KAISER PERMANENTE®

2025 Quality Program Description

Kaiser Foundation Health Plan
Southern California Region

The information provided in this document applies
to all lines of business unless otherwise noted.

KFHP Southern California Region
2025 Quality Program Description

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Approved by Southern California Quality Committee (SCQC) on March 28, 2025

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1. MISSION AND VISION

Mission
Kaiser Permanente exists to provide high-quality, affordable health care services and to improve the health status of our members and the communities we serve.

Vision
At Kaiser Permanente, we believe that life, liberty, and the pursuit of happiness require total health – and that includes equal access to high-quality health care for all. We are trusted partners in total health, collaborating with people to help them thrive and creating communities that are among the healthiest in the nation.

Through internal performance:

- Transforming care delivery
- Enabling performance through people
- Implementing infrastructure
- Improving cost structure
- Growing membership

Through external presence:

- Provide high quality, affordable health care and coverage
- Advocate for continuous improvement in healthcare
- Lead by example
- Advance the dialogue
- Shape the agenda

2. KAISER FOUNDATION HEALTH PLAN SOUTHERN CALIFORNIA

Overview of Organization Structure
Kaiser Foundation Health Plan, Inc. (KFHP) is a not-for-profit public benefit California Corporation that contracts with individuals and groups to provide, or arrange for, comprehensive health care benefits.

KFHP is a health maintenance organization and a California-licensed Knox-Keene health care service plan serving approximately 4.5 million members in the Southern California region. KFHP is regulated by the California Department of Managed Health Care (DMHC) and is subject to the requirements of the Knox-Keene Act and its regulations (California Health and Safety Code §1340, et seq.; Title 28, commencing with Section 1300.43, of the California Code of Regulations).

KFHP participates in an integrated healthcare delivery system with two separate, yet closely aligned, entities – Kaiser Foundation Hospitals (KFH) and Southern California Permanente Medical Group (SCPMG).

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KFHP has an exclusive contract with Kaiser Foundation Hospitals (KFH), a not-for-profit public benefit corporation that owns and operates hospitals that provide or arrange hospital services for KFHP members. Each KFH medical center and its professional staff maintain a quality assurance program subject to extensive licensing and regulation by the California Department of Public Health (CDPH) under California Health & Safety Code Section 1250 et seq. and by the Centers for Medicare & Medicaid Services (CMS) under Title 42 of the Code of Federal Regulations, Section 482.21. KFH is subject to compliance with The Joint Commission. The standards are designed to guide hospitals in the creation and monitoring of processes of patient care that are both safe and of high quality.

KFHP has an exclusive contract with Southern California Permanente Medical Group, Inc. (SCPMG). SCPMG is a multi-specialty physician general partnership that provides, and arranges for the provision of, medical services to members and patients in Southern California. SCPMG engages in a myriad of quality improvement activities at the medical center, regional, and interregional levels; on clinical department, interdisciplinary, hospital, and ambulatory services. SCPMG is contractually bound to fully collaborate with KFHP, enabling KFHP to comply with the California Knox-Keene Health Care Service Plan Act of 1975; including cooperating with KFHP's quality assurance program requirements as well as federal Medicare rules and regulations.

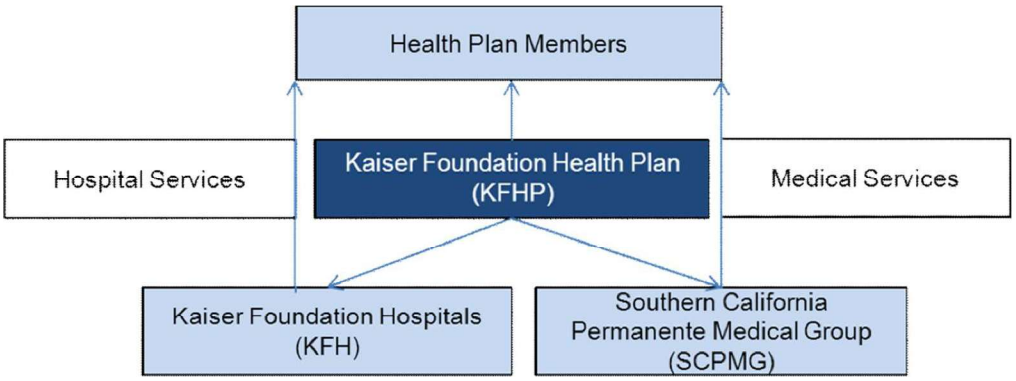
KFHP's network also includes contractual arrangements with community facilities and individual providers through its agreements with KFH and SCPMG. Approximately 95% of services provided to members are provided by KFH and SCPMG.

KFHP is responsible for the oversight and monitoring of quality improvement activities, which includes, but is not limited to, ensuring the appropriate compliance with legislative changes. KFH and SCPMG collaborate with KFHP to ensure the provision and coordination of appropriate, safe, and effective care and medical management to the communities in which they serve KFHP members in accordance with professionally recognized standards. Together, these three entities operate the Kaiser Permanente Medical Care Program in Southern California.

KFHP evaluates the performance of quality activities of the Contracting Parties to ensure that the quality program is operating in accordance with standards and processes defined in the Program Documents.

KFHP is committed to assessing, assuring, and continuously improving the care and service we deliver to our members. KFHP has created a systematic, integrated approach to planning, designing, measuring, assessing, and improving the quality of care and services provided (both internal and contracted) to members. Its comprehensive delivery system includes behavioral health (psychiatry and chemical dependency treatment), patient safety, health outcomes, utilization, risk management, contracted care, member satisfaction, service performance, prevention, population-based care, and access to care and treatment. Initiatives are aligned with KFHP's mission and vision.

Kaiser Permanente Integrated Health Care System:



Southern California Medical Center Structure

KFHP Southern California has thirteen service areas. Within those thirteen service areas, three service areas have Affiliated (Plan) Hospitals. Each service area may contain one or more KP hospitals in the following counties:

- Orange County
  - Orange County Service Area: KFH Anaheim, KFH Irvine
- Los Angeles County
  - Panorama City Service Area: KFH Panorama City
  - Antelope Valley Service Area: Antelope Valley Hospital
  - Baldwin Park Service Area: KFH Baldwin Park
  - Downey Service Area: KFH Downey
  - Los Angeles Service Area: KFH Los Angeles, KFH Los Angeles Mental Health
  - South Bay Service Area: KFH South Bay
  - West Los Angeles Service Area: KFH West Los Angeles
  - Woodland Hills Service Area: KFH Woodland Hills
- San Bernardino County
  - San Bernardino Service Area: KFH Fontana, KFH Ontario
- Kern County
  - Kern County Service Area: Adventist Health Bakersfield
- Riverside County
  - Riverside/Moreno Valley Service Area: KFH Riverside, KFH Moreno Valley, Inland Valley Community Hospital, Rancho Springs, Temecula Valley Hospital, Eisenhower Medical Center
- San Diego County
  - San Diego Service Area: KFH San Diego – Zion, KFH San Diego, KFH San Diego – San Marcos
- Ventura County
  - Woodland Hills Service Area: Community Memorial Hospital San Buenaventura

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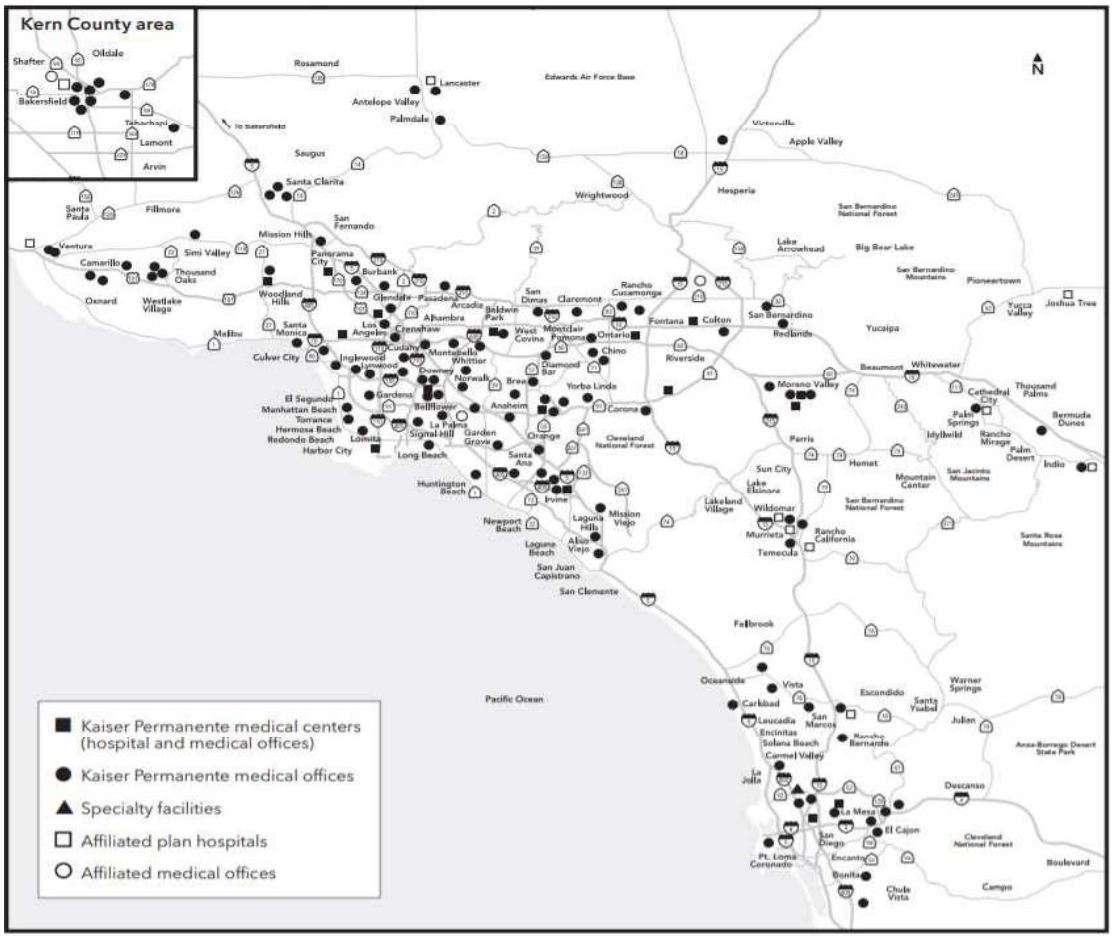


Each Medical Center is led by a KFHP Senior Vice President (SVP)/Area Manager. The SVP/Area Managers report to the Senior Vice President of Hospital and Health Plans Operations and to the KFHP Regional President and are responsible for KFHP operations, including the quality of care, access to care, and treatment provided to all members within the medical center. Each Medical Center has an Assistant Administrator for Quality. These KFHP leaders are accountable for ensuring that the Quality Program addresses the quality of care, utilization management, and services provided/available to all members within their respective medical center. Each leadership team reports access, quality, safety, utilization, and service activities and metrics to the Southern California Quality Committee (SCQC), which in turn reports this information to the Board of Director's Quality and Health Improvement Committee (QHIC). A corrective action plan is requested by SCQC when facility performance metrics demonstrate an opportunity for improvement.

Membership and Membership Diversity

KFHP's Southern California Region serves members under several commercial and government product lines. As of December 31, 2024, KFHP Southern California covers 4,816,599 members.

KFHP Southern California also serves a diverse cultural and linguistic membership. Of the members*:

- 27.45% identify as Caucasian/White
- 36.85% identify as Hispanic/Latino
- 11.85% identify as Asian or Pacific Islander/Native Hawaiian
- 7.70% identify as African American/Black
- 0.29% identify as Native American
- 15.87% identify as Multiracial/Unknown/Other

**Data Source is KP HealthConnect™ (as of December 31, 2024)*

As of December 31, 2024, Kaiser Permanente Southern California has collected 98.57% spoken language preferences in Kaiser Permanente HealthConnect. Out of these members, 9.68% (443,802) are limited English speaking or prefer to have healthcare delivered in a language other than English.

- 88.88% prefer English
- 8.25% prefer Spanish
- .42% prefer Chinese (Mandarin)
- .23% prefer Vietnamese
- .14% prefer Korean
- .09% prefer Tagalog
- .08% prefer Armenian
- .07% prefer Chinese, Cantonese
- .05% prefer Sign Language

As of September 2024, we have collected 8.67% of our members' Sexual Orientation and 8.45% of our members' Gender Identity (SOGI) information. Of the collected information using the SOGI questionnaire to input the patient's self-identified information patients have identified their Sexual Orientation as follows**:

- 0.31% identify as Bisexual
- 0.16% Choose not to disclose
- 0.06% identify as Don't know
- 0.24% identify as Gay
- 0.11% identify as Lesbian
- 0.00% identify as Lesbian or Gay
- 0.11% identify as Something else
- 7.67% identify as Straight (not lesbian or gay)
- 91.33% currently have blank/no response collected

Gender Identity as follows**:

- 0.05% Choose not to disclose
- 4.89% identify as Female
- 0.02% identify as Genderfluid
- 3.31% identify as Male

- 0.07% identify as Non-binary
- 0.01% identify as Questioning
- 0.04% identify as Transgender Female/Male-to-Female
- 0.05% identify as Transgender Male/Female-to-Male
- 91.55% currently have blank/no response collected

***Data Source is KP HealthConnect™ (as of September 2024)*

Equity, Inclusion & Diversity (EID)

Kaiser Permanente is committed to Equity, Inclusion and Diversity (EID) as a key business strategy essential to maintain high-quality and affordable healthcare, best-in-class service, and our status as the best place to work and leverages its rich diversity of people and enduring commitment to inclusion in order to remain a leader in providing high quality care that is affordable, improves total health, and is designed to ensure that all medically necessary covered services are available and accessible to all members. Kaiser Permanente maintains a high-quality care standard and does not discriminate. Refer to the Nondiscrimination section below. Southern California's EID Department ensures that all covered services are provided in a culturally and linguistically appropriate manner.

It is the policy of KFHP to require that its provider network of facilities and services be accessible to individuals with mental or physical disabilities in compliance with the Americans with Disabilities Act of 1990 ("ADA") and Section 504 of the Rehabilitation Act of 1973 ("Section 504") and other applicable federal and state laws and regulations that prohibit discrimination on the basis of disability.

KFHP requires culturally and linguistically appropriate services for members. SCAL Equity, Inclusion and Diversity (EID) will help to transform care delivery across the spectrum of care with the goal of eliminating disparities/inequities. EID provides assistance to care delivery by:

- Setting quality standards, building the continuously improving infrastructure, and monitoring practices that can eliminate barriers to culturally competent care, such as the provision of language interpretation, translation and disability-related auxiliary aids and services
- Advancing KP's ability to provide equitable care by supporting innovative efforts to reduce health care disparities/inequities, takes action towards reducing bias, and by spreading best practices.
- Collaborating with human resources to enhance the ability of our workforce to consistently deliver high quality patient care and services experience to our members and support efforts in building a diverse and inclusive staff.
- Providing expert consultation on cultural and linguistic services to KP marketing, sales, and member services functions, to improve members' and potential members' KP experience.
- Facilitating organizational compliance in the areas of cultural and linguistic services and supports the infrastructure responsible for driving regional strategic diversity initiatives.

KP Equity Principles

At Kaiser Permanente, our mission, values, and people define what we do, how we do it, and who we are as an organization. Throughout our 77-year history, this identity has been based on respecting and representing the diverse communities we serve. Today we have a shared responsibility to move beyond simply valuing diversity and inclusion; we need to actively build a more equitable future, together. Our equity principles define the expectations and accountabilities for each of us in promoting individual actions to uphold the racial, health, and workforce equity standards that reflect our mission, values, and history.

Nondiscrimination

KFHP does not unlawfully discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, immigration status, or identification with any other persons or groups defined in Penal Code section 422.56 to ensure that all covered services are provided in a culturally and linguistically appropriate manner.

Quality Assurance Program & Program Description

KFHP's regional Southern California Quality Assurance Program (QAP) has been established in accordance with applicable legal and accreditation requirements to ensure the continuous review of the quality of care, performance of medical personnel, and quality of services provided to our

membership. The QAP is described in the Regional Quality Program Description and in the other quality program documents identified below. Together the three documents memorialize the scope, structure, authority, and operations of the QAP, whose primary purpose is to effectively identify and resolve quality problems within the health care delivery system. The Quality Program is approved annually by SCQC and Quality and Health Improvement Committee (QHIC), a subcommittee of the KFHP Board of Directors.

The annual approval includes a review of the Quality Program Description, the prior year's Quality Work Plan Evaluation, and the current year's Quality Work Plan to ensure ongoing performance improvement. The three regional program documents, Southern California Trilogy Documents, are made available to all regional and medical center stakeholders.

The QAP is evaluated annually and, if needed, changes are made to the structure of the program. Evaluation includes:

- A review and revision of the Quality Program Description
- An annual update to the Regional Quality Work Plan to ensure ongoing performance improvement
- Routine reviews of the regional committee structure and committee charters
- Ongoing reviews by the departments participating in the quality program and the quality committees to ensure resources are adequate to the needs of the quality program and to ensure that there is adequate practitioner participation and leadership involvement in the quality program

3. QUALITY STRUCTURE & SCOPE, AUTHORITY, ACCOUNTABILITY, AND RESPONSIBILITY

The Quality Program includes three levels of authority, accountability, and responsibility related to quality of care and services provided to members. These include the KFHP Governing Body, the SCQC, and the local Medical Center quality structure. The Quality Program promotes positive patient outcomes and seeks to prevent negative events by continually assessing and improving governance, managerial, clinical, and support mechanisms that directly and indirectly impact outcomes.

Governing Body

The Kaiser Foundation Health Plan (KFHP) Board of Directors
(Attachment A: Kaiser Foundation Health Plan, Inc. Board of Directors and Executive Leadership of the Southern California Region)

The Kaiser Foundation Health Plan, Inc. (KFHP) Board of Directors is comprised of 12 external Directors and one internal Director, the Chief Executive Officer (CEO) of the Health Plan who serves as Chairman of the Board.

The Board members have a broad spectrum of skill sets and come from diverse professional backgrounds, including leadership roles in business, finance, academia, health care, and community nonprofit organizations. The composition of the Board of Directors reflects the organization's commitment to diversity. The KFHP Board of Directors, which meets quarterly, has ultimate accountability and responsibility for the quality of care and service provided to members.

The Board's primary responsibilities are fiduciary, stewardship of the organization's mission and resources, and strategy approval. The KFHP Board of Directors has ultimate accountability and responsibility for the accessibility, quality of care, and service provided to members.

Quality and Health Improvement Committee (QHIC)
(Attachment B: Quality and Health Improvement Committee Charter)

The Board meets its quality oversight responsibility through the establishment of a Board Committee known as the Quality and Health Improvement Committee (QHIC). The full Board receives a report from the Chair of QHIC at each Board meeting regarding quality of care and services for members and patients, and QHIC provides follow-up to any reports as appropriate or as requested.

QHIC meets at least quarterly and reports its decisions, actions, and recommendations to the KFHP Board of Directors. Annually, QHIC reviews and approves regional quality program descriptions, work plans, and evaluations.

QHIC receives and reviews minutes and other reports (as requested) from the Southern California Quality Committee (SCQC). QHIC holds the Regional President and the Regional Executive Medical Director accountable for the performance of the quality program. QHIC sends written follow-up memos to the Regional President and the Executive Medical Director after each meeting. These memos outline Board decisions, requests for clarification, and action. SCQC submits summary reports on follow-up actions to QHIC upon request.

QHIC reviews and, as appropriate, provides direction in the following areas:

- Overseeing quality systems, including quality goals, objectives, and performance measures
- Identifying and addressing deficiencies in quality
- Reviewing, and as appropriate approving, standards for quality assurance, patient safety, service quality, utilization, and risk management
- Reviewing and addressing the results of internal and external system audits
- Promoting progress in member and patient health improvement, including public policy direction, disease prevention activity, reduction of health disparities among population groups, and the development and dissemination of evidence based medicine
- Approving annual targets for health improvement (including HEDIS and improvement in members' health that contributes to community well being) and service quality (including access to services, the care experience and overall member, patient, and purchaser satisfaction)

- Monitoring and assessing performance against targets of the care delivery system, including clinical performance and patient satisfaction with the care experience
- Evaluating results of quality improvement activities, including recommended actions and follow-up
- Reviewing accreditation and licensing processes and reports, such as those of the National Committee of Quality Assurance (NCQA), The Joint Commission (TJC), the Centers for Medicare & Medicaid Services (CMS), and state agencies
- Reviewing the integrity of systems related to the selection, credentialing, and competence of physicians and other health care practitioners, including systems for granting or terminating clinical privileges, professional, medical, or clinical staff membership, peer review, proctoring and continuing education
- Approving applications for appointments/reappointments to the professional, medical, or clinical staff, clinical privileges, and other actions related to professional, medical, or clinical staff membership and clinical privileges that require governing body approval
- Approving professional, medical, or provider staff Bylaws and Rules and Regulations and amendments thereto
- Approving policies and procedures, when governing body approval is required, of hospitals and other facilities operated by the corporation
- Recommending the appointment of the hospital administrator and the administrators of other facilities operated by the corporation

Southern California Quality Committee (SCQC)

(Attachment C: Southern California Quality Committee Charter)

The Southern California Quality Committee (SCQC) is KFHP's quality oversight committee for the Southern California Region. The SCQC is established by the KFHP/KFH Southern California Regional President and the Southern California Permanente Medical Group (SCPMG) Regional Executive Medical Director.

The SCQC is co-chaired by the KFHP Vice President of Quality, Safety and Regulatory Services and the SCPMG Regional Physician Director for Quality and Risk Management. These individuals are appointed by the President and Regional Medical Director as the key senior leaders administratively responsible for the leadership and direction of the quality program. The co-chairs of SCQC, one a practicing practitioner, have substantial involvement in the QI Program and are accountable to the KFHP President and the SCPMG Regional Medical Director and oversee the quality oversight processes and initiatives. SCQC reports its activities and functions to the KFHP Board of Directors. Membership of SCQC is comprised of physicians and clinical and quality leaders.

Purpose of SCQC

- Evaluate the safety and quality of care and services provided to Kaiser Permanente members and patients in Southern California
- Support continuous improvement of quality and safety process and outcomes and recommend policy decisions in these areas
- Establish the Quality Program direction in partnership with the operational plans

- Ensure that the quality priorities are aligned and integrated with other key organizational strategic priority areas of work
- Ensure that the organization meets the standards established by regulatory agencies and accrediting organizations

The SCQC provides oversight, coordination of activities and functions, and communication to and from the SCQC Subcommittees. The reporting structure is diagrammed in the KP SCAL Quality Oversight Reporting Structure flowchart.

Sub-Committee and functional reports are submitted on a predetermined basis and reviewed by committee members. In addition, the Kaiser Foundation Hospitals submit reports to the SCQC and to QHIC that include:

- Performance on standard program-wide quality, patient safety, and utilization indicators.
- Summaries of significant event reports and follow-up actions.
- Summaries of accreditation, credentialing and licensing agency reports and findings.
- Summaries of other key quality/operational indicators including access metrics, member satisfaction, and continuing care indicators.
- Annual health plan, hospital, and continuing care (home health, hospice) quality program descriptions, quality work plans, and program evaluations.

All KFHP Committees and Subcommittees have practicing practitioners, and all have substantial involvement in the planning, design, implementation, and review of the QI Program.

