KAISER PERMANENTE®

2024 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
2024 Quality Program Description

Tara Harder June 28, 2024

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Deepak Sonthalia MD 7/17/2024

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

KFHP Southern California Region
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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.

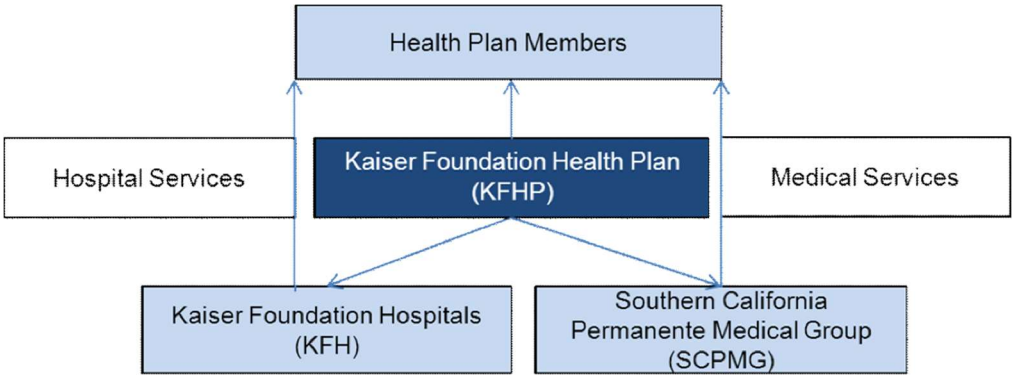
KFHP's network also includes contractual arrangements with community facilities and individual providers through its agreements with KFH and SCPMG. Approximately 95% of services provided to members are provided by KFH and SCPMG.

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.

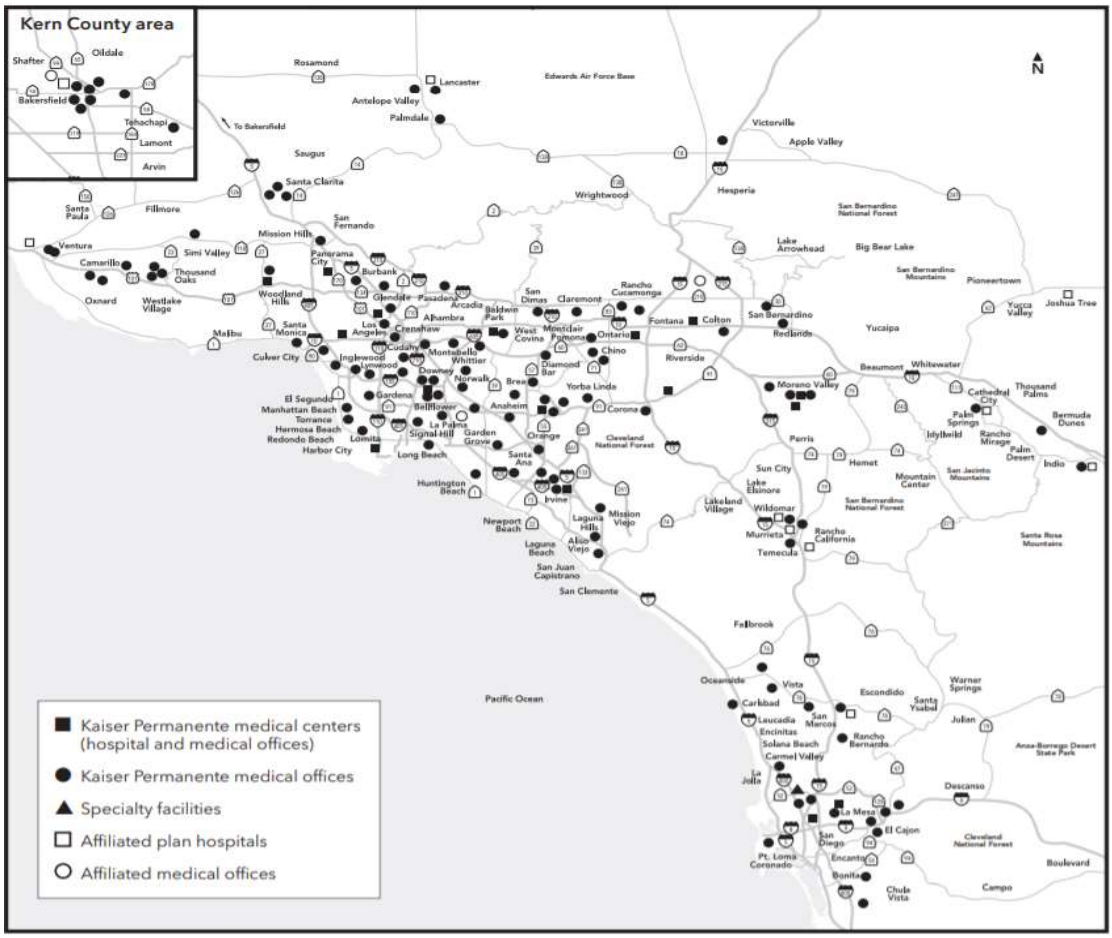
Kaiser Permanente Integrated Health Care System:



