Identify opportunities and implement interventions aimed at reducing the inequities that may be resulting in disparities in access to care, experience, or health outcomes.	SCPMG Clinical Analysis Ralph Vogal, Director Julley Jung, Consultant *(ECHO used in past; SCAL data available? HEDIS Measure by Language and by Product)*

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
	2. Implement at least one intervention to address an inequity. 3. Evaluate the effectiveness of an intervention to reduce an inequity. *New measure				Center for Healthy Living Anna Salvador, Sr. Manager Jessica An, Consultant *(DM)*

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
I. ENSURE THE APPROPRIATE, EFFECTIVE, AND EFFICIENT IMPLEMENTATION, MONITORING AND EVALUATION, AND CONTINUOUS QUALITY IMPROVEMENT OF THE KFHP UM PROGRAM TO MAINTAIN AN EFFECTIVE, ORGANIZED UM PROGRAM IN COMPLIANCE WITH APPLICABLE FEDERAL AND STATE LAWS/REGULATIONS AND STANDARDS SET FORTH BY ACCREDITING BODIES.					
NCQA DMHC DHCS	• Review and revision of KFHP UM Program Description • Evaluation of 2023 KFHP UM Workplan • Development and implementation of 2024 KFHP UM Workplan and goals	Met/Not Met	Q1 2024	1. Review and update the 2024 UM Program Description, 2024 Work Plan and 2023 Evaluation to ensure appropriate scope, leadership, structure, adequacy of issues and function for both Medical and Behavioral Healthcare aspects. 2. Acquire approval of 2024 UM Program Description and Work Plan and 2023 Evaluation of the UM program from the appropriate utilization and quality committees within 12 months of the prior year approval.	Utilization Management Steering Committee (UMSC) Committee Co-Chair: Dr. John Brookey - Health Plan Physician Advisor Committee Co-Chair: Dr. William Cory - Health Plan Physician Advisor
NCQA DMHC DHCS	• Evaluation of KFHP UM Processes to ensure appropriateness and relevancy: ○ UM Policies and Procedures ○ UM Denial letter process ○ UM Criteria	Met/Not Met	Year End 2024	1. Review and update Regional KFHP UM policies and procedures to meet current 2024 UM standards as needed. 2. Review and update UM Denial Letters per regulatory standards as needed. 3. Review and update UM Criteria sets used for decisions to reflect updates based on evidence-based medicine, current medical literature, EOC, and formulary changes.	Utilization Management Steering Committee (UMSC) Committee Co-Chair: Dr. John Brookey - Health Plan Physician Advisor Committee Co-Chair: Dr. William Cory - Health Plan Physician Advisor
NCQA DMHC DHCS	• Distribution of required KFHP UM communication to providers, practitioners, members, and employees, as required.	Met/Not Met	Year End 2024	1. Review and update the Annual Letter to all UM staff and practitioners (to include: Financial Incentive Statement, how to access the UM decision maker, and how to access or request for UM criteria) 2. Ensure that the UM Web Based Statement, which explains the UM process to members is in alignment with the UM Program.	Southern California Quality Committee (SCQC) Co-Chair, Deepak Sonthalia, MD, Regional Physician Director of Quality, Risk Management, Regulatory & Safety Co-Chair Tara Harder, Vice President, Quality, Safety & Regulatory Services Utilization Management Steering Committee (UMSC)

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
					Committee Co-Chair: Dr. John Brookey - Health Plan Physician Advisor Committee Co-Chair: Dr. William Cory - Health Plan Physician Advisor
NCQA DMHC DHCS	• Inter-Rater Reliability Testing	≥90%	Year End 2024	Monitor the accuracy and consistency of UM decisions through Inter-Rater Reliability testing of physicians and non-physician licensed (RN) staff making UM decisions.	Utilization Management Steering Committee (UMSC) Committee Co-Chair: Dr. John Brookey - Health Plan Physician Advisor Committee Co-Chair: Dr. William Cory - Health Plan Physician Advisor
NCQA DMHC DHCS	• Oversight of all delegated UM functions for the following services: ○ American Specialty Health (ASH) ○ Delta Dental ○ Cigna	Met/Not Met	Year End 2024	1. Evaluate effectiveness of the UM program to include compliance with state, federal, and NCQA standards. 2. Provide oversight of UM denials and appeals against regulatory standards for documentation and timeliness. 3. Discuss delegation oversight audit results at all applicable UM Committees.	Utilization Management Steering Committee (UMSC) Committee Co-Chair: Dr. John Brookey - Health Plan Physician Advisor Committee Co-Chair: Dr. William Cory - Health Plan Physician Advisor
NCQA DMHC DHCS	• Develop and implement education and training programs for new UM processes and procedures for all stakeholders as appropriate.	Met/Not Met	Year End 2024	1. Develop and implement UM education and training programs: a. Utilization Management Department b. DME/P&O Department c. Outside Referral Department d. Regional Utilization Compliance	Utilization Management Steering Committee (UMSC) Committee Co-Chair: Dr. John Brookey - Health Plan Physician Advisor Committee Co-Chair: Dr. William Cory - Health Plan Physician Advisor