Confidentiality

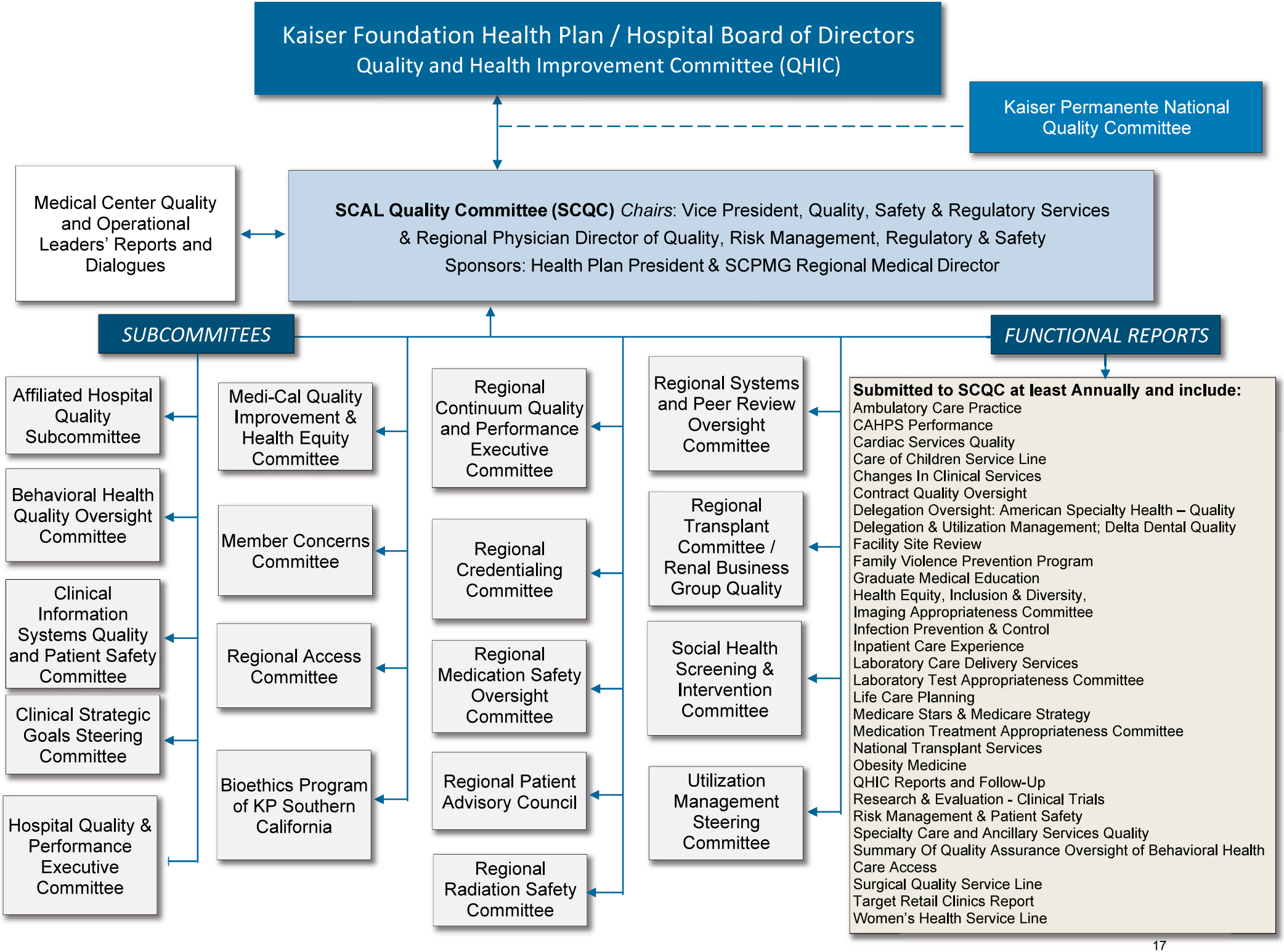
All SCQC and subcommittee minutes, reports, recommendations, memoranda, and documented actions are considered quality assessment working documents and are kept confidential. They are maintained in accordance with KFHP Southern California policies and procedures and are privileged and protected from discovery under statutes related to quality improvement/quality assessment and peer review. All records are maintained in a manner that preserves their integrity in order to assure that patient and practitioner confidentiality is protected. All staff receive training on confidentiality at the time of employment and annually thereafter.

Members of SCQC explicitly agree, as a condition of membership, to:

- Respect and maintain the confidentiality of all discussions and information.
- Make no voluntary disclosures of discussions and information except to persons authorized to receive it in the conduct of SCQC activities.
- Notify the SCQC Co-Chairs in the event any person or entity seeks to compel disclosure of privileged or confidential information.
- Not create or retain any copies or reproductions of discussions or information except as required for participation.

SCQC Subcommittees

The SCQC assigns certain responsibilities to subcommittees that are required to report to SCQC at least annually, or more often as necessary. The charters (attached) for each subcommittee are reviewed annually and include group composition, responsibilities, and activities. SCQC



Approved by SCQC on 3/28/2025

Reporting Structure Updated: 3/21/25

membership and subcommittee membership is reviewed annually. All KFHP subcommittees have practicing practitioner participation.

The subcommittees of the SCQC are:

- Affiliated Hospital Quality Subcommittee
- Behavioral Health Quality Oversight Committee (BHQOC)
- Clinical information Systems Quality and Patient Safety Committee
- Clinical Strategic Goals Steering Committee (CSGSC)
- Hospital Quality and Performance Executive Committee (HQPEC)
- Medi-Cal Quality Improvement and Health Equity Committee (QIHEC)
- Member Concerns Committee (MCC)
- Regional Access Committee
- Regional Bioethics Committee
- Regional Continuum Quality and Performance Executive Committee
- Regional Credentialing Committee (RCC)
- Regional Medication Safety Oversight Committee (MSOC)
- Regional Patient Advisory Council (RPAC)
- Regional Radiation Safety Committee (RRSC)
- Regional Systems and Peer Review Oversight Committee (RSPROC)
- Regional Transplant Committee (RTC)
- Social Health Screening & Intervention Committee
- Utilization Management Steering Committee (UMSC)

Affiliated Hospital Quality Subcommittee
(Attachment D: Affiliated Hospital Quality Subcommittee Charter)

The Affiliated Hospital Quality Subcommittee supports Kaiser Permanente's mission of providing access to high quality care for its members in the communities we serve, and a platform for collaboration and quality oversight for contracted Affiliated Hospitals in Southern California and Hawaii. The Committee is an integrated, multidisciplinary, oversight committee that works to provide a foundation to support safe, high-quality care through the collection, measurement, improvement, and reporting of safety metrics.

The Affiliated Hospital Quality Subcommittee's goals include:

- Developing and maintaining appropriate quality metrics and performance standards.
- Ensuring alignment and comparability of metrics and performance standards by leveraging those that are widely adopted at the State or National level and publicly reported with clearly published and technical definitions.
- Ensuring efficiency and avoiding duplication of work by selecting metrics that are already part of an established reporting process and seek to avoid establishing new reporting accountabilities for participants in the KP Affiliated Hospital Quality Data collaborative work.
- Development of technology platforms to support standardization for ongoing quality review and reporting.

- Incorporating the Voice of the Member.
- Continuous quality improvement through collaboration.

Behavioral Health Quality Oversight Committee (BHQOC)
(Attachment E: BHQOC Charter)

The Southern California Kaiser Permanente Behavioral Health Quality Oversight Committee (BHQOC) is a regional subcommittee of Southern California Quality Committee (SCQC). The BHQOC function is to ensure that Kaiser Foundation Health Plan (KFHP), Kaiser Foundation Hospital (KFH), and Southern California Permanente Medical Group (SCPMG) leaders have an established infrastructure for joint oversight of quality and regulatory performance within Behavioral Health, which includes both Psychiatry and Addiction Medicine.

The functions of BHQOC include, but may not be limited to, identifying, reviewing, and evaluating relevant quality, patient safety, and other performance improvement measures and reporting results to SCQC and ensuring regulatory compliance in Southern California's Behavioral Health Program.

The BHQOC focuses on:

- Standards and regulations
- Publicly reported quality measures
- Complaints and grievances
- Behavioral Health Contract Quality Oversight
- Patient safety initiatives, such as Risk Assessment and Suicide Prevention
- Behavioral Health Treatment (BHT) Quality measures including, but not limited to, Autism Spectrum Disorder (ASD) and Applied Behavior Analysis (ABA)

Clinical Information Systems Quality and Patient Safety Committee
(Attachment F: Clinical Information Systems Quality and Patient Safety Committee Charter)

The vision of the Southern California Clinical Information Systems Quality and Patient Safety Committee is to continually improve the care and safety of patients, workflows for clinical providers, and ensure regulatory compliance via the use of clinical information systems.

The overall goals of the committee are to:

- Identify, prioritize, track and trend quality and safety issues regarding clinical information systems that are being reported from Medical Centers, Regional Departments and Systems Solutions & Deployment (SSD) through resolution
- Promote consistency, continuity, and accuracy of electronic medical information as it relates to quality and patient safety
- Provide the forum to refine SCAL quality of care and patient safety needs from KP HealthConnect and create a communication path to the national level
- Provide recommendations to any relevant groups and individuals related to the quality of care and patient safety aspects associated with Clinical Information Systems and use of technology

- Act as a liaison between local and regional stakeholder leaders and committees with recommendations for operations

Clinical Strategic Goals Steering Committee (CSGSC)
(Attachment G: CSGSC Charter)

The KPSC Clinical Strategic Goals Steering Committee (CSGSC) coordinates and oversees:

- Development of Clinical Strategic Goals (CSGs) and CSG Clinical Quality Key Measures
- Development of proposed annual objective performance targets for approval by KPSC senior and executive leadership
- Reporting and communication of regional and medical center CSG performance
- Identification and communication of potential areas for improvement of quality of care and patient safety, including potential underutilization and overutilization of services

Hospital Quality and Performance Executive Committee (HQPEC)
(Attachment H: HQPEC Charter)

The Hospital Quality and Performance Executive Committee (HQPEC) will successfully drive high-priority clinical initiative performance in Kaiser Foundation Hospitals (KFH) through active oversight and removal of barriers.

The purpose of the committee is to oversee and govern Hospital Quality Composite (HQC) as the standard tool demonstrating KFH clinical quality performance, assist clinical initiatives with alignment with regional strategic and operating plans, provide feedback on metrics and targets for clinical initiatives (through the Hospital Quality Composite Subcommittee), identify barriers and work with sponsors to remove barriers to improving clinical quality and performance, communicate clinical quality priorities and opportunities to regional and local leaders, maintain the sustainability of initiatives, ensure consistent quality, and reduce unwanted variation throughout the hospital system through influence with hospital operations, and when appropriate, communicate with the Kaiser Permanente Affiliate Hospital Council about initiatives and practices of interest.

Medi-Cal Quality Improvement and Health Equity Committee (QIHEC)
(Attachment I: QIHEC Charter)

The SCAL Medi-Cal Quality Improvement and Health Equity Committee (QIHEC) is a subcommittee of the Southern California Quality Committee (SCQC). The purpose of the QIHEC is to assure that Medi-Cal members are provided with equitable and high-quality care and services. The QIHEC is co-chaired by the Medi-Cal Medical Director or designee, and an SCPMG Medi-Cal Director, in collaboration with the Chief Health Equity Officer. QIHEC membership includes a broad range of Network Providers, including but not limited to hospitals, clinics, county partners, physicians, Subcontractors, Downstream Subcontractors, Network Providers, and Members, that actively participate in the QIHEC.

The Medi-Cal QIHEC's responsibilities include the following:

- Analyzes and evaluates the results of QI and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of the Community Advisory Committee (CAC);
    - Includes reports/results of independent private accrediting agencies for Kaiser Permanente and all applicable Subcontractors/Downstream Subcontractors, including the following elements: Accreditation status, survey type, level, and expiration date; accreditation agency results; recommended actions/improvements; corrective action plans; and summaries;
- Institutes actions to address performance deficiencies, including policy recommendations and at least annual review of the Medi-Cal Provider Manual (or more frequently as needed to align with current regulations); and
- Ensures appropriate follow-up of identified performance deficiencies.

The Medi-Cal QIHEC is also responsible for the development, review, and approval of the Annual Medi-Cal Quality Improvement and Health Equity plan and plan evaluation. The Medi-Cal Quality Improvement and Health Equity plan shall be made publicly available on the website at least annually. The plan shall consist of the following elements, at a minimum:

- Comprehensive assessment of the QI and Health Equity activities undertaken, including an evaluation of the effectiveness of QI and Health Equity interventions
- Written analysis of required quality performance measure results, and a plan of action to address performance deficiencies, including analyses of each Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's performance measure results for QI and/or Health Equity activities and actions to address any deficiencies
- Analysis of actions taken to address any Kaiser Permanente-specific recommendations in the annual External Quality Review (EQR) technical report and specific evaluation reports
- Analysis of the delivery of services and quality of care of Kaiser Permanente and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, based on data from multiple sources, including quality performance results, Encounter Data, Grievances and Appeals, Utilization Review, and the results of consumer satisfaction surveys
- Planned equity-focused interventions to address identified patterns of over- or under-utilization of physical and behavioral health care services
- A description of Kaiser Permanente's commitment to Medi-Cal Member and/or family focused care through Medi-Cal Member and community engagement (CAC findings, Medi-Cal Member listening sessions, focus groups/surveys, etc.), and how information from community engagement is utilized to inform policies and decision-making
- Population Health Management (PHM) and Population Needs Assessment (PNA) activities and findings
- Outcomes/findings from Performance Improvement Projects (PIPs), consumer satisfaction surveys and collaborative initiatives

Member Concerns Committee (MCC)
(Attachment J: MCC Charter)

The Member Concerns Committee (MCC) is a subcommittee of the Southern California Quality Committee (SCQC). Its function is to present the member perspective on the care experience. The committee helps provide the member's outlook on initiatives and priorities as identified by the Southern California Region.

The functions of the MCC will include, but may not be limited to:

- Provide oversight of a standardized Southern California complaint, grievance, and appeal (CGA) reporting process.
- Identify areas of potential risk and develop recommendations. Report results to SCQC.
- Facilitate the spread of best practices related to learnings from CGA analysis, to address systems and processes that may improve care. Trend and analyze complaint, grievance and appeals types/volumes in the areas of patient care (including referrals to quality), attitude and service, access to care and billing and financial through the application of consistent and statistically appropriate methods including the identification of outliers. Present summarized findings and recommendations to SCQC for review, revision, and approval.
- Review and evaluate relevant complaint data for medical center leadership, business lines, and chiefs' groups, region wide department and peer groups with corresponding drill down, as appropriate.
- Request further local/regional analysis, assessment of other satisfaction measures as appropriate and corrective action plans from facilities or a department to identify drivers; request intervention when spikes or increasing trends are identified in specific complaint categories or member satisfaction data as formally defined by SCQC and evaluate the effectiveness of corrective actions.
- Review certain reports such as the Complaint, Grievance and Appeal Report, Annual Hospital Complaints and Grievances Report, Executive Leadership Escalations (ELE), Medi-Cal State Fair Hearings Report, Complaints Referred to Quality Review Report, Independent Medical Reviews (IMR) Report, Clinical Consultant Inter-Rater Reliability, Member Experience Analysis Reports, Member Relations Case Processing Timeliness Report, CMS 5 Star Rating Report, and Decision Oversight Committee Report.
- Note: Oversight of access performance is not under the scope of MCC, but rather under the scope of the SCAL Access Committee, which reports directly to SCQC.

Regional Access Committee
(Attachment K: Regional Access Committee Charter)

The Regional Access Committee is a subcommittee of SCQC, serving as the Health Plan oversight body to ensure members are being seen in a timely manner. Its function is to oversee the adherence to Health Plan regulatory and accreditation requirements around timely access and wait times for appointments, and to proactively address areas at risk for not meeting these requirements. The Access Committee assures systematic monitoring of access to care and services, reviews access performance and ensures improvement opportunities are addressed

through corrective action plans and communicates access concerns and corrective actions to KFHP and SCPMG leadership as necessary.

The roles and responsibilities of the Access Committee include, but are not limited to:

- Understanding and executing the access requirements by regulatory and accrediting organizations.
- Reviewing access performance data for all areas to identify and understand trends, distributions and outliers in wait times at the regional, medical center and department levels.
- Reviewing access trends and patterns and recommend areas of focus based on those data.
- Requesting and overseeing implementation of corrective action plans to address gaps in access.
- Escalating concerns and report resolution of CAPs to the SCQC.
- Providing oversight for submission of service area and county-specific and Rate of Compliance (ROC) data for annual Timely Access Report submitted to DMHC.
- Oversight of the Network Management Steering Committee (NMSC), a subcommittee providing oversight of network management activities across all lines of business, for improved network adequacy, capacity, stability, and transparency.

Regional Bioethics Committee
(Attachment L: Regional Bioethics Committee Charter)

The Regional Bioethics Committee serves as a deliberative and voting body for policies under the custody of Bioethics. The committee provides an advisory, inter-professional forum for the discussion of ethical concerns that arise in the legal, regulatory and professional context of patient healthcare. The goal is to foster the integration of ethical practice throughout the organization through:

- Providing consultation for entities within Kaiser Permanente Southern California. The committee may review and collaborate with relevant stakeholders regarding regional guidelines, relevant federal and state laws or proposed laws, policies, or other issues of an ethical nature
- Facilitating communication among the medical service area Bioethics Committees
- Providing counsel to the medical service area Bioethics Committees
- Supporting the ethics education of leadership, physicians, staff, and committee members from a regional level.

Regional Continuum Quality and Performance Executive Committee
(Attachment M: Regional Continuum Quality & Performance Executive Committee Charter)

The overall purpose of the Regional Continuum Quality & Performance Executive Committee is to:

- Align regional leaders and stakeholders in the Continuum (care and services provided outside of the hospital) regarding quality and compliance oversight.
- Ensure that each subcommittee has standardized practices that promote quality and shared best practices to reduce variation.

- Provide a forum for continued collaboration with stakeholders across services.
- Promote highly reliable quality standard work in the Continuum.
- Identify and remove barriers to improve quality.

The Regional Continuum Quality & Performance Executive Committee is a subcommittee of the SCQC and provides updates to SCQC twice a year. The key areas of focus are:

- Updates from Care at Home, Care Coordination/Case Management, Regulatory and Compliance for alignment across the continuum space.
- Review Quality Reports and Satisfaction Surveys.
- New pilots and programs.
- Performance and improvement of services.
- Oversight and monitoring of compliance with performance standards.

Regional Credentialing Committee (RCC)
(Attachment N: RCC Charter)

The Regional Credentialing Committee's function is to improve patient care and safety through optimization of the credentialing and privileging processes while meeting all regulatory requirements. The Regional Credentialing Committee collaborates with the Regional Systems and Peer Review Oversight Committee (RSPROC) and with members of each local Kaiser Foundation Hospital Credentials Committee on an as needed basis. The committee serves both as a decision-making body, an oversight body, and in an advisory role to the SCQC.

The RCC has decision making responsibilities for credentialing and privileging regionally as follows:

- Granting of Approval to Participate and Reapproval to Participate of affiliated, per diem, locum tenens, telemedicine, Allied Health Practitioners and all Organizational Providers to participate in the Kaiser Foundation Health Plan of the Southern California Region
- Approval of privileging and proctoring processes
- Review and Approval of delegated credentialing processes
- Oversight and management of the credentialing and privileging database
- Oversight of local implementation of the credentialing and privileging policies and procedures
- Ongoing review and monitoring of sanction activities and licensing board actions
- Oversight of the linkage with Regional Contracting and Claims Departments for the purpose of ensuring that Practitioners and Providers are credentialed, when appropriate, to see Health Plan members
- Oversight of Bylaws revision processes in conjunction with Accreditation, Regulation and Licensing
- Analysis of reports from monthly oversight reviews
- Review of reports from RSPROC and oversight of credentialing actions taken to ensure consistent standards across the Southern California program

The RCC has advisory responsibilities for credentialing and privileging regionally as follows:

- Review and revision of Credentialing and Privileging policies and procedures

- Development of educational programs to promote consistent implementation of consistent credentialing practices
- Promote consistency of credentialing practices and uniformity of privileging criteria across departments, hospitals and medical centers in the Southern California program
- Escalate significant issues, trends, and variations to SCQC
- Promote sharing of learning across the Southern California program
- Support compliance with Kaiser Permanente Policies and Procedures
- Support compliance with standards and regulations referable to credentialing and privileging, including the Department of Managed Health Care, The Joint Commission, National Committee for Quality Assurance, The Center for Medicare and Medicaid Services, Department of Health Care Services, and the California Department of Public Health

Regional Medication Safety Oversight Committee (MSOC)
(Attachment O: MSOC Charter)

The Regional Medication Safety Oversight Committee exists to eliminate medication errors that cause harm or potential harm to our patients by overseeing, coordinating, and supporting medication safety efforts, Just Culture, risk mitigation, and improved health outcomes across the continuum of care. Through these efforts, the committee facilitates and promotes the high reliability organizing (HRO) principles of deference to expertise, reluctance to simplify, preoccupation with failure, sensitivity to operations, and commitment to resilience.

The Committee oversight encompasses consideration of regulatory requirements, assessment of medication safety data and audits, review of sentinel events, and other causes of patient harm or potential harm pertaining to medications. Medication safety issues are forwarded from various internal and external sources. Oversight and collaboration include the following:

- Local medication safety committees
- SCPMG Directors of Ambulatory Clinical Practices
- Medication management teams
- KP HealthConnect® leads
- Pharmacy Nursing Committee
- Pharmacy Informatics and Pharmacy Operations
- Quality Leaders

Regional Patient Advisory Council (RPAC)
(Attachment P: RPAC Charter)

The purpose of the KPSC Regional Patient Advisory Council (RPAC) is to provide input and recommendations to KP leaders that improve processes of care with an emphasis on quality*, safety and care experience. The RPAC is composed of volunteer patient advisors representing the diversity of KPSC membership. The Council:

- Identifies and advises KPSC on regional issues related to quality, safety, care experience and all key areas of healthcare.

- Partners with KP regional and national leaders, committees, and other improvement teams to bring patient perspectives for more patient centered outcomes.
- Encourages KP leaders throughout the organization to invite and respond to requests for patient advisors to participate in meetings, conferences, workgroups, and performance improvement projects.

**In this context quality includes six aims which have been adopted throughout Kaiser Permanente: Safe, Efficient, Effective, Timely, Patient Centered, and Equitable.*

Regional Radiation Safety Committee (RRSC)
(Attachment Q: RRSC Charter)

The Regional Radiation Safety Committee (RRSC) is chartered to ensure radiation safety for physicians, personnel, patients, and visitors to Kaiser Permanente Southern California facilities by overseeing and managing the Regional Radiation Safety Program.

The RRSC provides oversight of the safe use of all sources of ionizing radiation, ensures verification that only qualified personnel use those sources, oversees the occupational radiation exposure monitoring program, and ensures compliance with applicable state and federal radiation control regulations and accrediting body requirements. The RRSC is assisted in its duties by the Regional Radiation Safety Officer (RRSO).

The roles and responsibilities of this committee include:

- Reviewing and approving all new and renewal applications for non-human use of radioactivity.
- Monitoring all uses and users of ionizing radiation by:
    - Identifying uses that require modification/correction/additional oversight
    - Directing corrective actions as needed
    - Ensuring that corrective measures associated with radiation-related incidents are implemented
    - Monitoring results for compliance
- Establishing regional policies necessary to ensure compliance with applicable laws, regulations, conditions of radioactive materials licenses, and accepted principles of good radiation safety practice.
- Reviewing the occupational radiation exposure monitoring program on a regular basis.
- Assigning/Overseeing the duties/responsibilities of the Regional RSO.