Southern California Medical Center Structure

KFHP Southern California has thirteen service areas. Within those thirteen service areas, five 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, Palomar Hospital
- Ventura County
  - Woodland Hills Service Area: Community Memorial Hospital San Buenaventura



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, 2023, KFHP Southern California covers 4,586,787 lives.

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

- 28.27% identify as Caucasian/White
- 36.16% identify as Hispanic/Latino
- 11.71% identify as Asian or Pacific Islander/Native Hawaiian
- 7.71% identify as African American/Black
- 0.29% identify as Native American
- 15.78% identify as Multiracial/Unknown/Other

**Data Source is KP HealthConnect (as of December 31, 2023)*

As of December 31, 2023, Kaiser Permanente Southern California has collected 98.43% spoken language preferences in Kaiser Permanente HealthConnect. Out of these members, 9.67% (443,592) are limited English speaking or prefer to have healthcare delivered in a language other than English.

- 88.76% prefer English
- 8.26% prefer Spanish
- .39% prefer Chinese (Mandarin)
- .23% prefer Vietnamese
- .14% prefer Korean
- .10% prefer Tagalog
- .08% prefer Armenian
- .08% prefer Chinese, Cantonese
- .05% prefer Sign Language

As of January 2024, we have collected 5.06% of our members' Sexual Orientation/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**:

- 0.02% identify as Bisexual
- 0.09% Choose not to disclose
- 0.03% identify as Don't know
- 0.15% identify as Gay
- 0.07% identify as Lesbian
- 0.00% identify as Lesbian or Gay
- 0.08% identify as Something else
- 4.45% identify as Straight (not lesbian or gay)
- 94.94% currently have blank/no response collected

Gender Identity as follows**:

- 0.02% Choose not to disclose
- 2.83% identify as Female
- 0.01% identify as Genderfluid
- 2.01% identify as Male

- 0.06% identify as Non-binary
- 0.00% identify as Questioning
- 0.04% identify as Transgender Female/Male-to-Female
- 0.04% identify as Transgender Male/Female-to-Male
- 94.96% currently have blank/no response collected

***Data Source is KP HealthConnect (as of January 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 and Regulatory Services and the SCPMG Regional Physician Director for Quality, Risk Management, Regulatory and Safety. These individuals are appointed by the President and Executive 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 Executive 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