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
NCQA DMHC DHCS	• Over/Under Utilization	Met/Not Met	Year End 2024	1. Systematically and routinely analyze utilization data to monitor potential over-and-under-utilization of services. 2. Action Teams or Appropriateness Committees periodically present utilization reports that include analysis, as well as action items of potential over- and/or under-utilization of services, to ensure professionally recognized standards of practice are maintained.	Utilization Management Steering Committee (UMSC) Committee Co-Chair: Dr. John Brookey - Health Plan Physician Advisor Committee Co-Chair: Dr. William Cory - Health Plan Physician Advisor
DMHC NCQA DHCS	• Timely and accurate denial decision and notification processes in compliance with regulatory timeframes	Met/Not Met	Year End 2024	1. Monitor, analyze and evaluate denial decisions and notices for compliance with timelines as established by federal, state, contractual and NCQA requirements.	Utilization Management Steering Committee (UMSC) Committee Co-Chair: Dr. John Brookey - Health Plan Physician Advisor Committee Co-Chair: Dr. William Cory - Health Plan Physician Advisor
II. ENSURE EFFECTIVE AND EFFICIENT BEHAVIORAL HEALTH PROGRAM					
DMHC NCQA DHCS	• Ensure Behavioral health compliance through annual review and update of program protocol	Met/Not Met	Year End 2024	• Behavioral Health policies and procedures should include the following elements: 1. Address all relevant mental health and substance abuse situations. 2. Define level of urgency. 3. Define appropriate setting of care. 4. Have been reviewed or revised in the past two years. 5. Use licensed practitioners to make decisions that require clinical judgment • A Centralized triage and referral crisis line (Behavioral Health Care Help Line) has been established and is monitored on an ongoing basis.	Utilization Management Steering Committee (UMSC) Committee Co-Chair: Dr. John Brookey - Health Plan Physician Advisor Committee Co-Chair: Dr. William Cory - Health Plan Physician Advisor

KFHP Southern California Region
2024 Quality Improvement Work Plan

Required By	GOALS	METRICS	TARGET COMPLETION DATE	ACTION STEPS & MONITORING	RESPONSIBLE LEADERS/ COMMITTEES
III. MAINTAIN PRACTITIONER AND MEMBER SATISFACTION WITH THE UTILIZATION MANAGEMENT PROGRAM					
DMHC NCQA DHCS	• Ensure satisfactory Member and Provider Experience with UM processes	Met/Not Met	Year End 2024	1. Annually survey satisfaction with the UM process: Collect and analyze data on member and practitioner satisfaction to identify improvement opportunities and take action designed to improve member and practitioner satisfaction a. Report the annual survey results and opportunities to improve are approved by the appropriate UM and Quality Committees	Utilization Management Steering Committee (UMSC) Committee Co-Chair: Dr. John Brookey - Health Plan Physician Advisor Committee Co-Chair: Dr. William Cory - Health Plan Physician Advisor
DMHC NCQA DHCS	• Monitor the rate of overturned UM appeals	Met/Not Met	Year End 2024	1. Review and analyze reports of UM denials, UM denials appealed and results of appeals of Independent Medical Review for UM denials	Utilization Management Steering Committee (UMSC) Committee Co-Chair: Dr. John Brookey - Health Plan Physician Advisor Committee Co-Chair: Dr. William Cory - Health Plan Physician Advisor