Regional Systems and Peer Review Oversight Committee (RSPROC)
(Attachment R: RSPROC Charter)

The Regional Systems and Peer Review Oversight Committee (RSPROC) is a subcommittee of the Southern California Quality Committee (SCQC). The function is to improve patient care and safety through optimization of the system/department and peer review quality processes while meeting regulatory requirements. The committee serves both as a decision-making body and in an advisory role to the SCQC and collaborates with all SCQC quality subcommittees.

The mission is to provide oversight of clinician-based errors and system issues with potential for harm, prevent repetition of errors that have already been identified, utilizing education and other performance improvement processes, identify and promote medical center uniformity and efficiencies of processes for peer review and system/department review, and advocate for improvement in systems to promote patient safety.

Regional Transplant Committee (RTC)
(Attachment S: RTC Charter)

The KPSC Regional Transplant Committee (RTC) has been established to provide comprehensive oversight of regional transplant care, quality, and ancillary services. The goal of RTC is to ensure access to high quality transplant care for KP members. RTC provides oversight for all pediatric and adult bone marrow, solid organ (kidney, liver, heart, and lung) and simultaneous pancreas and kidney (SPK) transplant services. The vision is to provide a seamless transplant patient experience through an integrated, multi-disciplinary transplant program committed to clinical success and excellent patient outcomes.

Social Health Screening & Intervention Committee
(Attachment T: Social Health Screening & Intervention Committee Charter)

The Kaiser Permanente Southern California Social Health Screening & Intervention Committee is a regional subcommittee of the Southern California Quality Committee (SCQC). The purpose of the Social Health Screening & Intervention Committee is to ensure that leaders from the Southern California Permanente Medical Group (SCPMG) and Southern California Kaiser Foundation Health Plan/Hospitals (KFHP/PH) have an established infrastructure for joint oversight of quality, equity, and regulatory performance of social health practices.

The functions of the SCAL Social Health Screening & Intervention Committee include, but are not limited to:

- Coordinating social health strategic priorities to align with enterprise objectives.
- Understanding and executing requirements by regulatory and accrediting organizations.
    - Coordinate market requirements to achieve the National Committee for Quality Assurance (NCQA) Health Equity Plus accreditation
    - Centers for Medicare & Medicaid Services (CMS)
    - California Department of Health Care Services (DHCS)
    - Others
- Implementing social health screening and intervention outside of care delivery (self-service) and within care delivery spaces (inpatient and ambulatory) using standardized screening tools.
- Identifying and addressing inequities to ensure equitable access to healthcare services and community resources.
- Ensuring social health data from various sources is integrated into a unified system.
- Analyzing social health screening and intervention data to identify trends, understand patterns, and make informed recommendations for improvement.

- Supporting research initiatives that explore the impact of social determinants or social drivers on health outcomes.
- Escalating concerns and reporting resolution of findings to SCQC.

Utilization Management Steering Committee (UMSC)
(Attachment U: UMSC Charter)

The Utilization Management Steering Committee is a sub-committee of SCQC that oversees and supports the 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.

The UMSC has authority and responsibility for ensuring compliance with the following:

- UM decision-making related to medically necessary treatment decisions is consistent with accepted standards of practice and all applicable laws, regulations, and benefit mandates
- Ensuring Mental Health parity in the development and application of UM policies and procedures
- Oversight, monitoring, evaluation and implementation of processes by which the Plan conducts utilization review
- Oversight and monitoring of the timely and accurate communication of UM decisions in accordance with state and federal requirements
- Oversight and monitoring of the entities with delegated UM functions
- Development and annual review of UM criteria with participation by actively practicing physicians in compliance with applicable state and federal requirements
- Appropriately licensed and credentialed physicians/healthcare professionals make UM decisions, based on medical necessity, to deny or modify services requested by providers of healthcare services for plan enrollees
- Oversight and monitoring of UM education and training to all relevant stakeholders
- No financial incentives exist that encourage UM decisions that result in denials or create barriers to care and services

The UMSC also conducts ongoing monitoring to identify potential UM practices within the KP delivery system to oversee the structure of the UM Program, and to identify potential quality issues.

Other Key Programs and Functions (Reporting to SCQC)
The SCQC fulfills its responsibility for evaluating the effectiveness of all other aspects of the Quality Program by reviewing the following functional reports:

Program/Function

- Ambulatory Care Practice
- CAHPS Performance
- Cardiac Services Quality
- Care of Children Service Line

- Changes in Clinical Services
- Contract Quality Oversight
- Delegation Oversight: American Specialty Health – Quality Delegation & Utilization Management; Delta Dental Quality
- Facility Site Review
- Family Violence Prevention Program
- Graduate Medical Education
- Health Equity, Inclusion & Diversity
- Imaging Appropriateness Committee (iMAGAC)
- Infection Prevention & Control
- Inpatient Care Experience
- Laboratory Care Delivery Services
- Laboratory Test Appropriateness Committee (LabTAC)
- Life Care Planning
- Medicare Stars & Medicare Strategy
- Medication Treatment Appropriateness Committee (MedTAC)
- National Transplant Services
- Obesity Medicine
- QHIC Reports and Follow-up
- Research & Evaluation – Clinical Trials
- Risk Management & Patient Safety
- Specialty Care and Ancillary Services Quality
- Summary of Quality Assurance Oversight of Behavioral Health Care Access
- Surgical Quality Service Line
- Target Retail Clinics
- Women's Health Service Line

The Appropriateness Committees recommend ways to promote appropriate utilization of services to optimize patient care. The outcomes of the under- and over- utilization are reported to SCQC.

Regional Imaging Appropriateness Committee (iMAGAC)
This committee works to optimize the use of diagnostic imaging to provide evidence-based care resulting in nationally leading performance in patient safety and clinical efficiency. Other goals include minimizing unnecessary radiation exposure and promoting imaging resource stewardship. Key indicators monitored by this committee include various utilization metrics (MRI Brain, CT Chest, CT-PA, CT Head, CT Abdomen/Pelvis, Echocardiogram, and NM Heart) and quality metrics (High-risk Mammography, HEDIS Low Back Pain, CT Head Syncope Concordance, Limited Abdominal Ultrasound, CT-PA d-dimer Concordance, Neck Imaging Syncope Concordance, ECHO Concordance).

Laboratory Test Appropriateness Committee (LabTAC)
This committee provides leadership and oversight to all laboratory appropriateness initiatives by providing data and analytical support, decision support tools, and educational materials that facilitate successful implementation of appropriate laboratory ordering practices. The objectives

of the committee are to identify opportunities to improve appropriate laboratory stewardship, develop SMART goals for improvement, and to establish implementation timelines and monitor progress on initiatives. The goals of the committee are to support and promote local LabTACs at each medical center and communicating and collaborating with Medical Center leadership, Chiefs' groups, subject matter experts, the iMAGAC, and the MedTAC.

Medication Treatment Appropriateness Committee (MedTAC)
This committee is committed to optimizing treatment appropriateness, with a focus on safety and quality of care to our members. MedTAC continually evaluates prescription patterns for a variety of drug classes to assure that members consistently receive the highest quality health care possible. In all cases individual physicians exercise their best judgment in deciding on the most appropriate medications to prescribe for their patients. To achieve success, the MedTAC workflow process in general comprises of the following:

1. Collaborate through partnership between Permanente Medical Group and Pharmacy
2. Develop initiatives for the group to pursue
3. Report initiatives performance
4. Provide actionable data and resources to the local MedTAC teams
5. Drive for results

Local Medical Center Quality Oversight
Medical Center Leadership reports at least twice a year to SCQC on a specified executive summary outlining key performance improvement activities/metrics.

The President and Executive Medical Director, through the Kaiser Foundation Health Plan/ Hospitals Medical Center Senior VP/Area Manager and the SCPMG Area Medical Directors, hold the medical centers accountable for quality of care and service provided to members. Each medical center leadership team is responsible for overseeing quality assessment and performance in each medical center.

The Medical Center Leadership Teams are responsible for:

- Establishing local quality programs and a quality committee structure in alignment with the national and regional program.
- Providing oversight, review, and follow up where opportunities for improvement are identified.
- Holding medical center physicians and staff, (KFHP, KFH & SCPMG) responsible for specific functions of quality assessment and performance improvement related to safety, risk and utilization management, monitoring and resolution of member complaints and appeals, assessment of member satisfaction, as well as regulatory and accreditation compliance, coordination, consultation, facilitation, and review.
- Establishing access, service, and quality goals that are aligned with Regional goals.
- Directing action as indicated to improve access to care and service.
- Overseeing the quality of contracted providers and services used.

The medical centers establish their own quality structures, programs, resources, and systems, and appoint at least one physician quality director (SCPMG) and one administrative quality director (KFHP/H) who are accountable for the quality program in the medical center. Annually, the medical center quality program descriptions, work plans, and evaluations are reviewed against program-wide criteria and approved locally by the medical center leadership and by the SCQC.

Medical centers design and implement programs that address local needs, issues, and priorities, and are most responsive to the clinical health care needs of the population served.

The Health Plan provides oversight of the local medical center quality/operational functions. Quality processes are parallel and have many similarities to the structure of the regional quality oversight processes. Some examples include:

- The physician directors of quality and the directors of quality from each medical center come together in regular forums with the regional Health Plan leaders and Regional Physician Director for Quality, Risk Management, Regulatory and Safety to discuss issues, processes and share ideas. In addition, the directors of quality meet monthly to discuss issues and processes.
- The SCQC requests local medical center reports and corrective action plans as appropriate on all Board of Director required reporting elements as well as the Regional reporting elements (e.g. Clinical Strategic Goals).
- The local medical centers are represented on SCQC and its sub-committees.
- The KFHP leaders receive regular reports on their local performance of all quality and regulatory issues.

Continuous Readiness Assessments at the local medical centers are conducted by a team of internal consultants reporting to the KFHP Vice President of Quality and Regulatory Services and the SCPMG Regional Physician Director for Quality, Risk Management, Regulatory and Safety. This team conducts scheduled site visits to each medical center, monitoring against regulatory standards and quality vulnerabilities as identified through previous surveys, trends on sentinel events or other regulatory agency vulnerabilities, and quality performance as reported through regional reports. The purpose of this monitoring is to assess ongoing sustained improvement of corrective action plans, identification of new high-risk vulnerabilities and ongoing accrediting and regulatory readiness.

4. PERFORMANCE IMPROVEMENT

Performance Improvement Strategy

KFHP Southern California strategic priorities are formulated from the national and regional priorities established by the KFHP Board and recommendations by Executive Leadership and the SCQC. Additional goals and activities are selected based on importance and relevance to KFHP membership and linkage to KFHP's mission. Activities reflect the needs of the membership and focus on high volume, high risk, and problem-prone areas for which quality improvement or loss prevention activities are likely to result in improvements in care and service, access, safety, and satisfaction.

KFHP Southern California Executives identify performance improvement opportunities and set goals with respect to the:

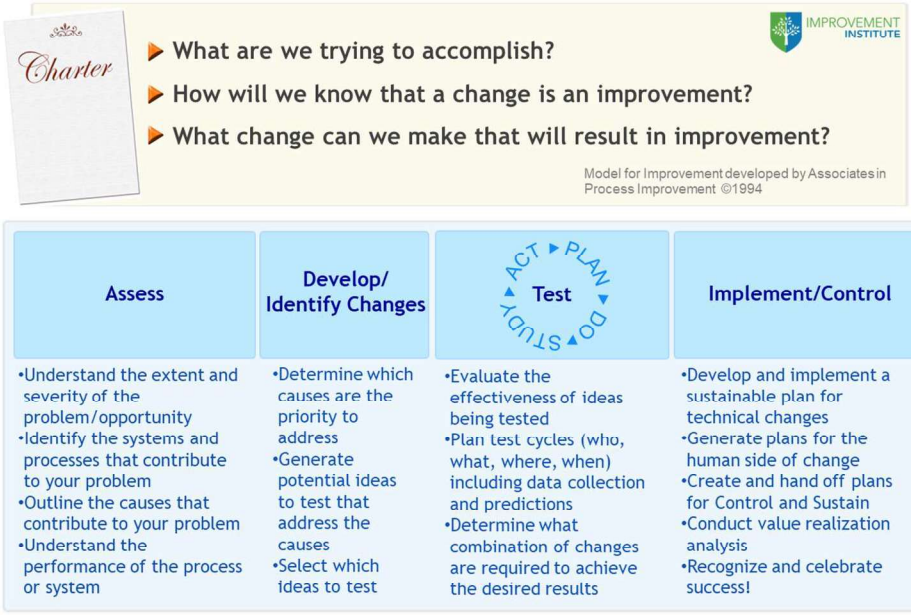
- Quality and safety of the care we deliver
- Care experience of our Members
- Coordination of care we deliver
- Timeliness of the care we deliver
- Venues where we deliver care
- Skills, motivation, and safety of our workforce

Relevant services, departments, teams, and individuals participate in establishing and/or defining performance expectations. Regional and Medical Center performance is monitored by leadership committees. Performance measures form the basis for plans and actions developed to improve care and service. Measure data is analyzed to determine strategic priorities and to ensure that opportunities for improvement are identified and/or best practices are defined and shared.

Performance Improvement Methodology

KFHP utilizes the KP Performance Improvement Model which is a phased approach that incorporates the Institute for Health Care Improvement (IHI) Model for Improvement. The KP Performance Improvement Model includes setting aims, forming teams, establishing measures, and selecting and testing changes. Medical Center and Regional staff are encouraged to achieve improvement continuously by using good daily management systems such as rounding and huddles in conjunction with the "Rapid Cycle Small Tests of Change Methodology."

The model Framework is depicted below. The four phases of improvement within the KP Performance Improvement Model include Assessing the problem and the processes that contribute to it, Developing and identifying solutions to test, Testing the solutions using the "Plan–Do-Study–Act Cycle" (PDSA) and, finally, Implementing the verified solutions as well as management controls to ensure their continued use.



Performance Improvement Leadership

Each Medical Center leadership team reports quality, safety, utilization, and service activities and metrics to the SCQC, which in turn reports this information to the Board of Director's QHIC. These Health Plan leaders work in partnership with SCPMG Physicians-in-Chief (PICs) to oversee the quality of care, utilization management, and services provided/available to all members they serve. Each Medical Center leadership team is responsible for:

- Overseeing quality assessment and performance.
- Establishing quality programs and a quality structure of committees that provide oversight and review.
- Holding Medical Center physicians, managers, and staff responsible for specific functions of quality assessment and improvement, patient safety, credentialing, risk management, utilization management, monitoring and resolution of member complaints and appeals, assessment of member satisfaction, medical records review, regulatory and accreditation compliance, coordination, consultation, facilitation, and review.
- Establishing quality goals based on Regional strategic priorities and ensuring ongoing improvement of the care experience and services.

Prioritization of Quality Improvement (QI) Activities

It is the responsibility of leadership to establish priorities for performance improvement and member health outcomes, with an emphasis on using outcomes-oriented measurement as a key method to improve the quality of care. Prioritization of QI activities are completed annually and at the time of planning. A prioritization matrix tool is available to enable quality committees and work groups to focus resources by rank-ordering projects using selected criteria and professional judgment. When determining the prioritized metrics, the following are considered:

- Linkage with strategic goals
- Clinical quality
- Service and access

- Patient safety
- Risk management
- Legal/regulatory and accreditation requirements
- Performance gaps
- Member complaints
- High volume diagnoses and procedures
- Problem prone diagnoses and procedures
- Leapfrog safe practices criteria

Performance Measurement Data

Performance measures developed have a specified data collection methodology and frequency. The methodology for data collection is dependent on the type of measure and available data. Data validation is part of the data collection process. Quality assessment and improvement activities are linked with the delivery of health care services in the Medical Centers. Qualitative and quantitative data are collected, aggregated, and analyzed to monitor performance. When opportunities for improvement are identified, a plan for improvement is developed and implemented. Data is used to determine if the plan resulted in the desired improvement. Data collection is ongoing until the improvement is considered stable. At that time, the need for ongoing monitoring is re-evaluated.

Performance Review/Benchmarks

KFHP Southern California compares its quality performance and outcomes against internal and external organizations when relevant criteria exist. The Quality Program assesses or evaluates the:

- Degree of compliance with process and outcome objectives
- Stability of a process and consistency of its outcome
- Opportunities to improve a stable process
- Efficiency of efforts to reduce or eliminate undesired variations
- Degree to which design specifications for new processes are me
- Priorities for possible improvement of existing processes
- Ability to spread best or successful practices
- Spreading Best or Successful Practices

Spreading Best or Successful Practices

Southern California Health Plan has developed a spread and sustainability methodology. When a key initiative supports the organization's ability to meet its strategy priorities follow an infrastructure and methodology to implement to ensure success. This approach has four key components:

- Standardization/systemization
- Leadership alignment
- Data that drives
- Project management

Performance Improvement: Ambulatory (Outpatient) Quality Initiatives

Clinical Quality Key Measures

To address the growing challenge of publicly reported data, the Southern California Health Plan and Medical Group leaders identify clinical quality key 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 list of 2025 Clinical Quality of Care Key (CQK) measures and the rationale for selecting these measures is available in the SCAL Clinical Strategic Goals (CSG) SharePoint library in the annual CQK memo: https://sp-cloud.kp.org/sites/teams-sccaa/CSG/CSG%20Report%20Library/CSG%20Current%20Monthly%20Reports/Archival%20CSG%20Reports/CSG_2025_Archives/Clinical_Quality_Key_Measures_2025_Memo.pdf

2025 Clinical Quality Key Measures	Target
Ambulatory Quality Composite Score (Area-specific)	100.0 or 10-point improvement
Proportion of Areas meeting AQC Target	13/13
Carre Coordination	
• Plan All-Cause Readmissions O/E ratio (Medicare members)	1.04*
Staying Healthy	
• HbA1c < 8.0% - Non-Latino Diabetes Population (18 ≤ 65 y/o)	71.0%*
• HbA1c < 8.0% - Latino Diabetes Population (18 ≤ 65 y/o)	64.0%*
• Childhood Vaccinations: Combo 10 – Non-AA/Black population	56.0%*
• Childhood Vaccinations: Combo 10 – AA/Black population	43.0%*
• Proportion of Days Covered by Medications: Statins (Ages 18-85)	89.0%*

***The targets displayed for these measures reflect the incentive targets for 2025, and they differ from the targets used in the Ambulatory Quality Composite z-score calculations.**

Please visit the CSG SharePoint (https://sp-cloud.kp.org/sites/teams-sccaa/CSG/default.aspx) to access the monthly reports of the 2025 Clinical Quality of Care Key Measures. For additional information on the measure specifications, refer to the annual CSG Measure Definitions (https://sp-cloud.kp.org/sites/teams-sccaa/CSG/Measure%20Specifications/Forms/AllItems.aspx).

Hospital Quality Composite

The intent of the KP Southern California Hospital Quality Composite is to provide leaders with a more comprehensive view of quality, a focus on where improvement is needed, and a way to reduce variation of the care we provide our patients. As the Clinical Strategic Goals provide a composite score for ambulatory care, the Hospital Quality Composite has been developed using a similar methodology, with a focus on the Inpatient setting.

The Hospital Quality Composite uses a set of preexisting measures to calculate a hospital quality "Composite Score" based on "Z-Score" methodology. Each metric's 'Z-Score" measures performance relative to agreed-upon targets. This standardization method facilitates apples-to-apples comparisons of the quality improvement potential of a full range of benchmark metrics,

thereby assisting hospital leaders in identifying their hospital's performance achievements and improvement priorities.

It is our vision that Hospital Quality Composite report, and the underlying metric performance contained within, be at the table when guidance is needed for our respective Medical Center areas to optimize efforts around consistency and improvement. The Hospital Quality Performance Executive Committee (HQPEC) is a subcommittee that reports to the Southern California Quality Committee (SCQC) and maintains oversight and governance of the Hospital Quality Composite.

The Hospital Quality Composite is available to KP employees on the internal intranet.

Performance Improvement: Hospital Quality Initiatives
(Inpatient/Outpatient/Emergency Department)

Hospital Strategic Priorities
KFHP in partnership with KFH has embarked in a comprehensive performance improvement strategy for KFH Hospitals. Success is reflected in public and internal information such as access to care, service, quality and safety "report cards."

The Hospital Quality Measures are guided by:

- KP strategic priorities. The Composite scoring has been expanded to include more focused sub scores for:
  - Patient Safety
  - Nurse Sensitive Indicators (in support of Magnet status)
- The Joint Commission's Core Measures initiatives
- California Assembly Bill 524 of 1991, which mandated that hospitals report certain specific health outcomes to California's Office of Statewide Health Planning and Development (OSPHD).
- SCQC and QHIC review data on inpatient quality measures via regional, local, and program office report cards.

Performance Improvement: Member/Patient/Workplace Safety
(Attachment I: Risk Management Patient Safety Program Description)

The Risk Management Patient Safety strategy is based upon safety that is systematic and uniformly applied across the entire organization and its processes. This Safety Management System focuses on accountability, reliability, and resilience in order to eliminate preventable injuries produced by medical care. It is grounded in a Just Culture, which acknowledges that most preventable harm is multifactorial, involving both the system and multiple individuals. These patient safety principles also apply to employee safety, and an understanding that the patient care experience and viewpoint, is integral to assuring a safety focused system. Risk Management and Patient Safety evolve around proactive management; no preventable harm- and reactive management; all possible repair to patient/family, provider/staff, and organization.

5. KFHP SOUTHERN CALIFORNIA OVERSIGHT OF QUALITY FUNCTIONS

Quality Assurance Program (QAP)

The KFHP Southern California Region administers its Quality Assurance Program (QAP) and oversees and monitors the quality activities performed by its network providers including KFH, SCPMG, and affiliated providers to ensure the provision of quality care and timely and appropriate utilization of services in accordance with professionally recognized standards of practice and legal requirements.

Additionally, KFHP oversees the performance of quality functions at the regional and service area levels.

Quality Assurance Program Agreement (QAPA)

The Quality Assurance Program Agreement (QAPA) is a mechanism for implementing KFHP oversight of the quality of clinical services provided to members. The QAPA outlines the respective roles and responsibilities of KFHP and its contracted providers (KFH and SCPMG) in connection with the performance of the quality and utilization management / resource management (UM/RM) functions that comprise KFHP's quality and UM/RM programs. SCPMG and KFH, via the QAPA, have agreed to:

- Cooperate and support KFHP's quality and UM/RM programs
- Comply with the quality program documents
- Perform the quality and UM/RM activities outlined in the QAPA.

The activities outlined in the QAPA include, but are not limited to:

- Quality of care monitoring and review
- Peer review and notification of physician conduct
- Adverse action determinations and fair hearing procedures
- Identification and appropriate escalation of systemic quality & risk issues
- Review of arbitration decisions
- Credentialing and recredentialing of practitioners and institutional providers
- Participation in and cooperation with regulatory audits
- Creation and submission of reports (to the SCQC or designated subcommittees) needed to assure appropriate QAP oversight
- Creation of the quality program documents
- Participation in performance improvement activities and quality initiatives
- Prompt notification between SCPMG, KFH, and KFHP of incidents that would likely affect any license, certification, privileges, or accreditation status
- UM/RM activities and processes to continuously evaluate the efficiency, efficacy, medical necessity, and quality of care given to our member

Delegation Statement – Contracted Providers

KFHP has direct responsibility and accountability for quality improvement, risk management, credentialing, member rights and responsibilities, and utilization management functions. Under certain circumstances, KFHP may delegate responsibility for conducting one or more functions

to a provider, provider group, agency, facility, health plan, or other supplier of services with whom it contracts.

Delegation occurs only in instances in which KFHP has determined the delegate's capability and capacity to perform the functions and meet KFHP's requirements and expectations. KFHP has a systematic method for conducting a pre-delegation site visit and data collection to evaluate a delegate's capacity to perform certain functions before delegation begins.