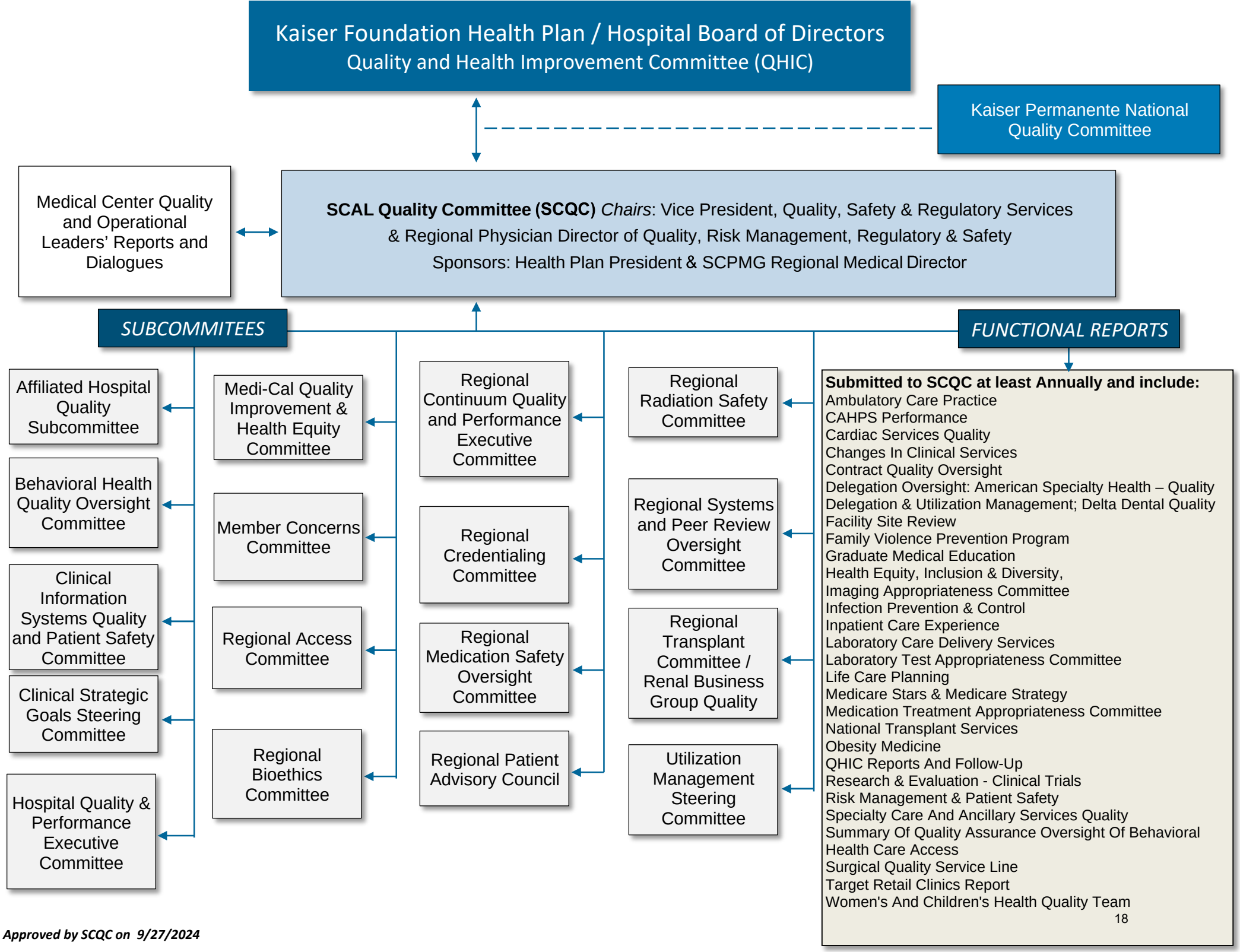
All SCQC and subcommittee minutes, reports, recommendations, memoranda, and documented actions are considered quality assessment working documents and are kept confidential. They are maintained in accordance with KFHP Southern California policies and procedures and are privileged and protected from discovery 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 9/27/2024

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)
- Surgical Quality Oversight Committee (SQOC)
- 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 seed 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 activities, 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). The MCC meets at least six times a year and reports to the SCQC twice a year. 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 Appeal Overturn Report (Qualitative and Quantitative), Complaint, Grievance and Appeal Report, Annual Analysis of Complaints and Grievances, Executive Member Feedback Report (EMFP), MAXIMUS Overturn Report, ALJ Overturn Report, ALJ State Programs Overturn Report, Complaints Referred to Quality Review Report, IMR Overturn Report and Grievance/Nurse Consultant Audit Report, Member Experience 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 complaints, 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 area-specific and regional 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. This body also serves as a deliberative and voting body for policies under the custody of Bioethics. 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.