Our KFHP written delegation agreements clearly outline all delegated activities and the responsibilities for KFHP and the delegated entity, which are mutually agreed upon. KFHP conducts an annual oversight audit to assure the delegate's continuing ability to meet requirements and expectations. Additionally, according to the reporting submission requirements, there is an ongoing review of reporting requirements and performance submitted documents and activity reports, at least semiannually.

KFHP retains the right to revoke delegation if the delegated entity does not fulfill its obligations. Although the SCQC's subcommittees have an active role in the delegation oversight process, SCQC ultimately has responsibility to oversee delegation. Hospitals which delegate responsibilities to vendors, assume local oversight and accountability for quality related contractual requirements.

The SCQC reviews these aspects of delegation agreement oversight:

A. Documentation and data about the performance of the delegated service
B. Results of audits of the provider's policies and mechanisms, prior to delegation
C. A summary assessment of the annual oversight audit and recommends corrective action plans, if needed
D. Follow-up plans as indicated
E. Recommendations to continue or terminate delegation

Affiliated (Contracted) External Provider Services

In certain circumstances SCPMG contracts with non SCPMG entities (providers/practitioners). Contracts include obligations to cooperate with KFHP's quality program to support member and practitioner communication, to provide access to medical records and to maintain confidentiality of member and personal health information. The KFHP quality program evaluates the care provided by providers and practitioners.

Network Development and Administration

Network Development and Administration Department (ND&A) manages contracts between Kaiser Foundation Hospitals and community hospitals, skilled nursing facilities and other facility providers to provide covered facility/institutional services for our members. Network Development and Administration is responsible for the day-to-day operational maintenance of the contracts, including, but not limited to, additions/deletions of services or facility sites/locations; changes to provider information (business names, addresses, telephone numbers, federal tax ID number etc.), and mergers and other changes in legal structure.

Credentialing and Recredentialing

All physicians, allied health practitioners, and Contracted Providers and Practitioners are credentialed according to the requirements set forth in the Kaiser Foundation Health Plan, Inc., Southern California Region Credentialing & Privileging Policies and Procedures prior to treating Health Plan members unless a Letter of Agreement (LOA) has been issued by the contracting department.

Credentialing/Recredentialing of Licensed Independent Practitioners and Allied Health Professionals Employed by SCPMG

KFHP in the Southern California Region is required to credential providers and practitioners who provide services to KFHP members. Further, the Professional Staffs of hospitals or other facilities operated by KFH are required under legal and accreditation standards to credential individuals who exercise clinical privileges and/or are members of their respective Professional Staffs.

The credentialing and recredentialing process involves a series of activities designated to collect, verify and evaluate data relevant to a practitioner's experience, ability, current competency and professional performance. In addition, as appropriate to a practitioner's practice, on an ongoing manner and at recredentialing, all practitioners are evaluated utilizing performance review thresholds and results of information gathered during quality review.

KFHP ensures that the credentials of all licensed independent practitioners (LIPs) and allied health professional (AHPs), within the scope of the policy, are verified and evaluated, either directly or by delegation. A practitioner shall be permitted to provide health care services once that practitioner's credentials are initially verified and approved. As a condition of continued credentialing in KFHP, a practitioner's credentials must continue to meet the criteria set forth in the policy and procedure and must be re-verified and re-evaluated at least every twenty-four months for practitioners who work in the hospital setting or thirty-six months for practitioners who work in the ambulatory setting.

Regional Credentialing Committee makes final decisions regarding delegation of credentialing, oversees compliance of delegates, and makes the final recredentialing/credentialing decisions for KFHP regarding contracted physicians and practitioners, shared and practicing at the medical centers. The Medical Center's C&P Committee makes the final credentialing/recredentialing decision for KFHP within its respective Medical Center and quality oversight for those physicians that are shared from another medical center. Credentialing and recredentialing decisions are separate and independent from employment actions or decisions made by SCPMG, KFHP, or KFH.

Credentialing/Recredentialing of Contracted Providers and Practitioners

KFHP ensures that the credentials of all Contracted Providers and Practitioner are within the scope of the policy are verified and evaluated. Contracted Providers or Practitioners shall be permitted to provide covered services to KFHP members once a LOA has been issued or until a credentialing application has been evaluated and approved.

The Regional Credentialing Department supports credentialing and re-credentialing of Contracted Providers and Practitioners based on regulatory standards and internal Kaiser Southern California Health Plan policies.

As a condition of continued credentialing, a Contracted Provider must continue to meet the criteria set forth in the policy and procedure. Contracted Provider credentials must be re-verified and re-evaluated at least every thirty-six months.

Monitoring of Credentialed Practitioners

KFHP has an ongoing monitoring process to track:

1. currency of license to practice medicine in California
2. currency of malpractice insurance coverage
3. currency of DEA and/or other prescribing authority
4. currency of board certification
5. currency of the California Department of Public Health, Radiologic Health Branch certificates and permits
6. state and federal sanctions/limitations/exclusions
7. Medicare Opt-Out status, and
8. member complaints between credentialing cycles to ensure credentialed practitioners maintain compliance with credentialing criteria at all times.

Notification of Practitioner Conduct

The "Notification of Practitioner Conduct" Agreement is a mechanism for implementing KFHP oversight of the quality of clinical services provided by licensed independent practitioners to members. Pursuant to the "Notification of Practitioner Conduct" Agreement KFH and SCPMG are required to notify KFHP when a practitioner's conduct comes within the scope of the conduct delineated in the Agreement. Health Plan may take disciplinary action against a licensed independent practitioner, when appropriate, through a Credentials and Privileges Committee acting on behalf of KFHP.

Practitioner Input into Quality

Practitioners are encouraged to actively participate in the Quality Program as it relates to member care and services. Input may be accomplished through participation on quality committees and designated quality improvement activities. The Quality Program at Kaiser Permanente document is also available to practitioners on the internal intranet or by calling the Member Service Call Center to request a hardcopy. The Quality Program Description is also available to practitioners on the internal intranet.

Conflict of Interest Statement

No physician or other individuals involved in performance improvement, utilization management, or risk management shall have the direct responsibility for the review of the quality of patient care or appropriate utilization of resources for a patient with whom the individual is professionally or personally involved.

Decisions related to care are made by the member's physicians and other members of the care team. There is no personal gain or incentives that promote denials or under-utilization.

Benefits
All clinical practice guidelines are sent to the Director of Benefits/Policy Development, Health Plan, to ensure that the recommendations are aligned with existing benefits.

Peer Review Process
The Peer Review process is a mechanism by which KFHP continuously assesses the care provided to the members. This process evaluates potential quality of care concerns involving licensed independent practitioners and allied health professionals to determine whether standards of care are being met. The Health Plan has initiated and oversees compliance with the "Peer Review & Evaluation of Licensed Independent Practitioners Performance" and "Peer Review and Evaluation of Allied Health Professionals Performance" policies through its Regional System and Peer Review Oversight Committee (RSPROC).

Health Plan Oversight of New and/or Changed Clinical Services
The Agreement for Review and Approval of Changes to or the Addition of Certain Health Care Services and QHIC Guidelines for Change/Internalization of Clinical Services sets forth the Health Plan's process to review and approve new services or a change in the manner in which services are provided under the following circumstances:

- Clinical services which are added, discontinued, or modified including regional and sub-regional services and those requiring regulatory approval or notification.
- Clinical services that require capital expenditures of $1 million or more
- Any service that meets the criteria in the Agreement must be approved by the SCQC and KFHP Board (QHIC) prior to its implementation. In Southern California, requesters of new or changed services which meet any of these criteria are required to develop a comprehensive quality oversight and regulatory compliance plan. Prior to SCQC review, these plans are approved by the Regional VP of Quality and Regulatory Services and Health Plan Physician Advisor in collaboration with regional subject matter experts and leaders associated with the specific service change.

In this way, the Health Plan ensures that proposed changes in clinical services have the structure, processes and oversight to ensure high quality health care to members.

Behavioral Health Care Program
(Attachment II: Behavioral Health Care Program Description)

KFHP offers Behavioral Health, (Addiction Medicine & Psychiatry) services within KPSC. KPSC Behavioral Health Care services are part of our integrated medical care program at each medical center and at the regional level. As such, Psychiatry and/or Addiction Medicine practitioners participate in medical center and regional quality committees. The Behavioral Health Care Program Description, annual work plans, and annual evaluations are components of the overall KPSC Quality Program Description. All Behavioral Health related quality issues are

managed through our KPSC Quality structure at both the medical center and regional level; there is no separate Behavioral Health Care quality structure.

The goals and objectives of the Behavioral Health Quality Program are consistent with the overall KPSC Quality goals and objectives outlined in the KPSC Regional Quality Program Description, Behavioral Health Care quality goals are focused on integration/collaborative care, continuity of care, access, availability of practitioners, member experience, HEDIS measures and utilization. Annually, the Behavioral Health Care Work Plan outlines specific goals and objectives.

At the medical centers, each Psychiatry and Addiction Medicine department develop quality plans to address unique departmental goals as sponsored by the Chief and Department Administrator, medical center goals and major regional goals that are outlined in the Annual Behavioral Health Care Quality Workplan Evaluation.

At the KPSC regional level, Behavioral Health Care Representatives are members of, or report to, the following committees and/or advisory groups:

- Southern California Quality Committee (SCQC)
- Behavioral Health Quality Oversight Committee (BHQOC)
- Regional Access Committee
- Regional Behavioral Health Department
- Psychiatry and Addiction Medicine Chiefs and Department Administrator Meetings

Behavioral Health access and availability of services is monitored through the Regional Access Committee where regional leaders participate in reviewing access performance data to identify and understand trends and opportunities at the regional, medical center and department levels. The Committee requests and oversees implementation of Corrective Action Plans (CAPs) to address gaps in access and monitors those CAPs through resolution to ensure the regulatory targets are met.

Member complaints are referred to the medical center quality department when the Member Services RN coordinator identifies a potential quality of care issue (peer and/or department review).

Behavioral Health Care licensed independent practitioners are reviewed through the Focused Practitioner Review (FPR) process per the 'Peer Review and Evaluation of Licensed Independent Practitioner Performance Policies.

The need for additional Behavioral Health facility providers is assessed as part of the overall regional strategic planning process. The components of Behavioral Health Services are outlined in the attached Behavioral Health Care Program Description.

Utilization Management Program
(Attachment III: UM Program Description)

The scope of medical and behavioral health services subject to the KFHP UM Program includes, but is not limited to: outpatient, acute and post-acute care, outside medical referrals, as well as specialized services including acupuncture and organ transplantation.

The scope of the Behavioral Health UM program is included in KFHP UM Program structure. Behavioral Health Care Services, including Psychiatry and Addiction Medicine, is an integrated component of the KFHP UM Program. UM activities occur at multiple behavioral health service sites and levels of care, including intensive outpatient, partial hospitalization and inpatient settings. Additionally, SB 855 was signed into law in September 2020 and requires commercial health plans in California, for contracts issued, amended or renewed on or after January 1, 2021, to cover medically necessary treatment for specified mental health conditions and substance use disorders under the same terms and conditions applied to other medical conditions. As such, SB 855 redefined the description for medically necessary mental health conditions and substance use disorders. Health plans must use the most recent criteria developed by a nonprofit professional association for the relevant clinical specialty when conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders.

6. KEY REGIONAL QUALITY INITIATIVES AND PROCESSES

The following quality initiatives and processes illustrate KFHP's oversight of quality functions to ensure the health of our member populations.

Healthcare Effectiveness Data and Information Set (HEDIS)
HEDIS is a group of standardized performance measures designed by NCQA to ensure that the public (including employers), the Centers for Medicare and Medicaid Services (CMS), and researchers have the information needed to accurately compare the performance of health care plans. These data allow users to both evaluate the quality of different health plans along a variety of important dimensions, and to make their decisions about health plans based upon demonstrated value rather than simply on cost. The performance measures in HEDIS are related to many significant public health issues such as cancer, heart disease, smoking, asthma, and diabetes. HEDIS measures are an integral part of health plan accreditation by NCQA. The Southern California Region's performance is reported to the SCQC annually.

Select HEDIS measures are publicly reported by the California Center for Data Insights and Innovation (CDII). The California CDII represents the interests of health plan members by publishing annual Quality of Care Report Cards on Health Plans and Provider Organizations. The report cards can be found on the CA.gov website: http://www.cdii.ca.gov/consumer-reports.

Clinical Practice Guidelines (CPGs) Process
Kaiser Permanente Southern California (KPSC) has a formal evidence-based Clinical Practice Guidelines (CPG) Program designed to assist physicians, administrators, and other health care

professionals in determining the most effective medical practices to improve the health of Kaiser Permanente members. Many of the clinical practice guidelines (CPGs) address topics that are aligned with Southern California's Regional Clinical Strategic Goals and other clinical priorities. For selected guidelines affecting large populations of Kaiser Permanente members, KPSC works closely with the KP Care Management Institute (CMI) in the development of these guidelines. Guidelines are updated with the two-year update schedule and when significant changes are made, they are distributed via email, the KPSC intranet site, and other communication venues.

KPSC clinical practice guidelines are designed to assist clinicians by providing an analytical framework for the evaluation and treatment of the more common problems of patients. They are not intended to replace a clinician's judgment or to establish a protocol for all patients with a particular condition. It is understood that some patients will not fit the clinical conditions delineated within these guidelines, and that a clinical practice guideline will rarely establish the only appropriate approach to a problem.

The guideline recommendations are not intended to be used as standards for utilization management or performance. SCPMG clinicians are responsible for applying recommendations to the specific clinical characteristics of each patient. In all clinical situations, SCPMG physicians have authority and autonomy in planning and directing the care of patients.

Complete Care Program

Complete Care is the foundation of PHM programs and activities made available for members in all lines of business: Commercial, Exchange, Medicare, and Medicaid. Complete Care is the overarching philosophy that supports the culture of care delivered at KPSC. It creates a standardized infrastructure and approach to disease management and preventive care services comprised of integrated systems, programs, and people that come together to help focus on each person, to align the organization around the needs of the patient.

The Complete Care Program is an evidence-based healthcare system that supports patients with a wide range of health statuses, including those who are healthy, have specific health issues, are chronically ill, or are nearing the end of life. It employs a population approach that integrates disease management into the care delivery system, providing preventive, risk factor, and chronic disease care to patients at every encounter. The system is designed to be person-centric, focusing on the individual's health profile instead of just their disease. It delivers integrated care that encompasses multiple conditions, wellness, and prevention from the patient's perspective.

The Complete Care Program has various components that are focused on keeping members healthy, managing those who are at risk of developing diseases, ensuring patient safety, and caring for those with multiple chronic illnesses. Program interactions with a clinician can be done over the phone or through video conferencing. The term "virtual visit" is used to refer to the phone or through video conferencing for patient/clinician interaction.

In Southern California, the following functional strategies have been implemented to address the individual's needs at every encounter:

Electronic Medical Record. Members with care gaps or who need follow-up by a care manager are identified via the electronic medical record, KP HealthConnect. KP HealthConnect feeds into a robust platform that compiles data from the chart, laboratory, pharmacy, and outside medical to allow for complete and accurate reporting on patients in the target groups.

Proactive Encounter (POE) involves the processes, tools, and workflow that support the health care team prior to, during, and after a patient encounter. Proactive Office Encounter impacts all care settings and is also available in virtual visits with recommended instructions/workflows on how patients can proceed to close their gaps in care. Appropriate gaps in care are addressed and documented. All specialties engage in POE activity by using a Proactive Care Checklist at the point of care designed to be acted upon by staff in any specialty/department. Lab orders for screening and monitoring specific conditions have already been signed by the patient's primary care physician through a Bulk Order program. This allows the specialty staff to inform members that labs are due, without having to take the extra responsibility of following up on abnormal labs, as those results will be directed back to the primary care physician. The Proactive Office Encounter has been nationally recognized by groups like the Institute for Healthcare Improvement (IHI), Alliance of Community Health Plans (ACHP), National Business Coalition on Health (NBCH), and others.

Proactive Panel Management utilizes tools and a team of population support coordinators/LVNs and RNs to manage Primary Care physician panels, particularly intervening on those individuals who fall into specific chronic condition populations. The panel management team identifies individuals with both clinical and non-clinical gaps in care. The non-clinical care gaps like labs or preventive screenings are handled by lower-level staff, while the more clinical needs are acted on by RNs who prepare patient charts to review with the primary care provider and act on any recommended treatment, such as medication titration, by following specific protocols.

Online Personal Action Plan (oPAP). The online Personal Action Plan (oPAP) changes the way patients interact and take control of their health – truly becoming part of their own care team. Initially released in November 2012, the online Personal Action Plan uses the patient's EMR, in conjunction with data from the Proactive Office Encounter (POE) platform and other external sources, to create a fully personalized view of each patient's key gaps in care. It allows patients to quickly review and take the appropriate actions to close care gaps, as well as giving health education and other information relative to their health using articles or videos. oPAP has been developed to allow access to all KP Southern California patients initially via a web version and then expanded in 2014 to allow availability in KPHC at the point of care. This functionality at the point of care can be used by frontline staff to engage the patient at the time of their visit summarizing their open care gaps. Because it is patient facing, English or Spanish language is available to the patient and what they can personally do to improve their health. If a health education class or follow-up appointment is needed, oPAP will provide contact information specific to that patient's service area.

Bulk Order Program. The Complete Care Auto-orders Program is designed to ensure that active lab, screening, or other orders are available in KPHC when a patient is due with minimal provider intervention. Sophisticated algorithms identify patients for specific "Complete Care"

programs and then program orders are loaded into the primary care physician's Cosign – Clinic Orders folder of the KPHC In Basket. Signing the order enrolls the patient into the Complete Care Program for a 5-year period. Following program enrollment approval, lab, cancer screening, and other orders are loaded into KPHC per SCPMG Clinical Practice Guidelines, where the order remains active for 185 days. Patients are notified through our Regional Outreach program of active orders by letter followed up with phone calls. Expired orders are automatically replaced to eliminate further provider intervention. Test results are directed to the primary care physicians' In Baskets to facilitate the appropriate intervention.

Regional Outreach and Patient Engagement team is an infrastructure for efficiently coordinated, centralized, actionable, and standardized online and outbound mass communications to members, aimed to improve clinical quality and outcomes. The team ensures that strategic initiatives are thoroughly documented within each patient's HealthConnect chart, optimizing resource utilization, and promoting consistent message delivery. Outreach modalities include letters, digital notifications through kp.org, automated telephone outreach, and text messages, all designed to provide members with actionable steps for proactive health management and enhanced member engagement. The team is responsible for developing and maintaining outreach initiatives that support the core functions of Comple Care, including:

- Clinical Information, Systems, and Decision Support
- Health Education and Wellness
- Practice Guidelines and Continuing Medical Education
- Prevention and Lifestyle Change
- Medication Management

Case/Care Management. Licensed Case/Care Managers work within their scope of practice or work under protocol. Individuals with care gaps across a wide range of programs or initiatives are targeted for intervention and may be involved in programs over short term or ongoing time periods. They may receive in-person, remote interventions, or both.

Indirect Member Interventions. KPSC conducts multiple activities within the Complete Care Program that are not considered direct patient interventions but have a significant impact on supporting patient care.

- Integrated electronic medical record system allows documentation and review by all practitioners and facilities.
- Complete care program inclusion information is available at the point of care in the electronic medical record.
- Decision support tools are available at the point of care.
- Data and information sharing with practitioners and physician leadership through unblinded successful opportunity reports and clinical strategic goals.
- Patient safety initiatives in primary, specialty, and behavioral care and ancillary departments.
- Collaboration with KP facilities to improve patient safety.

Medication Management. Physicians, pharmacists, registered nurses, and advanced practice providers give medication therapy, education, and drug information to patients. They utilize

evidence-based guidelines, standardized practices, and tools to optimize pharmacologic efficacy and improve clinical outcomes. Clinicians are trained to identify barriers and offer solutions to help patients use medications correctly. In addition, patients overdue for refills for certain medications, or those with low adherence to certain medications, receive telephone outreach via recorded message, local Complete Care staff, email notifications, online Personal Action Plan prompts within our patient portal on kp.org, and/or from a pharmacist.

SureNet is a small, centralized clinical team leveraging the Complete Care philosophy of establishing reliable care processes to ensure region-wide consistency, measurability, accuracy, and complementary support to ongoing frontline care. SureNet staff help educate patients on the benefits of medication adherence, as well as the importance of specific screening procedures/labs. This work has significantly helped improve patient outcomes, treatment monitoring and protect clinician's practicing in an environment with ever increasing clinical information. The program focuses on categories of outpatient safety risk: Diagnosis Detection and follow up, Care Coordination and Medication Safety.

Complex Case Management

Kaiser Permanente offers several case management programs for the coordination of health care and for continuity of care across the continuum. These programs promote high-quality, cost-effective care and services for members through the proactive provision of care coordination, targeted education and resource management. Licensed Case/Care Managers work within their scope of practice or work under protocol. Individuals with care gaps across a wide range of programs or initiatives are targeted for intervention and may be involved in programs over short term or ongoing time periods. Members who meet pre-established criteria may be automatically enrolled into the case management programs. Referrals to the case management programs may be made by a member of the healthcare team to include, physician, nurse, case/care manager, social worker, and by the member's caregiver or by the member him/herself. Members may receive in-person, remote interventions, or both. Annually an assessment is conducted to determine the impact of targeted activities and interventions to address members' needs.

Complex Case Management programs have been established for patients with poorly controlled and/or complex conditions. The goal is to optimize member wellness, improve clinical outcomes and promote self-efficacy and appropriate resource management across the care continuum, through efficient care coordination, education, referrals to health care resources, and advocacy.

The following Complex Case Management programs are offered:

End Stage Renal Disease Care Management Program manages the complex needs of the member with Chronic Kidney Disease (CKD) and End Stage Renal Disease (ESRD). The program seeks to maximize health potential while assuring appropriate utilization of resources.

Southern California Transplant HUB provides case management and care coordination to members who are being considered for solid organ or stem cell transplantation. The program focuses on coordination of care between Kaiser Permanente and contracted Centers of Excellence (COE) as the member progresses through the transplant care continuum.

Patient Centered Medical Home (PCMH) model focuses on providing personalized, comprehensive and evidence-based medical care using a physician-led team of professionals. PCMH promotes cohesive coordinated care by integrating the diverse, collaborative services a member may need. This integrative approach allows primary care providers to work with their patients in making healthcare decisions based on the fullest understanding of information in the context of a patient's values and preferences. As part of the PCMH model, providers are informed about the Complete Care Program and its offerings, including disease management and complex case management services and other services to support member needs.

Population Health Management (PHM)

(Attachment IV: Population Health Management Strategic Program Summary)

The purpose of the PHM program description is to describe the framework for Population Health Management (PHM) programs and activities developed and implemented across the entire Southern California membership through collaboration with quality leaders in Kaiser Foundation Health Plan (KFHP), the Southern California Permanente Medical Group (SCPMG), and affiliated community providers.

KP Southern California (KPSC) uses Complete Care as an overarching philosophy that supports a culture of how we deliver care to our members. Complete Care Support Programs is a proactive team-based model for PHM that uses an evidence-based, person-focused approach to provide care and concentrate on an individual's health care needs, from wellness and prevention to acute, chronic, and end-of-life care. It is interwoven throughout the care continuum and crosses into urgent and emergent care, as well as ambulatory, inpatient, and continuing care. This approach works best for our members because this integrated care delivery system allows every patient encounter as an opportunity to provide necessary preventive, risk-related, and chronic disease care.

PHM Program Goals and Objectives

The overarching goals of the PHM program are:

- To use an evidence-based, population approach to provide care for members across the spectrum of health: healthy, healthy with a specific health issue, chronically ill, and end of life.
- To use a person, rather than disease-centric, focus on the individual's health profile. Complete Care Management criteria include members with physical or developmental disabilities, multiple chronic conditions, severe injuries, members who will benefit from intensive post-discharge care who are identified using a validated predictive model which evaluates length of stay, acuity of admission, pre-existing co-morbidities, and multiple emergency department visits.
- To optimize member wellness through education and preventative care at all stages of life.
- To improve clinical outcomes by utilizing a care team, patient-centric approach to meet individual health goals and needs.
- To promote self-efficacy and appropriate resource management across the care continuum, through efficient care coordination, education, referrals to health care resources, and advocacy.

- To care without delay through timely appropriate follow-up and care transition.
- To reduce health care disparities and improve outcomes.

KFHP Care Coordination and Case Management

Medi-Cal and State Programs provide regulatory guidance to various stakeholders involved with our Medi-Cal managed care members. In collaboration with the Care Coordination and Case Management department and other key stakeholders, the Medi-Cal and State Programs department ensures that as new regulations are released, they are communicated and implemented.

Below are state and/or national programs implemented by the SCAL Regional Care Coordination and Case Management department:

Population Health Management is designed to ensure that all members have access to a comprehensive set of services based on their needs and preferences across the continuum of care, which leads to longer, healthier, and happier lives, improved outcomes, and health equity. The Regional Care Coordination and Case Management department provides outreach and care management to members who are referred to care management as well as members required to receive an assessment, including high risk SPD, ECM, CSHCN, LTSS, CCM. It also facilitates provision of Community Supports.

- **Seniors and Persons with Disabilities Program (SPD)** offers care management to our Medi-Cal members with complex healthcare needs due to multiple chronic conditions or with underlying psychosocial factors effecting frequent encounters with the health care delivery system.

- **Children with Special Health Care Needs (CSHCN)** care management provides care management outreach and ongoing care management as needed to children who are at an increased risk for a chronic physical, behavioral, developmental, or emotional condition, and who require health or related services of a type of amount beyond that generally required by children.

- **Long Term Services and Supports (LTSS)** are provided to members who require home and community-based services, including those utilizing HCBS waivers, CBAS, and other supports designed to help individuals remain in their homes. Care management at the appropriate level will be delivered to address these needs.

- **Enhanced Care Management (ECM)** is a benefit with a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Members with the most complex medical and social needs through systematic coordination of services & comprehensive care management that is community based, interdisciplinary, high touch and person centered. Replaces the Health Homes Program and Whole Person Care Pilots. Community based care management for ECM is conducted by KP's Network Lead Entities (NLE).

- **Complex Care Management (CCM)** coordinates services for the highest risk members with complex conditions and helps them access needed resources. Complex Care management provides ongoing support for members with complex medical and psychosocial needs, including those with complex social determinants of health.

- **Transitional Care Services** provides an added layer of support as a member transitions from one care setting to another setting. Core components of this work include establishing daily notifications of admissions, transfers and discharges to this new team and identifying high risk vs low risk members. For both member groups, the team ensures completion of the post-discharge follow up visit and ensures members are assessed for Enhanced Care Management, Complex Case Management and Community Supports. High risk members receive additional services such as post-discharge calls with active monitoring and intervention as needed to ensure completion of all necessary post-discharge services.

- **Community Supports** are services intended to substitute for and potentially decrease utilization of a range of covered Medi-Cal benefits such as hospital care, nursing facility care, and emergency department use. Community Supports services have specific eligibility criteria provided by the Department of Health Care Services.

Whole Child Model (WCM) applies to KFHP managed care members under 21 years of age, eligible for CCS and with Medi-Cal in Orange County. The purpose of WCM is to incorporate CCS covered services into Medi-Cal managed care for CCS-eligible members. KFHP assumes responsibility for authorization of CCS eligible medical services, consistent with CCS Program standards. KP also provides care coordination and case management to Whole Child Model members and ensures the provision of care of the whole member.

Dual Complete, *also known as Dual Special Needs Plan* (D-SNP) is a Medicare Advantage Plan that enrolls beneficiaries who are dually eligible for Medicare and full benefits under Medi-Cal. As a Dual Complete member, KFHP offers enhanced benefits that support the needs of these complex, high risk and vulnerable members. The goal for these members is to improve access to care and better health outcomes by reducing hospitalizations, nursing home placements, and assists with keeping the member in the least restrictive setting.

- **Enhanced Care Management Like Services (ECM-LS)** is a benefit with a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of D-SNP members with the most complex medical and social needs through systematic coordination of services & comprehensive care management that is community based, interdisciplinary, high touch and person centered.

- **Chronic Care Improvement Project (CCIP)** The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) requires Medicare Advantage Organizations (MAOs), as part of their quality improvement efforts, to implement a CCIP and QIP. The Centers for Medicare and Medicaid Services (CMS) requires MAOs to have an ongoing quality improvement program and conduct quality improvement projects that have a favorable effect on health outcomes and member satisfaction. These projects

focus on clinical and non-clinical areas and involve performance measurement, interventions, and follow-up on the effect of the interventions.

Medi-Cal Quality Improvement and Health Equity Transformation Program (QIHETP)[1]

KFHP is committed to the delivery of quality and equitable health care services and ensures that quality and health equity activities are aligned with the Department of Health Care Services (DHCS) Comprehensive Quality Strategy. KFHP maintains responsibility for the quality and health equity of all Medi-Cal covered services, even if those services are delegated to a Network Provider, Subcontractor, or Downstream Subcontractor.

The KFHP Board of Directors is responsible for overall approval of the Medi-Cal QIHETP and annual plan, which are embedded in the Quality Program Description, annual work plan, and annual evaluation (Trilogy documents). The Board shall direct any necessary modifications to QIHETP policies and procedures to ensure compliance with the quality improvement and health equity standards in KFHP's contract with DHCS, and the DHCS Comprehensive Quality Strategy.

KFHP monitors, evaluates, and takes timely action to address necessary improvements in the quality of care provided to Medi-Cal members, and takes appropriate action to improve upon health equity. Throughout the process, KFHP engages with both Network Providers and Medi-Cal members in the design, planning, and implementation of continuous quality improvement (CQI) activities, or other issues identified by either KFHP or DHCS.

KFHP ensures that Network Providers, Fully Delegated Subcontractors, and Downstream Fully Delegated Subcontractors participate in the Medi-Cal QIHETP. These entities receive regular updates on the activities, findings, and recommendations of QIHETP.

- Network Providers, Delegated Subcontractors, and Downstream Fully Delegated Subcontractors shall also participate in the KFHP Population Needs Assessment (PNA) including sharing data and results as appropriate to be incorporated in the development of the PNA.

KFHP Southern California identifies the Medi-Cal Quality Improvement and Health Equity Committee (QIHEC) as a subcommittee of the Southern California Quality Committee (SCQC). QIHEC's responsibilities include analyzing and evaluating the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of the Community Advisory Committee (CAC), which meet the minimum requirements for the annual DHCS submission (Please see Attachment I: QIHEC charter).

Member Care Experience - Member Satisfaction

KFHP Southern California engages in a variety of performance improvement interventions and strategies aimed at promoting the availability and accessibility of health care services and increasing satisfaction of its members. Strategic service priorities are set based on identified

[1] The entirety of this 2024 Quality Program Description document serves as the Quality Improvement and Health Equity Transformation Program (QIHETP) Description for the Medi-Cal line of business. This section is meant to describe additional services provided for the Medi-Cal line of business.

areas of opportunity to address the service needs of members. Comprehensive strategies and measurements are assessed at least annually to assure the effectiveness of strategic goals and imperatives relating to improving member satisfaction. The five key imperatives set by leadership are to 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 %ile)
3. Getting needed care (close the gap to the Health Plan CAHPS Pacific 75th %ile)
4. Overall rating of specialist (maintain Health Plan CAHPS Pacific 75th %ile)
5. Helpful, courteous office staff composite (close the gap to the PAS California 90th %ile)

Availability of Practitioners

KFHP, in partnership with SCPMG, has defined which practitioners are included in the definitions of primary care and specialty care practitioners, including high volume and high impact practitioners. High volume specialty care departments are reviewed each year and are determined by the number of visits to the specialty. The four departments with the highest volume, plus OB/GYN are included in the availability standards monitoring and analyses. Oncology is defined as high impact specialty care. This determination was made by assessing the high morbidity and mortality rates, as well as the significant resources required for treatment within this specialty. KFHP, in partnership with SCPMG, has also defined which practitioners are included in the definitions of high-volume behavioral health care practitioners.

Annually, the availability of practitioners for primary care, high volume specialty care and high impact specialty care are analyzed and reported to the Regional Access Committee. The availability of practitioners for behavioral health care is analyzed and reported to the Regional Behavioral Health Quality Oversight Committee. Geographic availability of practitioners is analyzed at the regional and medical center levels. The geographic analysis provides details such as the percentage of members who are within the required time and distance standards of their PCP's office. Annually, provider/enrollee ratios for primary care and high-volume specialty care are analyzed and reported to the Regional Access Committee. Provider/enrollee ratios for behavioral health care are analyzed annually and reported to the Regional Behavioral Health Quality Oversight Committee. Provider/enrollee ratios are analyzed at the regional level.

The practitioner network is assessed to ensure it has the types and number of practitioners necessary to meet the cultural, ethnic, racial, and linguistic needs of its members within defined geographical areas and the availability of practitioners is adjusted to meet those needs.

Accessibility

KFHP, working with SCPMG, has established access and availability standards as required by State or Federal statutes and/or regulations. Standards are reviewed and approved at least annually by the Regional Access Committee and reported directly to SCQC.

KFHP assures the adequacy and accessibility of the Kaiser Permanente Southern California network by establishing and monitoring performance of appointment access standards for primary care, specialty care, behavioral health care, and ancillary services.

The Regional Access Committee serves as the Health Plan oversight body to ensure members are being seen in a timely manner. The Regional Access Committee assures systematic monitoring of access to care and services, reviews access performance, ensures improvement opportunities are addressed through corrective action plans and communicates access concerns and corrective actions to KFHP and SCPMG leadership as necessary. (For more information, see Attachment K: Regional Access Committee Charter)

Member Input into Quality

Members are encouraged to take an active role in managing their health. KFHP Southern California promotes member input into its Quality Program regarding the members' care experience. Depending on the specific program, project or topic, this input may be accomplished through member focus groups, member surveys, or Regional Patient Advisory Council. A document summarizing the quality program is available to members upon request. Members are notified via the Member Guidebook of the availability of this summary.

Members may request and receive the "Quality Program at Kaiser Permanente" document by calling the Member Service Call Center to request a hardcopy.

Member Experience Surveys

Measuring how well KFHP meets or exceeds members' expectations is a critical activity for quality assessment and improvement, and to evaluate changes in care delivery and service. Member Satisfaction is measured through a variety of sources.

- CAHPS
- Complaint and appeal data
- Internal CAHPS Off-Cycle Monitor Survey
- Behavioral Health Member Experience Survey

A comprehensive analysis of this data is conducted quarterly, semi-annually, and/or annually at Medical center and/or regional levels with opportunities for improvement as identified.

Consumer Assessment of Healthcare Providers Systems (CAHPS)

The CAHPS program is a group of standardized surveys that ask health care consumers to report on and evaluate their care experience. While CAHPS surveys are a means to provide usable information about quality of care for the consumers, it is a quality improvement tool for health care organizations. KFHP uses CAHPS standardized data and benchmarks to identify relative strengths and weaknesses in performance, determine where improvement is needed, and track progress over time.

Oversight of Member Complaint, Grievance, Appeals

Kaiser routinely collects valid data on member complaints and appeals for all services in all care settings (including behavioral health) for all product lines (including Marketplace)

- Quality of care
- Access
- Attitude and service

- Billing and financial issues
- Quality of practitioner office sites

On an ongoing basis, via the regional initiatives or actions taken on at a medical center level (hospitals, ambulatory, and home settings), the organization identifies opportunities for improvement and implements appropriate actions and interventions.

To assess member experiences with out-of-network services, the organization performs an annual analysis of member complaints, grievances, and appeals in the same five categories of concern listed above. Data on requests for out-of-network services are also compiled, analyzed, and acted upon as appropriate.

Member Rights and Responsibilities

Members are informed about access to services and benefits through their Evidence of Coverage (EOC). The EOC is made available at the time of enrollment. Members may request copies, upon request, through the Member Services Call Center (MSCC), through the local Member Services (LMS) typically located on the KP Medical Center campuses, or through the member's employer group. Also, members receive an EOC annually, as KFHP membership contracts are renewed. Marketing materials to members are evaluated through satisfaction surveys.

Member Rights and Responsibilities (MRR) are distributed to members upon enrollment as part of their New Member Packet and annually in the Member Guidebook. Members may also access the MRR's on kp.org, or request a copy of the MRR, at any time, by contacting the MSCC or LMS. The Member Guidebook describes the organization's commitment to Member Rights and Responsibilities. Members may make recommendations regarding the MRR policies. In addition, members receive information regarding KFHP's Notice of Privacy Practices (NPP). The NPP fully comply with state and federal law requirements.

Health Education Programs

The Center for Healthy Living (CHL) provides evidence-based and clinically effective health education programs. CHL offers easy-to-understand health information in a variety of convenient ways across Southern California and partners with members to make healthier choices easier by utilizing a variety of tools that respect members' needs, readiness, and learning preferences. Programs are provided in-person, virtually, via telephone, text/SMS (short message service), and online. As health behavior change experts, CHL encourages small steps to change by helping members choose their own, achievable goals and supports healthy living at every stage along the wellness to illness continuum.

Areas of Expertise:

The Regional Center for Healthy Living, in partnership with 13 local CHL departments in the Southern California Region, leads the integration, consultation, communication, and coordination of high-quality, consistent, cost-effective healthy living programs, products, and services that advocate for total health, motivate health behavior change, and facilitate self-care. CHL expertise lies in the following areas:

- Healthy Living Programs and Resources – Provide members with workshops, programs and services, and support members in their efforts to sustain behavior change for the long-term. Develop action-oriented communications about key health topics and resources for members, leaders, physicians, employees, and purchasers.
- Member Education Materials – Develop, produce, translate, promote, and distribute clinically accurate, high quality and easy-to-understand educational materials in print and digital formats that meet regulatory and health literacy standards. Materials are delivered in workshops, emailed via kp.org, and provided through telephone coaching/consults/provider visits.
- Health Information and Education Programs – Develop, deliver, and promote Wellness Coaching by Phone, online health education videos, text/SMS programs, synchronous and asynchronous group workshops, Health Encyclopedia, and other digital educational tools and resources via kp.org, including the Center for Healthy Living website https://kp.org/centerforhealthyliving.
- Consulting and Evaluation – Provide needs assessment, analysis, systematic review, environmental scanning, qualitative/quantitative clinical evaluation, human-centered design, motivational interviewing, product development support, curriculum and health education material review/production, translation into other languages and alternative formats, and identify potential digital solution vendors to develop, implement, and measure lifestyle behavior change/self-management programs and products that are aligned with KP's clinical strategic goals and national initiatives.

Southern California Regional Products:

- Standardized virtual and in-person health education workshops and promotional material
- Standardized regional participant manuals for core class curricula
- Online health education videos
- Text message patient support programs
- Wellness Coaching by Phone
- Worksite wellness consultation and health education workshops delivered in-person and virtually
- Online education about conditions and diseases via health encyclopedia https://healthy.kaiserpermanente.org/health-wellness/health-encyclopedia
- Online education to support healthy living via health guides, videos/podcasts and tools, and tools and calculators https://healthy.kaiserpermanente.org/health-wellness
- Online information about available health education programs https://thrive.kaiserpermanente.org/care-near-you/southern-california/center-for-healthy-living/
- Online health education resources https://thrive.kaiserpermanente.org/care-near-you/southern-california/center-for-healthy-living/bookshelf/
- Center for Healthy Living Website https://centerforhealthyliving-southern-california.kaiserpermanente.org/
- Center for Health Living Healthy Balance Website https://kp.org/healthybalance/

- Center for Healthy Living Options: Metabolic and Bariatric Surgery and Support https://kp.org/optionsprogram/

Member Education Materials

All publications available for members are listed by category and can be found on Kaiser Permanente's public-facing Clinical Library website or for order by local CHL departments via the platform SmartWorks. Publications are available in Spanish as well as English, and many are available in other languages, including Arabic, Armenian, Chinese, Russian, Vietnamese, Korean, Cambodian/Khmer, Farsi, and Tagalog.

How to Use Clinical Library

Print materials provided by Kaiser Permanente are available for order, viewed and printed on the Center for Healthy Living website or can be printed directly from Clinical Library. Third-party items are described and listed with ordering information. If members have any questions regarding member health education materials, they can contact their local Center for Healthy Living, Publications Review Committee (PRC) Member, or Regional CHL Project Manager leading the delivery of health education materials.

Publications Review Committee (PRC) Member

In cases in which guidelines are non-controversial and straightforward, generic member education pieces from national agencies or health education companies may be used (e.g., educational pamphlets may be ordered from the National Institutes of Health or National Cancer Institute). In certain cases, such as when guidelines address sensitive or complicated issues (e.g., mammography screening for breast cancer), member education tools are developed specifically to accompany the KPSC Clinical Practice Guidelines. The physicians involved in guideline development, work with member health education specialists to develop these tools for members. All member education tools are reviewed by CHL's Quality Unit and the Publications Review Committee to ensure consistency with existing KPSC guidelines prior to purchase or distribution. Member education materials that are created specifically for the guideline are reviewed and revised, as necessary, in accordance with changes in guideline recommendations.

Continuity and Coordination of Care

KFHP requires measurement and analysis of metrics related to coordination of care activities. Care is measured between primary and specialty care practitioners/services, primary care and behavioral health practitioners/services, and primary care practitioners and provider services. Coordination of care metrics are measured and analyzed at least annually. Action plans are developed when needed to improve continuity and coordination of care across the delivery system. Some of the monitoring methodologies include medical record audits, practitioner satisfaction surveys, clinical studies, and review of medication.

Continuity of Care for Medi-Cal Managed Care Enrollees

Eligibility for Continuity of Care (also known as Completion of Covered Services) is determined in accordance with California Department of Health Care Services (DHCS) guidance and described in the Plan's Completion of Covered Services Policy and Procedure (P&P). New

Medi-Cal enrollees of KFHP undergoing active treatment may be eligible to continue to receive that care from their current provider even if the provider is not in the Plan's provider network, upon request and where certain requirements are met. In other circumstances, a health service that was previously only offered outside of Medi-Cal Managed Care must later be covered by Medi-Cal Managed Care Plans (MCP). Eligible enrollees are typically able to continue to receive the eligible treatment from their pre-existing, out-of-network provider for up to 12 months following enrollment with the Plan. Still, in other circumstances specific to the 2024 Medi-Cal MCP Transition, transitioning enrollees are eligible for additional Continuity of Care protections.

Continuity of Care/Notification for Members for when Practitioners Terminate

Pursuant to KFHP's Completion of Covered Services Policy and Procedure, which addresses regulatory compliance for the Commercial Medi-Cal, and Medicare lines of business, and its *Medi-Cal Network Provider Subcontractor Terminations and Changes in Availability or Location Covered Services* Policy and Procedure, KFHP provides timely written notification to members who are affected by the termination/departure of their regularly visited primary care or specialty care practitioner/practitioner group. KFHP complies with regulatory requirements to notify members at least 60 days (when possible) prior to a primary care practitioner's or practitioner group's termination/departure, and 30 days prior to a specialty care practitioner's termination/departure. KFHP also provides written notification to members when other changes to their provider's practice impacts their care, such as a change in practice location, or a change in their practice type. This process assists members in selecting a suitable alternative practitioner. Members who do not contact KFHP to select an alternative practitioner are assigned one and notified of the assignment by mail. Members who are undergoing active treatment for the following conditions may be able to continue access to the terminating practitioner/hospital, if available:

- An acute condition, for the duration of the condition.
- A serious chronic condition (including but not limited to congenital), for a period of time necessary to complete a course of treatment and provide for a safe transfer of the member, not to exceed 12 months from the contract amendment/termination date or the effective date of the new member's coverage.
- A pregnancy, for the duration of the pregnancy and through the immediate postpartum period.
- Pregnant members who have a mental health condition that occurs, or can impact the member, during pregnancy, during the postpartum period, or during interpregnancy, and that includes, but is not limited to, postpartum depression, not to exceed 12 months from the mental health diagnosis or from the end of pregnancy, whichever occurs later.
- A terminal illness, for the duration of the illness.
- Care of a child, between birth and 36 months, not to exceed 12 months from the contract termination date, or the effective date of the new member's coverage, or the child's 3rd birthday (whichever is earlier).
- Performance of a surgery or other procedure (including related post-operative services), authorized by the plan as part of a documented course of treatment, and recommended and documented to occur by a Qualified Current Member's terminated Plan Provider or Plan Provider whose terms of participation have been amended to eliminate previously

included services, or a Qualified New Member's Non-Plan Provider within 180 days of the contract amendment/termination date or the effective date of the Qualified New Member's coverage, respectively.
- When the member is receiving inpatient care at a hospital or is institutionalized at a licensed facility for the duration of the inpatient care.

KFHP also works with members to assist them with transitioning to other care if necessary, when KFHP benefits terminate.

Continuity of Care/Contracted Providers and Practitioners
To comply with applicable continuity of care and legal requirements, Health Plan notifies members of relevant contract terminations.

Continuity and Collaborative Care between Behavioral Health and Medical Services
Behavioral Health Care (BHC) providers share clinically relevant information, other than psychotherapy notes, with a patient's primary care provider via the KP HealthConnect electronic medical record. Initiatives designed to enhance the coordination and collaboration of care for clinically relevant populations exists across the region (e.g., major depression & chronic disease population care, substance use diagnosis and peri- and post-partum depression screening initiatives).

Both Psychiatry and Addiction Medicine Departments provide consultation liaison services for members in acute medical hospitals and have staff on-call for members presenting in the Emergency Departments on a 24/7 basis.

Additionally, all medical care outpatient providers (e.g., primary care) who may be treating co-morbid behavioral disorders along with medical disorders can obtain telephone consultations with BHC practitioners.

Within the integrated medical care practice, there are numerous examples of primary care and specialty medical care departments working with their physician colleagues in Psychiatry and Addiction Medicine. An example of an ongoing effort is the KPSC Depression Complete Care Program:

The Complete Care program uses a proactive, team-based, evidence-based approach to provide care for members across the care continuum of ambulatory, urgent, emergent, inpatient, and continuing care services. Prevention, wellness, acute care, and chronic condition management (Disease Management) are embedded in the care delivery system. This comprehensive care system affects the patient before, during, after, and between visits. Every encounter is an opportunity to provide the member with necessary preventive and chronic disease care management. The approach is person-focused in order to address each individual's complete health profile.

The comprehensive approach toward conditions such as asthma, cancer, cardiovascular disease, chronic pain, diabetes, depression and weight managements is not a separate carve out of incremental programs for select populations. And because we are an integrated care delivery

system, it is convenient for members to manage multiple conditions because all necessary services are likely to be in the same location.

Within the Addiction Medicine Department, we have **SUD Champions** (*Regional Group with representation from APC Physicians from each Medical Center and ADM Leaders, now adding Pediatricians*). The Substance use Diagnosis (SUD) Champion group consists of Adult Primary Care physicians from each Medical Center, as well as Addiction Medicine leaders. The SUD Regional group meets monthly in efforts to improve collaboration, develop awareness of services delivered, and increase competency and training around diagnosing an SUD, SUD treatment, Motivational Interviewing, and evidence-based medications/practices. SUD champions present this information periodically to APC physicians and leadership information about SUD and support local APC physicians through consultation.

- **The Cannabinoid Workgroup** is developing a Clinical Reference Guide for Primary Care physicians. The Clinical Reference Guide for Cannabinoid will be reviewed and discussed at scheduled Lunch and Learn meetings for Primary Care physicians. Online training as well as presentations have been developed in conjunction to the Clinical Reference guide.
- **Inter-regional efforts of the MHALO (Mental Health Addiction Leaders of Operations) group** incorporates work based on the research by members of the group that are heavily involved in looking at how substances are being addressed in the Primary Care setting. A sub-group of MHALO is focused on Screening, Brief Interventions and Treatment which aims to have adults and children screened for SUD at Primary Care and Pediatric settings. MHALO subgroup for addiction medicine also focuses on collaboration and anti-stigma work, aimed to reduce societal and systemic stigma, hoping to improve access to treatment by members in primary care, urgent care, and emergency room settings if they are unwilling to be referred to Addiction Medicine.

The Kaiser Care Management Institute (CMI) provides additional information and resources to supplement the KPSC PCM program.

Continuing Care Quality Program
(Attachment V: Home Health Program Description; Attachment VI: Hospice Program Description)

In adherence to strategic priorities, the Care at Home Service Line is tasked to provide strategic, operational, and tactical direction of all home health care delivery. The Care at Home service line develops workplans, implements strategic imperatives, conducts process improvement, and oversees clinical/operational performance.

The Care at Home service line sets market-wide priorities, organizes best practices/regional implementations, and collaborates with all partners on the physician, network agency or other departments to ensure adherence to the Home Health Quality Program Description. The daily operation of the Care at Home is vested in the Management Team who collectively and individually assume daily responsibility for Agency operations, staff performance and patient care outcomes.

Care at Home uses the concepts of system Quality Management (QM) practice model.

The scope of Quality Management includes the following areas:

- Standards and policy development
- Continuing education
- Professional credentialing, assessment for competency and ongoing performance appraisal
- Patient and family perception surveys and complaint monitoring
- Regular periodic concurrent and retrospective monitoring
- Utilization management
- Risk management, including incident tracking, safety and infection control monitoring, monitoring and evaluation for medication-related errors and adverse drug events
- Active problem identification
- Compliance with applicable laws, regulations, and accreditation body standards
- Outsourced agency (contract) services
- Publicly reported data monitoring of performance improvement and service quality

Organizational and clinical functions are designed, measured, assessed, and improved on an ongoing basis to meet professional, regulatory and accreditation standards.

Virtual Medical Center

(Attachment VII: Virtual Medical Center Program Description)

The Kaiser Permanente Southern California (KPSC) Regional Virtual Medical Center enables convenience and high-quality care for our patients and promotes wellness for our care teams. Virtual care is delivered quickly, efficiently, and effectively by physicians and clinicians, through members' preferred assisted or self-service channels. KPSC leverages care delivery professionals to direct patients to the right care, right time, right place, and right choices. The Virtual Medical Center provides seamless 24/7 access to appointment services, care delivery, and care coordination through telephone and digital channels.

The Clinical Operations Department is where physicians and clinical staff of the Virtual Medical Center come together to deliver a virtual care experience for Southern California Kaiser Permanente members. In addition to delivering virtual care, Clinical Operations also coordinate care experiences across Southern California medical centers. With over 8,000 partners, the department helps SCPMG Frontline Physicians with real-time medical advice, InBasket support, Home Health orders, new member clinical onboarding pre-visit encounter work, reconciliation of outside information activity (ROIA), and the management of ever evolving workstreams.

Medical Director of Medicare Advantage and Part D Pharmacy Plans

The Medical Director is responsible to:

- ensure clinical accuracy of coverage determinations involving "medical necessity", for Medicare members,

- provide oversight for Health Plan operations involving medical/utilization review for Medicare members,
- provide oversight for Health Plan's benefit, formulary and claims management activities affecting Medicare members, and
- provide oversight for Health Plan's quality assurance activities affecting Medicare members.

Permanente Medical Group medical directors active in these areas are accountable to the Medical Director of Medicare Advantage and Part D for this work.

Visiting Member Program

Kaiser Permanente strives to ensure that members experience KP's best everywhere and every time. Members who are away from their home region can seek care and services in any KP region, in what is referred to as "Visiting Member Benefits." An administrative services agreement has been filed in all regions to formalize offering reciprocal access to the internal provider networks of each regional health plan as a delegated benefit.

KFHP has credentialing, quality improvement and utilization management processes and policies, in compliance with regulatory and accreditation requirements, to protect members when they are seeking services outside of their home region. Collective Representatives from National and Regional Quality, Credentialing and Utilization Management Departments perform delegation oversight in all regions as it pertains to the Visiting Member Program.

7. KP HEALTHCONNECT, ELECTRONIC MEDIA, MEDICAL RECORDS AND PERFORMANCE DATA

Kaiser Permanente HealthConnect Program Overview

Kaiser Permanente HealthConnect® is a comprehensive health information system that integrates the electronic medical record (EMR) with appointments, registration and billing programs. This system links KP facilities and provides physicians secure electronic access to Member/patient information and enables the following:

- Access to KP HealthConnect is available 24/7.
- Any member's EMR can be viewed by more than one clinician at any point in time.
- Having the complete EMR available allows practitioners to have complete knowledge regarding co-morbidity, past visits and complaints, and recommendations the member has received from other clinicians.
- Test results are immediately available allowing clinicians to view the most complete information available and provide the best service possible.
- Clinicians have access to recommended best practices in real time. The latest clinical information and evidence-based research is available to provide point-of-care recommendations for a wide variety of clinical conditions.
- HealthConnect has helped to reduce medication errors stemming from difficulties reading hand- written prescriptions.

- Visual patient alerts assist clinicians when a member's record is brought up in HealthConnect (e.g. alerting clinicians to medication allergies).
- After visit summary (AVS) is available to print and give to each member at the end of each appointment. This visit review reinforces any verbal instructions given by the clinician.
- Members can be shown relevant parts of their record while visiting with a clinician and members can access their medical record by visiting kp.org.
- Use of HealthConnect enhances personalized care. Since all information about the member is available, even a clinician who has not yet seen the member can immediately know a member's history and preferences.

Electronic Media

Personal Health Records: All members may access the "My Health Manager" tool on kp.org. This tool is a personal health record (PHR) that is populated by real-time clinical information from KP HealthConnect.

Electronic Device Access: Members may use electronic devices to access their kp.org accounts via a variety of interfaces (e.g. smart phone applications, internet browsers). Electronic devices include computers, laptops, smart phones, and tablets. On these devices members have the ability to:

- View their lab results
- View diagnostic information
- Email their physicians and upload relevant documentation
- Order prescription refills
- Receive timed alerts and references for needed preventive health screenings and immunizations
- Receive appointment reminders
- View appointment details
- Manage upcoming appointments with one-click cancellations and calls to reschedule
- View locations, maps, and hours for the facilities.

Medical Records (MR)

KFHP requires that each KFH hospital, SCPMG physicians, and Contracted Providers maintain medical records (MR) in a manner that is current detailed and organized and which permits effective and confidential patient care and quality review. KFHP has implemented a method to improve medical record keeping and distributes policies and procedures to practice sites. Policies and Procedures include the following information:

- Confidentiality of MR
- MR documentation standards
- An organized MR keeping system and standards for the availability of MR
- Performance goals to assess the quality of MR keeping
- The MR Standards are compliant with regulatory requirements, including the Health Insurance Portability and Accountability Act (HIPAA).

Southern California Repositories of Performance Data

Kaiser Permanente Quality Measures

The Kaiser Permanente Quality Measures are used to report a comprehensive and integrated view of Kaiser Permanente Quality & Service performance to the QIHEC. The Kaiser Permanente Quality Measures are a repository of quality performance data over time. The Kaiser Permanente Quality Measures are used to better understand, track, and improve the performance of the entire healthcare system and they provide a view of a core set of whole-system measures in six related domains of quality. Those quality domains are:

- Clinical Effectiveness
- Patient Safety
- Risk Management
- Service
- Resource Stewardship
- Equitable Care

These domains are used to better understand and improve the overall performance of KFHP's care delivery system in the Southern California Region. The measures provide a coherent, top-level view of clinical performance for senior leadership and governance, as well as an integrated, cascading measurement system for quality improvement and benchmarking throughout the organization.

Clinical Analysis Department

The Clinical Analysis Department designs, conducts, and evaluates strategies for measuring and reporting clinical quality, and is responsible for the extraction and tabulation of selected clinical quality indicators for formal reporting to various quality oversight bodies including SCQC. Clinical Analysis produces and maintains databases reflecting performance on HEDIS-like Clinical Strategic Goals (CSG) and Joint Commission (TJC) measures and produces regular reports highlighting strengths and opportunities for improvement.

The Southern California HEDIS and CSG performance metrics are also available on the Clinical Strategic Goals (CSG) SharePoint site which contains reports on CSG measures and the Ambulatory Quality Composite Scores (see the "Current Monthly Reports" folder): https://sp-cloud.kp.org/sites/teams-sccaa/CSG/CSG%20Report%20Library/Forms/AllItems.aspx

Medical centers performance is reported on "Clinical Strategic Goal" indicators, which incorporate analysis of potential over- and under-utilization of services. Clinical Strategic Goal measures include HEDIS effectiveness of care measures, as well as other publicly reported measures. Reports display several data points for each measure, including (1) the percentage, or rate, performance for the medical center; (2) the change in performance from the end of the prior year; (3) the "Z-Score," which shows the comparative performance to benchmark levels, and which can be used to compare performance between medical centers; (4) the numerator, meaning how many patients are compliant for a particular measure; and (5) the denominator, meaning the total number of patients in the population for the particular measure. In addition, the report indicates the medical center's target for each metric. The target is influenced heavily by national benchmarks as reported annually by NCQA.

KP Insight

KP Insight provides a variety of reporting and analytical services to the communities that KP serves through our standard reporting platform which comprises of Dashboards, Standard Report Libraries and Self-service utilities. In addition, KP Insight also provides analytic products for key regional and program office strategic priorities.

- Quality Regulatory Reporting
- Business Line Reporting
- Performance Reporting
- Financial Regulatory Reporting
- Community Benefit Reporting

KAISER PERMANENTE®

Risk Management Patient Safety Program Description 2025

Southern California Health Plan Kaiser Permanente

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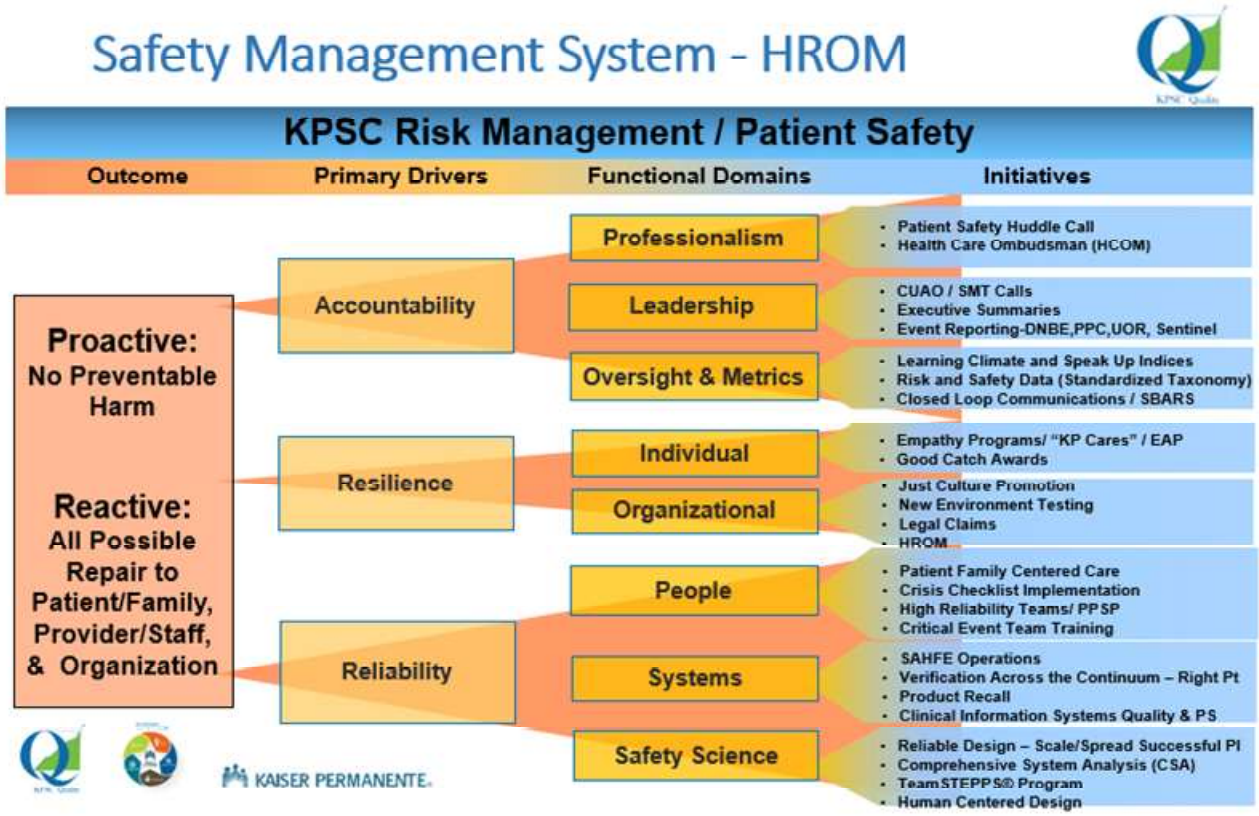
Kaiser Permanente Safety Strategy

Purpose: SCAL KP strategy is based upon safety that is systematic and uniformly applied across the entire organization and its processes. This Safety Management System focuses on **accountablity, reliability,** and **resilience** in order to eliminate preventable injuries produced by medical care. It is grounded in a Just Culture, which acknowledges that most preventable harm is multifactorial, involving both the system and muliple individuals. These patient safety principles also apply to employee safety, and an understanding that the patient care experience and viewpoint, is integral to assuring a safety focused system. Risk Management and Patient Safety evolve around proactive management; no preventable harm- and reactive management; all possible repair to patient/family, provider/staff, and organization.

2025 Risk Management Patient Safety Driver Diagram



Primary Drivers: Acountability, Resilience, and Reliability

I. **Accountability:** The obligation of an individual or organization to account for its activities, accept responsibility for them, and to disclose results in a transparent manner, demonstrable commitment to safety is achieved with tactics in the following three functional domains:

   I. **Professionalism:** A set of behaviors to which physicians, other clinicians, and employees adhere. Initiatives that support professionalism are:

      a. **Patient Safety Huddle Calls:** Biweekly regional inter-professional call to discuss serious patient safety events. Teams involved in the event discuss the issues, learnings and action plans resulting from the analysis. All care providers are encouraged to participate. The regional safety team will ensure that any specific information important to share broadly will be included in communication forums.
      b. **Health Care Ombudsman (HCOM):** The HCOM assists patients and providers with concerns about unanticipated adverse outcomes, medical errors, provider-patient communication breakdown, and dissatisfaction with treatment outcome or quality of care. The HCOM navigates the dynamics of patient-provider communication and the relational aspects of dispute resolution with sympathy and empathy. The four cornerstones of this unique role, is independence, neutrality/impartiality, confidentiality, and informality. The HCOM does not participate in any formal processes of event investigation, such as a Comprehensive Systematic Analysis.

   II. **Leadership:** Shapes the culture and determines what is considered good, valued and expected. Initiatives that support leadership are:

      a. **Communicating Unanticipated Adverse Outcomes (CUAO) / Situation Management Team (SMT) Calls:** The reactive side of risk management requires a team of experts to understand how to deal with presenting crisis in real time. As close to the event as possible, a core group with defined leadership expertise will convene to discuss unanticipated adverse patient care outcomes. The SMT will work out the details of how the disclosure to the patient and or family member(s) will take place and what immediate steps are needed to repair patient/family members, provider/staff, and organization.
      b. **Executive Summaries:** Certain risk issues unfold from event analysis that require each medical center executive leadership team to be accountable to implementing the action plans identified to prevent re-occurrence. The communication channel for these is through an Executive Summary. At the Southern California Quality Committee (SCQC), each medical

center will report out on their progress in completing the action plans laid out within the Executive Summary.

c. **Event Reporting; Do Not Bill Events (DNBE), Provider Preventable Conditions (PPC), Patient Safety Reporting Online (UORO):** Healthcare team members are encouraged to identify patient safety issues through the online patient safety event reporting system (UORO). This is a system where team members can report anonymously if they chose. Do Not Bill Events and Provider Preventable Conditions should also be reported through the UORO so that trending and appropriate understanding of events is known at both a local and regional level. This is a confidential system that is protected under the quality privilege. Reports from this system can identify trends to consider pro-active patient safety improvements.

III. **Oversight and Metrics:** Safety is everyone's responsibility. National, Regional, and Local facilities all have safety committees that discuss specific safety programs and display and discuss process, outcome and balancing metrics that are tracked to understand the ways in which we can reduce unnessary harm to patients and staff. Initiatives that support oversight and metrics include:

a. **Learning Climate and Speaking Up Indices from the People Pulse Annual Survey:** There is substantial evidence in safety science, that a healthcare team's attitudes related to comradarie and teamwork within their department, correlate with better clinical outcomes for the care they deliver. The People Pulse survey is administered annually and integrates questions that enable a better understanding of the culture of safety for a given department. Currently SCAL does not survey the physicians, so the whole team dimension is not well understood. Work continues to ensure the physician voice is included in the safety culture annual assessment.

b. **Risk and Patient Safety Data:** Monthly and/or quarterly metrics are tracked across all of our hospitals. Many patient safety metrics are tied to line of site goals and executive leadership goals at a national level and cascade to each hospital. Data in these reports included closed claims, UOR-O reports, patient safety near misses, infection prevention, medication safety, clinical technology, product and equipment recalls, patient harm, and reportable events.

c. **Closed Loop Communication / SBAR Templates:** Standardized communication templates to raise awareness related to a patient safety event or potential safety event that has broad applicability or high likelihood for repeated harm if not addressed. These communications reinforce the system fixes and call out TeamSTEPPS© tools and strategies that could mitigate harm in the future. These can include the accident causation model to help understand what latent safety threats were present, and what safety barriers can mitigate the event in the future. These are shared broadly

throughout the region, and depending on the event or subject, will be share inter-regionally.

2. **Resilience:** The ability of physicians, other clinicians and employees, and the organization, to function optimally, recover from setbacks, adapt well to change, and make improvements in the face of adverse events. Resilience has two functional domains that promote this driver:
    I. **Individual:** Fostering emotional, physical and mental harmony within our healthcare teams to support engagement from our workforce when providing care to our patients. Initiatives that support individual resilience include:
        a. **Emapathy Programs / "KP Cares" / Employee Assistance Program (EAP):** It is important to recognize and address the wellness of the Second Victim (healthcare team member(s) involved in the patient harm event) when a medical error occurs. Addressing the devastation that a team member may feel, in the aftermath of a patient harm event, is critical to the wellness of physicians, clinicians, and employees. A variety of programs are available to promote recovery and resilience to healthcare team members. Staff and physicians are encouraged to participate.
        b. **Good Catch Awards:** Awards that celebrate physicians and employees who trapped a patient safety harm event before it touched the patient are routinely given out at medical centers. Quarterly, the medical centers have the opportunity to nominate their local medical center Good Catch Awards for a Regional Good Catch Award. Rewarding proactive surveillance of patient safety will foster resilience and encourage team members to speak up for safety.

    II. **Organizational:** Hardwiring the organizational culture that values patient safety training, learning from harm events, and adopting transparent venues in which to share and learn and spread best practices. Initiatives that support organization resilience include:
        a. Just Culture Promotion: Individuals involved in a patient safety event are evaluated in an objective process to understand individual accountability. System issues are separated from individual culpability. A standard algorithm is used to categorize reckless actions, at risk actions, and system induced human errors. An important component of this algorithm involves a substitution test to discern if other healthcare team members would do the same thing, given the same circumstance. This allows understanding if department education is needed, rather than assuming the team member should have known the right procedure. Aside from this standard tool to guide event management, all members of the healthcare team, including the patients, are always

encouraged to speak up about any concerns they have. Leaders promote a speaking up culture during rounds, town halls, huddles, and department meetings.

b. New Environment Testing: Prior to opening a new unit, department, medical center, or medical office building – new workflows are considered for the new space. Simulations and/or walkthrough orientations are performed prior to go-live dates. New equipment that is brought into a facility is tested for safety, for training needs, and orientation related to any partner supplies needed prior to implementation of the new equipment.

c. **Legal Claims:** Risk Management works closely with Legal and the Medical Centers to assure that any harm that comes to our patients is followed up with quality reviews and/or department reviews.

d. **Operational Excellence:** Regional Presidents have defined the need to take best practices from individual medical centers, and assure they are broadly shared throughout all of Kaiser Permanente. A focus on a just and accountable culture and system thinking to promote reliability.

3. Reliability: The ability of the healthcare system to consistently perform its intended function or mission, in spite of complexity and risk, without diminished performance or failure. This primary driver has three functional domains that promote reliability:

I. **People:** Promoting teamwork and active communication amongst the healthcare team and amongst our patients and family will enable consistent performance across the organization. Initiatives that support people include:

a. **Patient and Family Centered Care / Patient Advisory Councils:** Integration of person centered care is at the forefront of everything we do. Patient Advisory Councils exist at each medical center and a regional council as well. The patient perspective continues to be sought out. Many committees have asked for member participation, and many medical centers are also using patients to co-design new buildings and services. Involving our patients in decision making will promote a safer healthcare system that is more nimble to patient needs.

b. **Crisis Checklist Implementation:** Managing emergency situations quickly and correctly are enhanced by tools that offer help in remembering all important components. Each Operating Room has a booklet of emergency checklists that can be followed to help manage an emergent event. These checklists are based on evidence – based criteria.

c. **High Reliability Teams (HRT):** Many high risk departments are working on standardizing safety practices, making it easy to do the right thing, and incorporating briefings / huddles into their daily workflows. Interprofessional teamwork and communication are the practices that are emphasized within

these teams. The Perinatal Patient Safety Program is the first example of a department that adopted the HRT program. They were the first area to rehearse emergencies then debrief the process.

d. **Critical Events Team Training (CETT):** Rehearsing emergencies with the complete healthcare team allows discovery of system issues that could get in the way of managing a crisis quickly, in a safe environment. Simulation scenarios are created and the healthcare team responds to the manikins as if it were a real patient in crisis. These CETTs allow the frontline teams to understand gaps in current practice and offer the opportunity to discuss how situations and processes could be improved in the future. It also allows safety experts to pull out exemplery examples of great teamwork and communication.

II. **Systems:** People need to be supported with excellent equipment, reliable tools and nimble technology that makes it easy to deliver safe care to the members we serve. Initiatives that support systems include:

a. **Simulation and Human Factors Education (SAHFE) Operations:** SAHFE Committees exist at each medical center to enhance safe patient care. A partnership between physician education, nursing education, and patient safety creates the forum to define what patient safety needs should be tackled through healthcare simulation programs. High and mid fidelity manikins, along with video capture technology, are resourced to help drive learning, deliberate practice, and targeted safety focused debriefs. These committees work at standardizing best practices, enhancing safety briefings, and assuring identified regional patient safety programs are implemented, observed, and coached to reliability.

b. **Verfication Across the Care Continuum – Right Patient:** Integral to, “Do no harm”, is assuring that we have a solid two person identifier verification process across out care continuum. Vigilence that we are performing the right medical care on the right patient is critical to safety. Implementation of armbands in our outpatient areas is currently underway. Utilizing bar code scanning techniques to help identify the right medications, right patients, and right specimens will go along way in enhancing verification safety.

c. **Product Recall:** As complexity, equipment and technology expands in our healthcare environments it is critical that a robust product recall process is managed. Recalls normally come through our national product recall department, which are then cascaded to all medical centers and clinical spaces that utilize the product/equipment. All products and equipment that cause patient harm are reported through the FDA (MAUDE) database, they will also be communicated through the med center, region, national product recall interface.

d. **Clinical Information System Quality and Patient Safety Committee:** The importance that the electronic medical record and all the technology programs that interact with it (lab, pharmacy, imaging, membership legacy systems, etc.) can not ever be overlooked. Constant vigilence and identification of clinical system technology glitches are continually under surveilience and escalated as needed.

III. **Safety Science:** To become a High Reliability Organization, a continual effort to proactively identify hazards, redesign clunky systems, and scale and spread successful evidence-based leading practices. Initiatives that support safety science include:

a. **Reliable Design – Scale and Spread Successful Performance Improvement Projects:** Current performance improvement methodology avails application of reliable design principles (standardization, simplicfication, and engineering controls) to prevent and trap errors; monitor results and re-design as needed to obtain desired out comes. Each year, more team members are trained in performance improvement. There are mentors, improvement specialists, and improvement advisors to help scale and spread best practices. These projects are driven by the healthcare teams at the frontline, as they understand the work and the problems that impede best.

b. **Comprehensive System Analysis (CSA):** When an unintended patient safety harm event needs to be analyzed, the CSA style of investigation analysis is implemented. Through cause and effect relationships, it is more clear to see where the contributing factors that led to the error surfaced. This helps inform action plans that are thorough and credible.

c. TeamSTEPPS© Program: All patient safety training is coached through the four domains of Leadership, Mutual Support, Situational Monitoring, and Communication. There are specific tools and strategies that can be used in any situation to help develop teamwork and communication across the healthcare organization. All levels of the organization should understand the concepts, tools and strategies of this program. Integration across executive leaders, directors, frontline managers, physicians, staff, and patients is the optimal state. Growing a learning culture through implementation of TeamSTEPPS© tools and strategies will continue to develop to promote a fair, just, and accountable culture.

d. Human Centered Design: Realizing that to design better systems and initiatives, a focus on understanding the customer at all design phases is integral to robust solutions. The importance of the voice of the customer in all phases of design will be explored and managed through human centered design constructs and ethnographic interviewing techniques.

KAISER PERMANENTE®

SOUTHERN CALIFORNIA

REGIONAL BEHAVIORAL HEALTH QUALITY PROGRAM DESCRIPTION

2025

KAISER PERMANENTE® SOUTHERN CALIFORNIA

Table of Contents

Behavioral Health Care Vision: *Kaiser Permanente is known as the national leader in providing a safe and effective behavioral health care experience that meets the needs of the patient and the community.*

The purpose of this Behavioral Health Care (BHC) Quality Program Description is to inform both internal and external audiences about how Kaiser Permanente Southern California (KPSC) is organized to support the Program's commitment to assessing and improving performance of our BHC Services on a continuous, systematic, and outcome-oriented basis. The Departments of Addiction Medicine and Psychiatry comprise Behavioral Health Care within KPSC. There is no separate BHC Quality program structure but rather these departments have oversight through the Southern California Quality Committee (SCQC) like all other specialty departments. The annual BHC Program description, work plans, and annual evaluations are components of the overall KPSC Quality Program oversight. This document is an addendum to the KPSC Quality and Utilization Management Program Descriptions.

1. KPSC BHC Quality Structure & Scope
Authority, Accountability, Responsibility

KPSC Behavioral Health Care services are part of our integrated medical care program at each medical center and at the regional level. As such, Psychiatry and/or Addiction Medicine practitioners participate in medical center and regional quality committees. All BH related quality issues are managed through our KPSC Quality structure at both the medical center and regional level.

Physicians and other appropriate licensed professionals who provide care to the plan's enrollees are an integral part of the quality improvement program. They adequately participate in the implementation and monitoring of clinical services rendered, resolve problems, and ensure that corrective actions are taken when opportunities are identified. An appropriate range of specialist providers are involved, as necessary.

Implementation of the QA program is supervised by a designated physician(s), or other licensed professional providers, as appropriate.

At the KPSC regional level, BHC Representatives are members of, or report to, the following committees and/or advisory groups:

- **Southern California Quality Committee (SCQC)** – A BHC physician (psychiatrist or addiction medicine specialist) and Health Plan Quality Leaders are members of SCQC. In that role, the BHC representative participates in SCQC meetings and provides expert input on quality issues that may have a behavioral health component. This person provides linkage between the Psychiatry and Addiction Medicine Chiefs groups and SCQC on quality issues.

- **Kaiser Permanente Southern California Behavioral Health Quality Oversight Committee (BHQOC)**
  PURPOSE: The Southern California Kaiser Permanente Behavioral Health Quality Oversight Committee (BHQOC), is a subcommittee of Southern California Quality Committee (SCQC). The BHQOC function is to ensure that Kaiser Foundation Health Plan (KFHP), Kaiser Foundation Hospital (KFH), and Southern California Permanente Medical Group (SCPMG) leaders have an established infrastructure for joint oversight of quality and regulatory performance within Behavioral Healthcare, including both mental health services provided by our Psychiatry departments and substance use services provided by our Addiction Medicine departments.

AUTHORITY AND SCOPE: The functions of BHQOC will include, but may not be limited to:

- Identifying, reviewing, and evaluating relevant quality, patient safety and other performance improvement measures and report results to SCQC.
- Review data and facilitate compliance with quality and regulatory standards.
- Identify regulatory gaps in Behavioral Health and determine necessary actions to improve care delivery process.

REPORTING STRUCTURE:

- The BHQOC is a subcommittee of the Southern California Quality Committee (SCQC) and reports to SCQC.
- Committee Sponsors: The Assistant Medical Director SCPMG Quality, Risk Management, Patient Safety and the KP Senior Vice President of Quality, Regulatory and Clinical Operations.

- **Kaiser Permanente Southern California Regional Access Committee –** Behavioral Health Care Regional Leaders participate in reviewing access performance data to identify and understand trends and opportunities at the regional, medical center and department levels. The Committee requests and oversees implementation of Corrective Action Plans (CAPs) to address gaps in access and monitors those CAPs through resolution to ensure the regulatory targets are met. In addition, the Committee provides oversight for the submission of Regional Rate of Compliance (ROC) data for the Annual Timely Access Report submitted to DMHC.

- **Regional Behavioral Health Department –** The Regional Behavioral Health Department is led by an SCPMG Regional Administrator. All staff members engage in the clinical quality oversight process and standardization of programming across the southern California region. Additionally, several consultants focus on the operational side of behavioral health.

  The Regional Behavioral Health team also includes the following:
    - Assistant Regional Medical Director – Behavioral Health Service Line Leader
    - Regional Chief of Psychiatry, MD
    - Regional Chief of Addiction Medicine, MD
    - Executive Leader, Behavioral Health
    - Regional Clinical Director
    - Regional Operations Director
    - Licensed Clinical Staff
    - Non-clinical staff

  Some (not all) of the responsibilities of the Regional Administrative Leader, Behavioral Health Service Line:

    - Works with Physicians-In-Charge to identify and establish programs and practices which are cost effective and provide quality service to members, staff, and physicians.
    - Assures compliance with administrative, legal, and regulatory requirements of the Health Plan Contract and government/ accrediting agencies.
    - May represent the organization in activities involving leaders in business, government, labor, the community at large, Health Plan Members and health care providers in the area.

As part of the service improvement process, the Regional BH Team is an active part of the regional oversight process involving access and member satisfaction. The Team facilitates improvement discussions at both the medical center, regional level, and program wide level.
This is evidenced through participation in the following groups or committees at either or both the Regional and local Medical Center level:

- Physician Chief of Service meetings
- Clinical Department Director Administrator meetings
- Kaiser Permanente Southern California Regional Access Committee
- Member Concerns Committee
- BH Quality Oversight Committee
- SCQC

The Regional BH Team participates in review of medical center access action plans as part of the regional access oversight process.

An annual BHC Program Description, annual BHC Work Plan, and annual BHC Work Plan Evaluation are completed each year and presented to appropriate regional quality committees.

As part of the quality process, the Regional BH Team and the BHQOC provide strategic direction to BHC quality initiatives, facilitates discussions at the medical centers on relevant issues and is part of the regional oversight process.

- **Psychiatry and Addiction Medicine Chiefs and Department Administrator Meetings.**
  - Joint meetings of the Psychiatry and Addiction Medicine Chiefs occur at least once per year.
  - Joint meetings of the Psychiatry Chiefs and their Department Managers and joint meetings of the Addiction Medicine Chiefs and their Department Managers occur at least twice per year.
  - Chief of Service and Department Manager meetings include discussions on operational issues that examine current care processes and identification of opportunities for standardization within KPSC. Topics include access, quality, member experience, feedback informed care, clinical outcomes, and utilization.

Goals & Objectives of the BHC Quality Program

Consistent with the overall KPSC Quality goals and objectives outlined in the KPSC Regional Quality Program Description, Behavioral Health Care quality goals are focused on integration/collaborative care, continuity of care, access, availability of practitioners, member experience, HEDIS measures and utilization. Annually, the BHC Work Plan outlines specific goals and objectives.

At the medical centers, each Psychiatry and Addiction Medicine department develop quality plans to address unique departmental goals as sponsored by the Chief and Department Administrator, medical center goals and major regional goals that are outlined in the Annual BHC Quality Workplan Evaluation.

Effectiveness of BHC Quality Program/Annual Evaluation

The KPSC quality program assesses its overall performance against the previous year's work plan through an annual BHC written evaluation completed by the Regional BH team in collaboration with the regional quality staff and other relevant medical group operational departments.

The annual BHC Work Plan Evaluation is reviewed by the BHQOC and/or QuEST and SCQC. The annual evaluations are approved by Senior Management and submitted to the KFH/HP Boards' QHIC for review and approval. The evaluation contains elements required by the KFHP/KFH Board and QHIC.

Medical center quality improvement program descriptions, work plans, and annual evaluations are reviewed annually. Revisions occur on an as needed basis. These documents are submitted to Regional Quality staff for review and assessment and are reviewed by SCQC. BHC specific issues are discussed with the Health Plan Executive Director KFH/KFHP Quality and Regulatory Services, the Regional Administrator for BHC Services and/or local medical center BHC quality representatives.

KPSC Behavioral Health Utilization Management

KPSC Behavioral Health departments are included as part of our KPSC UM Program. For more details, see the 2025 KPSC UM Program for Authority, Accountability and Responsibility.

2. BHC Other Committees/Work Groups/Teams

There are several additional quality and utilization management regional or local medical center committees, work groups or teams where BHC representatives are members or serve as an ad hoc expert consultant. The following are some examples:

- **Medical Center QI & UM Committees –** Medical Center QI & UM Committees are composed of Health Plan and Medical Group leadership.
    - All medical centers include an ad hoc BHC representative on their local QI and UM Committees. In that role, the behavioral health representative participates in meetings on an as needed basis and provides expert input on quality or utilization management issues that may have a behavioral health component. The representative provides linkage to the local Psychiatry and Addiction Medicine Departments.

- **Medical Center Pharmacy &Therapeutic Committees –** Through the physician Chief of Service in Psychiatry and/or Addiction Medicine in each Medical Center, expert opinion is provided on pharmaceutical issues.

- **Regional Credentials Committee (RCC)** – A Behavioral Health physician is a member of the committee, and the Regional Behavioral department serves as ad hoc expert consultant to the RCC. In that ad hoc role, a member of the regional Behavioral Health department attends RCC meetings on an as needed basis and provides expert input on credentialing and privileging issues that may have a behavioral health component.

3. Overview – Kaiser Permanente Southern California BHC Program

BHC Services & Continuum of Care

KPSC offers a comprehensive health care delivery system, including behavioral health (mental health and substance use treatment) services. BHC Services are in full compliance with all the DMHC Language Assistance Regulations.

Embodied within the KP Promise, the mission of Behavioral Health Care (BHC) is to provide a continuum of Behavioral Health Care services to our members and purchasers that is of high quality and that improves the health of our members as demonstrated through continuous monitoring and evaluation. Additionally, BHC services should be affordable, accessible, and integrated with general medical care.

Within Kaiser Permanente Southern California (KPSC), the specialty care departments of Psychiatry and Addiction Medicine provide a full range of inpatient and outpatient services including, but not limited to, the following levels of care:

- Acute Psychiatric Inpatient
- Inpatient Detoxification
- Residential
- Partial Hospital
- Day Treatment
- Intensive Outpatient
- Outpatient Service

Within these levels, individualized treatment plans based on medical necessity may include:

- Individual Therapy
- Group Therapy
- Medication evaluation/monitoring
- Case management
- External Referrals provided as appropriate

Medically necessary treatment of a mental health or substance use disorder means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all the following:

- In accordance with the generally accepted standards of mental health and substance use disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.

- Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB855#:~:text=(a)%20The%20California%20Mental%20Health,emotional%20disturbances%20of%20a%20child.

SB 855 was signed into law in September 2020 and requires commercial health plans in California, for contracts issued, amended, or renewed on or after January 1, 2021, to cover medically necessary treatment for specified mental health conditions and substance use disorders under the same terms and conditions applied to other medical conditions.

As such, SB 855 redefined the description for medically necessary mental health conditions and substance use disorders. Health plans must use the most recent criteria developed by a nonprofit professional association for the relevant clinical specialty when conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders.

At Kaiser Permanente, treating physicians and health care professionals determine whether a service or treatment is clinically necessary and appropriate. Care is determined by the treating clinician based on their judgement of clinical appropriateness and by using the following criteria and guidelines as part of their clinical decision-making process:

Clinical Specialty	***Nonprofit Professional Association Criteria/Guidelines***
Substance use disorders	ASAM (American Society of Addiction Medicine)
Adult Mental Health	LOCUS (Level of Care Utilization System), as developed by the AACP (American Association of Community Psychiatrists)
Child and adolescent mental health	CALOCUS-CASII (Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument) ECSII (Early Childhood Service Intensity Instrument), both developed by the AACAP (American Academy of Child and Adolescent Psychiatry)
Autism Spectrum Disorder	National Standards Project Guidelines, as developed by the National Autism Center
Transgender	World Professional Association for Transgender Health (WPATH) Standards of Care

KPSC is committed to patient centered care and "feedback informed care"

- In Addiction Medicine, adult patients complete an evidenced based clinical questionnaire called SATSS (Substance Abuse Treatment Support System) at intake and at every individual visit with a Physician or Therapist/Counselor during treatment. Initial patient severity scores are produced for a variety of clinical areas of focus.

  Initial patient severity scores include an overall behavioral health impairment, symptom severity (including the PHQ and GAD questions), overall functional impairment, social impairment, focused substance use areas of focus and therapeutic alliance. Changes in patient severity scores are monitored during treatment. As part of our suicide prevention program, the Columbia Suicide Severity Rating Scale (CSSR-S) questions are administered automatically based on response to the PHQ questions; providers develop safety plans based on CSSR-S severity scores. A Youth-SATSS clinical questionnaire was implemented in Q1 2020.

- In Psychiatry, adult patients complete an evidenced-based clinical questionnaire called TPI (Treatment Progress Indicator) at intake and at every individual visit with a Physician or Therapist during treatment. Initial patient severity scores include an overall behavioral health impairment, symptom severity (including the PHQ and GAD questions), overall functional impairment, social impairment, focused substance use screening and therapeutic alliance. Changes in patient severity scores are monitored during treatment. As part of our suicide prevention program, the Columbia Suicide Severity Rating Scale (CSSR-S) questions are administered automatically based on response to the PHQ questions; providers develop safety plans based on CSSR-S severity scores. Children/adolescent and/or parents complete a Youth TPI at intake and at every individual visit with a Physician or Therapist during treatment.

4. Behavioral Health Member Experience

KPSC implements mechanisms to assure member satisfaction and monitors experience within its services and identifies potential areas for improvement.

We obtain input from members and monitor our performance in several ways:

- Behavioral Health Regional Patient Advisory Council (BH-RPAC)

- Behavioral Health Member Experience Survey
- Monitoring complaints and grievances/appeals
- Monitoring telephone access

Behavioral Health - Regional Patient Advisory Council (BH-RPAC)

KPSC embraces the concept of Patient and Family Centered Care. As part of our quality improvement work, we recognize the importance of partnering with patients and/or their families who have received Behavioral Health care to gain their input on how we can best meet the mental health needs of our patients. KPSC has developed a BH-RPAC which includes members with direct experience with our mental health programs.

- Patient Advisors (KPSC members) are asked to provide input on Behavioral Health issues that affect patients throughout the Kaiser Permanente Southern California Region.
- Regional KPSC Behavioral Health leaders, project leads and members of committee's present ideas to obtain patient and family perspectives in the design and delivery of Behavioral Health care.
- Council meetings will occur regularly with dates and times to be determined by the Council.
- BH-RPAC goals include member's providing input on new or existing clinical and educational programs, forum to surface issues/concerns from the member perspective and advocacy for the inclusion of patients or family members on appropriate regional and local workgroups.

Behavioral Health Member Survey

KPSC administers an annual member experience survey which is designed to target patient experiences that are important to behavioral health care, such as patient engagement with their treatment plan, shared treatment decision making regarding types of therapy and prescription medication, access, telehealth, and others.

The survey is administered online to KPSC members across all geographic areas who have had least one visit in the Psychiatry department in the last 12 months. The goal is to have a minimum of 2500 responses.

- Patients complete questions that apply to the provider(s) they saw most often in the last 12 months, which can include a psychiatrist, therapist in the Psychiatry department, or any provider in the Addiction Medicine department.

- Survey items pertain to:
  - Experiences with front office staff
  - Provider communication
  - Treatment experiences
  - Access
  - Telehealth experience
  - Overall ratings of care

Behavioral Health Complaints and Grievances/Appeals

KPSC evaluates member complaints and grievances/appeals on a quarterly basis for each of the five categories:

- quality of care
- access
- attitude and service
- billing and financial issues
- quality of practitioner office sites

The organization works to improve member's experience with behavioral healthcare and services, annually by:

- Assessing data from complaints and appeals or from member experience surveys
- Identifying opportunities for improvement
- Implementing interventions
- Measuring effectiveness of interventions

Telephone Access

Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against the following behavioral health telephone access standards:

1. The quarterly average for screening and triage calls shows that telephones are answered by a non-recorded voice within 30 seconds
2. The quarterly average for screening and triage calls reflects a telephone abandonment rate within 5 percent.

After Hour Operations

After hour services are available via the KPSC Behavioral Health Care Help Line or through hospital emergency departments.

The KPSC BHC Help Line is available 24/7, 365 days per year and is staffed by licensed clinical staff.

- The Helpline is a crisis line that is answered live by a staff composed of Licensed Clinical Social Workers, Marriage Family Therapists. Each quarter the State of California receives a current listing of the Helpline staff and verification of their licensure.

- The staff responds to crisis calls and informational calls from members, as well as employee assistance professionals. The interventions of the clinician are guided by protocols.

- The philosophy of the Helpline is to facilitate linkage between our members and the local medical offices. Along with providing crisis intervention and information, the Help Line staff facilitate access to Kaiser Permanente medical offices and/or emergency departments.

- For patients that require or select access to services via our emergency departments or community emergency departments, the BHC Help Line staff may be consulted once the patient is medically stable.

- Through an agreement with LA County Mental Health, KPSC has a mobile Psychiatric Emergency Treatment team (PET Team) using licensed BH clinicians who are dispatched to KPSC Emergency Departments in LA County on an as needed basis for after hour consultations.

- Additionally, each Psychiatry and Addiction Medicine Department has staff on call 24/7, 365 to serve as consultants once a patient is medically stable. They may consult with clinical staff from the BHC Help Line, the KPSC PET team or directly with KPSC Emergency Departments. These local teams serve as a back-up should services of the BHC Help Line be interrupted for any reason.

5. Behavioral Health Accessibility of Services

The organization establishes mechanisms to assure the accessibility and maintains appropriate access to behavioral health services including standards for telephone access to behavioral health care.
The following definitions are encompassed in our KPSC Appointment Standards and Definitions that are reviewed, at least annually, by our Regional Access Department in collaboration with our Regional BH Team and are included in the Annual Quality Letter sent to all physicians, external contractors, and staff.

Based on valid methodology, KPSC monitors its access performance against established access targets monthly. A report is generated by the Regional Access department and is reviewed by the Regional Access Committee. The report is distributed to the local and regional Medical Group and Health Plan leaders. Actions are taken by the Local Medical Group and Health Plan leaders. The Local and Regional Access Committees monitor the actions.

Using valid methodology, the organization collects data and performs an analysis at both the regional and local medical center level for both the NCQA and DMHC standards for behavioral health access on at least a quarterly basis.

NCQA Standards

Care for a non-life-threatening emergency within 6 hours

Our standard for life threatening or non-life threatening emergent behavioral appointments is immediate. Patients are directed to 911 or an emergency department for either life threatening or non-life-threatening behavioral health emergency needs.
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.

Urgent care within 48 hours

- Urgent Behavioral Medicine - A behavioral health crisis that is not deemed to be emergent, but symptoms demonstrate impaired ability to function in normal roles at home, work and/or school.
- Our standard for urgent behavioral health appointments is 48 hours.

Routine Initial Office visit for either Physician or non-Physician practitioners within 10 business days

- Routine Initial – Physician, Therapist, or member-initiated appointment for initial assessment by specialist which is not deemed to be of an emergent nor urgent need.
- Our standard for routine behavioral health appointments is 10 business days.

Routine Follow-up Appointment

- In accordance with Senate Bill (SB) 221, Behavioral Health: Non-urgent follow-up appointments with a non-physician mental health care or substance use disorder provider must be offered within 10 business days of the member's prior appointment.
- Our standard for routine follow-up physician appointments is 10 business days from the date specified by the physician.

DMHC Standards

The California Department of Managed Health Care (DMHC) monitors access for all Health Plans. They utilize different performance standards for some of the access categories. Additionally, KPSC has agreed to measure and report "percent visits within standard" as the primary measurement tool based on DMHC published "appointment wait time" standards.

Urgent Care within 48 hours

- Urgent Behavioral Medicine - A behavioral health crisis that is not deemed to be emergent, but symptoms demonstrate impaired ability to function in normal roles at home, work and/or school.
- Our KPSC standard for urgent behavioral medicine appointments is 48 hours.
- KPSC has established a standard of 80% of patients that are booked to an urgent behavioral medicine visit type will be seen within 48 hours.

Physician Routine Initial (Consult)Access within 15 business days

- Routine Initial (Consult) - Physician or member-initiated appointment for initial assessment by specialist which is not deemed to be of an emergent nor urgent need.
- Our standard for Physician Consult appointments is 15 business days.
- KPSC has established a standard of 80% of patients that are booked to Physician Consult visit type will be seen in 15 business days or less.
- Access data is split for child/adolescent and adult members.

Non-Physician Routine Initial (Routine Behavioral Medicine) Access within 10 business days

- Routine Initial (Routine Behavioral Medicine)- Therapist or member-initiated appointment for initial assessment by specialist which is not deemed to be of an emergent nor urgent need.
- Our standard for Non-Physician Routine Behavioral Medicine appointments is 10 business days.
- KPSC has established a standard of 80% of patients that are booked to a Non-Physician Routine Behavioral Medicine (RBM) visit type will be seen in 10 business days or less.

Non-Physician Follow Up Access within 10 business days of prior appointment

- In accordance with Senate Bill (SB) 221, Behavioral Health: Non-urgent follow-up appointments with a non-physician mental health care or substance use disorder provider must be offered within 10 business days of the member's prior appointment.

6. Availability of Behavioral Health Practitioners

Behavioral Health Practitioners Definitions

Behavioral Health Practitioner definitions are reviewed annually and updated, as necessary. This review includes definitions of high-volume behavioral health practitioners, and common behavioral health practitioner types which are used for Geo Access and BH Practitioner Availability Analysis.

- Behavioral Health Practitioners are defined in KPSC as: Psychiatrists (MD/DO), Addiction Medicine physicians (MD/DO), Psychologists* (Ph.D./Psy.D.), Licensed Clinical Social Workers (LCSW), Licensed Marriage & Family Therapists (LMFT), Medical Social Workers (MSW),

Psychiatric Clinical Nurse Specialists (CNS), Psychiatric Nurse Practitioners (NP), Physician Assistants (PA) and substance abuse counselors.

*Note: Psychologists are used primarily for psychological testing which is done to support the determination or the severity of a diagnosis in conjunction with other BH Practitioners.

- A Behavioral Health practitioner is a licensed external or Southern California Permanente Medical Group clinician who sees 50 or more unique members per year based on claims or internal encounter data.
  We group the above Behavioral Health Practitioners 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 abuse counselors in Addiction Medicine

Behavioral Health Practitioner Availability Analysis

The organization ensures the availability of sufficient numbers and types of high-volume behavioral health practitioners (BHPs) for both core and affiliated networks.

A Behavioral Health practitioner analysis is completed at least annually and reported based on the five (5) common practitioner types as defined in the Behavioral Health Practitioner Definition section of this report. Analysis of practitioner ratios is an NCQA requirement for Behavioral Health.

- Minimum practitioner ratios are NOT used to determine staffing but serve as a guidance metric
- Analysis for the NCQA requirement occurs at the regional level with Medical Center input

- Reporting delineates the five (5) common practitioner types as defined above and in relation to relevant membership populations served by the practitioner.

KPSC reports a ratio for Mental Health practitioners as part of a DMHC required Ratio report; these ratios are different than those used for the NCQA analysis.

KPSC Staffing methodology is based on:

- Member penetration rate which is the percentage of members with at least one visit in our Psychiatry Department.
- Utilization for each member accessing care (total visits)
- Clinical Program enhancements or new clinical programs
- External regulatory or economic conditions

Definition of Psychiatric Practitioners for Availability Analysis

- Psychiatric Practitioners are separated into three (3) common practitioner types:
    - Adult Psychiatrists – Ratio analysis based on members ages 18 and above
    - Child Psychiatrists – Ratio analysis based on members ages 0-17
    - Psychiatric Therapists* – Ratio analysis based on members ages 0 and above

** Psychiatric Therapists include both LCSW and LMFT licensed clinicians as either licensure is appropriate for Therapist job postings.*

Definition of Substance Use Practitioners

- Substance Use Practitioners are separated into two (2) common practitioner types:
    - Addiction Medicine Physician (MD/DO) – Ratio analysis based on ages 13 and up
    - Substance Use Practitioners* - Ratio analysis based on ages 13 and up

**Substance Abuse Practitioners include LCSW and LMFT licensed clinicians and CADAC certified counselors. Our Substance Use programs primarily use licensed practitioners but may, although they are not required to utilize CADAC certified counselors to supplement the program.*

BHC Geographic Locations Overview and GeoAccess Analysis

BHC Geographic Locations Overview

- BHC services are provided in thirteen geographic areas within KPSC and are managed by KPSC senior managers and physicians collectively known as the Medical Center Administrative Team (MCAT) (of which the KFHP Executive Director is a member) in each geographic area. Reporting

to the Area Medical Center leadership team, each Psychiatry and Addiction Medicine Department is managed by a physician Chief of Service and Department Manager.

- BHC services in the Ventura geographic area have been integrated into the Woodland Hills Psychiatry Department.

- Riverside Medical Center has responsibility for members in the Coachella Valley where they contract with Windstone Behavioral Health to provide BH services. Windstone maintains a clinic in Palm Desert with multiple practitioners for both adult and pediatric members and subcontracts with community providers in the Coachella and Yucca Valleys on an as needed basis to meet membership access demands.

- Within each of the thirteen geographic areas, KPSC supplements our internal Behavioral Health practitioner staff with community providers based on member demand for services.

GeoAccess Standards & Analysis

A high-volume Behavioral Health Practitioner GeoAccess analysis is completed annually and reported based on 5 common practitioner types as defined in the Behavioral Health Practitioner Definition section of this report.

- KPSC uses a standard of 80% of members within 15 miles or 30 minutes for Adult Psychiatrists, Child Psychiatrists and Psychiatric Therapist practitioner types.

- KPSC uses a standard of 80% of members within 30 miles or 60 minutes for Addiction Medicine Physicians and Substance Use Therapist/Counselor practitioner types.

    - <u>KPSC evaluates geographic access at the Substance Use program level.</u>

    - While many of our Psychiatric Practitioners can and do see patients with co-morbid Psychiatric and Substance Abuse conditions, our analysis seeks to ensure the availability of more specialized and defined Substance Use programs.

- We consider Substance Use locations to include both physician and therapist/counselor practitioners AND a full array of individual, group and intensive services directed toward substance abuse conditions.

Since the most clinically appropriate treatment is often provided in groups, the programs must serve a large enough geographic area to have a sufficient volume of patients.

Behavioral Health Facility Planning

Behavioral Health facility planning for Southern California is an important part of the overall Regional Delivery System Strategy. It is assessed as part of the overall Regional Strategic Planning process and developed for each individual geographical area.

- The strategy is discussed and adjusted, as necessary, as part of the development of the 10-Year Capital Plan for the Southern California Region. (Occurs twice annually)
- The Behavioral Health provider office forecast is developed and refreshed annually for each medical center area, based upon membership projections, demand and clinical program enhancements.
- The existing Behavioral Health provider office capacity is assessed based upon the forecasted office demand and specific hiring plans for each Medical Center Area.
- Based on this assessment, the Region works with the local Medical Center Areas to develop or revise strategies to accommodate the projected office and space needs.
- If there are space needs, the Region will look at how to add capacity by better utilizing existing office capacity, expansions of existing space, new site locations, or adding services in new medical office buildings being planned.
- If there is a shortage of office space that cannot be accommodated by internal space options, Medical Centers utilize existing practitioner external contracts to meet access demands. External contracting is considered a flexible component of our model and does not permanently offset the need for internal office space.
- Potential projects are prioritized and phased by the Region, as part of the overall planning process. Once approved, the projects are executed throughout the year, per the overall capital plan.

7. Assessment of Behavioral Health Network Adequacy

KPSC assesses member experience accessing the network which includes:

- Quarterly analysis of member complaints and grievances/appeals
- Annual behavioral health member survey
- Request for and utilization of out-of-network services

Analysis of the member experience results includes consideration of whether the complaints and grievances/appeals are specific to geographic areas.
KPSC prioritizes identified improvement opportunities from analysis of availability, accessibility, and member experience results.

- KPSC identifies at least two opportunities for improvement and implements interventions
- KPSC measures the effectiveness of the interventions.

8. Collaboration Between the Organization and Behavioral Health Specialists

At least annually, the organization's activities to improve the coordination of behavioral health and general medical care include:

Behavioral Health Clinical Practice Guidelines

- The organization is accountable for adopting and disseminating clinical practice guidelines relevant to its enrolled membership for the provision of acute, chronic, and behavioral health services.
- KPSC recognizes that clinical practice guidelines (CPG's) based on scientific evidence are essential tools for improving and demonstrating quality of care. The goal of the KPSC Clinical Practice Guidelines Unit is to improve the quality of medical services by developing evidence-based guidelines that support the organization's Clinical Strategic Goals, as well as clinical decision-making at the point of service. BHC clinicians engage in a collaborative guideline development and review process of clinical practice guidelines related to Mental Health and/or Addiction Medicine with Medical Care colleagues.

- To keep current with changing medical practices, all guidelines are reviewed and, if appropriate, revised at least every two years. Guidelines are revised more frequently in response to the publication of important new evidence. The Clinical Practice Guidelines Unit and the members of the Guideline Development Team are responsible for continually evaluating new evidence and initiating review and revision of guidelines. BHC may also request development of a specific clinical guideline and work in conjunction with the Regional Clinical Guidelines Development staff.

Collaborative Care within KPSC

Within our integrated medical care practice, there are numerous examples of primary care and specialty medical care departments working formally or informally with their physician colleagues in Psychiatry and Addiction Medicine.

- Addiction Medicine and Psychiatry Departments provide consultation liaison services for members in our acute medical hospitals and have staff on-call for members presenting in our Emergency Departments on a 24/7 basis.

- SCPMG Regional Primary Care Substance Use Disorder (SUD) Champions are Primary Care Physicians representing each Medical Service Area who partner with Addiction Medicine based SUD Champions. The SCAL Regional SUD Workgroup focuses to improve quality care delivery for patients with SUDs.

- Medical care outpatient providers (e.g. primary care) who may be treating co-morbid behavioral disorders along with medical disorders can obtain telephone consultations with BHC practitioners.

- Local medical center Developmental Evaluation Teams that evaluate and diagnosis children with developmental delays such as autism spectrum disorders include clinical experts from the Psychiatry Department, Pediatrics, Speech Therapy, and Occupational Therapy/Physical Therapy. There is a licensed Developmental Case Manager that is often involved as both a member of the clinical team and serves as a liaison with families once an ASD diagnosis is made.

- Collaborative Disease Management Programs which involve medical care and behavioral health care providers working together to provide care for our members. Our ADAPT program is an example:

- Regional ADAPT Program
    - ADAPT is a virtual based, collaborative care, mental health treatment program that serves patients with anxiety and/or depression as well as related diagnosis. The program was originally developed at the AIM's Center at the University of Washington and uses evidence based/empirically validated therapeutic modalities and measures to target treatment on the reduction of unwanted symptoms. The program also provides medication management and patient centered outreach creating a whole team approach to services. The treatment team is comprised of Pharmacists, Licensed Therapists, Associate Therapists, and Support Coordinators, all who play a special role in the patient's recovery. Regional administration and consulting Psychiatrist support the treatment team and run program operations. The Regional ADAPT program provides services to all Southern California.

    - The ADAPT team Pharmacists and Advanced Practice Providers (Nurse Practioners/Physician Assistants) work hand in hand with Primary Care providers at the onset of treatment, in partnership, allowing Pharmacists and Advanced Practice Providers to start medication management. At graduation or completion, the patient returns to Primary Care and is provided with a treatment summary and medication refill.

    - The ADAPT program serves patients who can benefit from Problem Solving Therapy as well as Cognitive Behavioral Therapy and Behavioral Activation. Patients who agree to treatment are directly booked into our therapist schedules by the Psychiatry call center. ADAPT treats patients who experience mild to moderate anxiety and depressive symptoms, which is determined by the Depression Index (PHQ9) and the Generalized Anxiety Disorder Scale (GAD7).

        - At the onset of treatment, in a 60-minute Intake, the treating provider takes a full assessment of the patients' history to gain a full picture of the patients' needs and to create a direction for treatment. During the initial stages of therapy patients are educated about the treatment modality used in session to ensure that patients feel knowledgeable and confident in the program.

        - During the beginning, middle and end phases of therapy specialists use a combination of empirically validated modalities. Problem Solving Therapy,

Behavioral Activation, Motivational Interviewing and Cognitive Behavioral Therapy are all utilized to ensure that patient treatment is individualized and helpful.

- Patients may also be scheduled with a pharmacist or Advanced Practice Provider should they already be on a front-line medication that treats anxiety and or depression in efforts to do the "heavy lifting" for the Primary Care Physician working to stabilize the patient while in the program. Patients can also be referred to a pharmacist by a therapist that believes the patient may benefit.

- Patients are seen, by the treating therapist, in "rounds" of therapy dependent on the acuity of their symptoms. First patients are seen weekly on 30-minute sessions until the therapist and the patient see a 50% reduction in the patients' symptoms as demonstrated by patient self-report and the measures mentioned above.

- Once a patient and therapist identify the reduction the patient is then moved to the second "round" of therapy where they are seen every other week and titrate down from there to every other month even once in three months to ensure that the patients' feelings of relief of the symptoms that the patient identified in the beginning of therapy remain low. The ADAPT program can last up to 6 months in total however patients are offered "booster sessions" if needed, with their past therapist, up to 6 months after graduation to review skills that the patient may need to review to feel successful.

- When patients graduate the ADAPT program, they are provided with an in-depth relapse plan as well as a graduation certificate. Both the patient and the therapist carefully include items in the relapse plan that have been shown as successful in therapy and how they may apply to issues the patient faces in the future. A treatment summary is also sent to the treating Primary Care Physician at the conclusion of treatment when the patients medication management is turned back over to the Primary Care Physician. Patients are also given a 100-day supply of medication to ensure that they do not have a break in their medication treatment.

- The goal of the ADAPT program is that patients are seen quickly, often and are treated to remission.

- Multidisciplinary Clinical teams work together to improve quality measures.
  For example:
  - SCPMG through has sponsored a multidisciplinary workgroup to improve our HEDIS results for IET and FUA measures. This workgroup is led by our Regional Physician Champion for Substance Use Disorders who is an Addiction Medicine physician. The workgroup includes Addiction Medicine clinical leaders/managers, Psychiatry leadership, Primary Care SUD Champions, Emergency Department leaders and administrative staff involved in reporting results and facilitating leadership discussions. Addiction Medicine department leaders collaborate in each Medical Center Area with Primary Care, Psychiatry, Emergency Department, etc. to develop workflows to improve performance.

9. Continuity and Coordination Between Medical Care and Behavioral Healthcare

The organization collaborates with behavioral health specialists to monitor and improve coordination between medical and behavioral health care across continuum of care.

At least annually, the organization reviews and, where necessary, collects data about the following opportunities for collaboration between medical and behavioral health care:

- Exchange of information
  - Continuing KPSC's commitment to provide high quality, integrated medical care to our members, KPSC has implemented an electronic medical record system (KP HealthConnect) of which the Clinical Ambulatory component is the primary component related to sharing of information. Given our BHC Care departments (Psychiatry and Addiction Medicine) are part of our integrated system; appropriate information can be easily shared among providers. Some aspects of BHC services are extremely sensitive (e.g., sharing of CDRP treatment is regulated by federal statutes). Consistent with federal, state, and other regulatory requirements, patient information can be shared among those providers who are mutually providing care to a member. Medication, lab

results and allowable treatment plans/recommendations are available. Additional information can be easily exchanged in physician-to-physician consultations.

- Appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care
    - KPSC behavioral health clinicians collaborate with medical care clinicians to improve performance with patients being diagnosed with a Substance Use Disorder (SUD) and initiate treatment within 14 days or less of diagnosis. HEDIS IET and KPSC Clinical Strategic Goal (CSG) are used to monitor improvements.

- Appropriate uses of psychotropic medications
    - KPSC behavioral health clinicians collaborate with medical care clinicians to improve antidepressant medication management. HEDIS Antidepressant Medication Management and KPSC Clinical Strategic Goal (CSG) are used to monitor improvements.

- Management of treatment access and follow-up for members with coexisting medical and behavioral disorders
    - KPSC behavioral health clinicians collaborate with medical care clinicians to improve follow-up of members discharged from the Emergency Department with a substance use disorder (SUD) diagnosis. HEDIS Follow-up after Emergency Department Visit for Alcohol or Oher Drug Abuse or Dependence (FUA) measure and KPSC Clinical Strategic Goal (CSG) are used to monitor improvements.

- Primary or secondary preventive behavioral health program implementation.
    - KPSC behavioral health clinicians collaborate with medical care clinicians to improve the utilization of the PHQ 9 to monitor depression symptoms for adolescents & adults, and to monitor depression remission or response for adolescents & adults.
      HEDIS DMS and DRR measures, and KPSC Clinical Strategic Goal (CSG) are used to monitor improvements.

- Special Needs of Members with Severe and Persistent Mental Illness
    - The organization collects data on specific issues around the continuity and coordination of services for members with severe and persistent mental illness.
    - Areas of focus may include suicide prevention and members with substance use problems and severe mental illness.
    - KPSC tracks ED referrals from our 24/7 Behavioral Health Helpline to insure they follow through on an initial treatment plan to go to the nearest emergency department.

10. Medi-Cal Services

Mental Health Services

Benefits include non-specialty, outpatient behavioral health services, labs, and consults. KPSC is responsible for non-Specialty Mental Health Services (NSMHS) for eligible Medi-Cal Members with a mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder, as defined by DHCS guidelines through the current Diagnostic and Statistical Manual of Mental Disorders (DSM). Specialty Mental Health Services (SMHS) are the responsibility of county Mental Health Plans (MHPs).

- Kaiser Permanente clinical and non-clinical staff screens new members who present with mental health needs using the mental health screening tools issued by DHCS to determine the appropriate system of care. Existing members are evaluated routinely by their clinician to assess needs for higher levels of care. If the member is believed to meet the “specialty care service” definition, Kaiser Permanente uses the DHCS transition of care (TOC) tool to refer the Member to the appropriate County resources for an intake assessment and treatment planning. Kaiser Permanente and the County share responsibility to ensure Medi-Cal Members receive all medically necessary Behavioral Health services in a timely manner.

OUTPATIENT MENTAL HEALTH SERVICES POLICY

Kaiser Permanente covers Outpatient Mental Health Services that are within the scope of practice of Primary Care Providers and mental health care providers, as defined in Kaiser Permanente's contract with DHCS and All Plan Letters.

Covered services provided by Primary Care Providers and/or mental health providers as appropriate include:

- Individual/group/family mental health evaluation and treatment (psychotherapy)
- Psychological and neuropsychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring drug therapy
- Psychiatric consultation, outpatient laboratory, supplies, and supplements

ALCOHOL USE DISORDER/SUBSTANCE USE DISORDER BENEFIT & COVERAGE POLICY

Specific Alcohol Use Disorder (AUD) and Substance Use Disorder (SUD) services are covered Medi-Cal benefits. Kaiser Permanente provides Medi-Cal members with AUD/SUD screening, brief interventions and appropriate referral for additional evaluation and treatment and medications for addiction treatment when brief assessments indicate a probable AUD or SUD. Non-primary care AUD/SUD treatment services are also available to Medi-Cal members, primarily through county alcohol and drug programs as part of the Drug Medi-Cal program.

Substance Use Disorder Coverage

Limited substance use services are covered Health Plan benefits:

- Emergent Acute Inpatient Detoxification- the medical management of active withdrawal symptoms. Coverage for emergent inpatient detoxification would be the same as any other medical condition that requires inpatient hospitalization. Use of multiple substances may be considered for emergent impatient detoxification.
- Facilitated Access to Voluntary Inpatient Detoxification Services - When a Medi-Cal member presents for detoxification services, but does not meet criteria for acute inpatient detoxification, Kaiser Permanente provides the member with a hand-off to the appropriate county alcohol and drug program. County Drug Medi-Cal program is responsible for Voluntary Inpatient Detoxification Services.

- Screening for Alcohol and Drug Use - Alcohol and Drug screening and counseling services for members ages 11 and older with appropriate follow-up, including referral to county alcohol and drug treatment programs.

Kaiser Permanente provides all medically indicated screening services for Medi-Cal beneficiaries under 21 years of age, including any related to AUD/SUD. Further, Kaiser Permanente ensures care coordination, transportation, and case management of all medically necessary EPSDT services required by Medi-Cal members under 21 years of age, including those provided through contractual carve-outs to county drug and alcohol programs.

11. Patient Safety & Significant Events

These events are managed at the medical centers through local Significant Event reporting processes. Refer to the Regional Risk Management/Patient Safety Program Description for further information. An integrated quality plan reflects patient safety activities for members including those receiving behavioral health services.

12. Oversight of Contracted BHC Providers (Facilities)

In collaboration with the appropriate local and regional Quality, Credentialing and Contracting staff, a local Medical Center Psychiatry and/or Addiction Medicine Department Manager, Chief of Service or designee provides expert consultation regarding contracting for new providers or practitioners.

Newly contracted BHC Providers (offices) receive an initial site visit if the facility is not accredited. Accredited facilities may provide their accreditation certificate and/or receive an initial site visit if deemed necessary.

Ongoing monitoring of contracted BHC Providers (facilities) includes review of quality & complaint data occurs at the local Medical Center level on at least an annual basis. More frequent reviews are conducted should specific quality issues be identified for a provider. As part of the on-going oversight process, a Psychiatry and/or Addiction Medicine Department Manager, Chief of Service or designee participates in the review of relevant quality measures/issues.

13. Behavioral Health Help Line, Triage, and Referral Process

The Behavioral Healthcare Helpline is an adjunct service to support the operations of the Southern California Regional BHC services. The Helpline is a 24 hour/day, 7 day/week crisis line that is answered live by a staff composed of Licensed Clinical Social Workers and Marriage Family Therapists. All staff that answer the Helpline are California Licensed Mental Health professionals. The staff responds to crisis calls and informational calls from members, as well as employee assistance professionals. The interventions of the clinician(s) are guided by protocols. Along with providing crisis intervention and information, they facilitate access to Kaiser medical offices and/or emergency departments. The Behavioral Healthcare Helpline Coordinators are supervised by a Licensed Clinical Social Worker with post-Master's clinical experience. A board-certified Psychiatrist with experience in clinical risk management oversees all clinical operations. Triage and referral are guided through the approved protocols which are reviewed and approved every two years by the BHC Helpline Management Group and are approved by the Southern California Quality Committee. The protocols address appropriate mental health and substance abuse situations for the Kaiser Permanente membership. Each protocol describes the level of urgency appropriate for the situation and the setting of care needed. The Behavioral Healthcare Helpline Coordinators are supervised by a Licensed Clinical Social Worker with post-Master's clinical experience. A board-certified Psychiatrist with experience in clinical risk management oversees all clinical operations. Triage and referral are guided through the approved protocols which are reviewed and approved every two years by the BHC Helpline Management Group and are approved by the Southern California Quality Committee. The protocols address appropriate mental health and substance abuse situations for the Kaiser Permanente membership. Each protocol describes the level of urgency appropriate for the situation and the setting of care needed.

After Hour Operations

After hour services are available via the KPSC Behavioral Health Care Help Line or through hospital emergency departments.

The KPSC BHC Help Line is available 24/7, 365 days per year and is staffed by licensed clinical staff.

- The Helpline is a crisis line that is answered live by a staff composed of Licensed Clinical Social Workers, Marriage Family Therapists.

- The staff responds to crisis calls and informational calls from members, as well as employee assistance professionals. The interventions of the clinician(s) are guided by protocols.

- The goal or mission of the Helpline is to facilitate linkage between our members and the local medical offices. Along with providing crisis intervention and information, the Help Line staff facilitate access to Kaiser Behavioral Healthcare offices and/or emergency departments.

- For patients that require or desire access to services via our emergency departments or community emergency departments, the BHC Help Line staff may be consulted once the patient is medically stable.

- Through an agreement with LA County Mental Health, KPSC has a mobile Psychiatric Emergency Treatment team (PET Team) using licensed BH clinicians who are dispatched to KPSC Emergency Departments in LA County on an as needed basis for after hour evaluations.

- Additionally, each Psychiatry and Addiction Medicine Department has staff on call 24/7, 365 who are available for consultation. They may consult with clinical staff from the BHC Help Line, the KPSC PET team or directly with KPSC Emergency Departments. These local teams serve as a back-up should services of the BHC Help Line be interrupted for any reason.