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.

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 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 sanctioned activities
- 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, NCQA, The Center for Medicare and Medicaid Services, MDQR, 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 management and improved health outcomes across the continuum of care.

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 care ambulatory practice leaders
- 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 our processes of care with an emphasis on quality*, safety, and care experience. The RPAC will be composed of volunteer patient advisors ideally representing the diversity of our KPSC membership. The Council will:

- Identify and advise KP on regional issues related to quality, safety, care experience and organizational strategic initiatives.
- Partner with KP regional and national leaders, committees, and other improvement teams to bring patient perspectives for more patient centered outcomes.

- Encourage 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 have 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 our 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.

Utilization Management Steering Committee (UMSC)
(Attachment T: 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
- 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 and Children's Health Quality Team

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 Abdomen, CT Abdomen/Pelvis, Echocardiogram, and NM Heart) and quality metrics (High-risk Mammography, HEDIS Low Back Pain, CT Head Syncope Discordance, Limited vs. Full Abdominal Ultrasound, Pre-operative Chest X-Ray).

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 utilization, facilitate implementation plan development, and to establish implementation timelines and monitor progress on initiatives. For instance, indicators monitored by the committee include trends in orders for tests of limited clinical value, frequency of ordering of CBC without differential, frequency of 25-Hydroxy Vitamin D result values, and metrics regarding flu tests (including total orders vs. positive results by test type).

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:

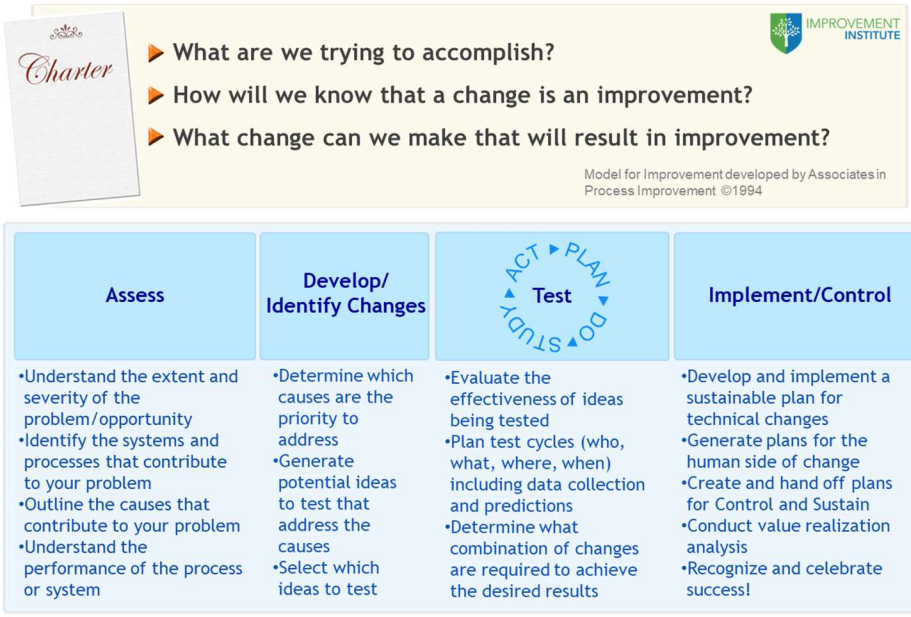
- Quality and safety of the care we deliver
- Care experience of our Members
- Coordination of care we deliver
- Timeliness of the care we deliver
- Venues where we deliver care
- Skills, motivation, and safety of our workforce

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 2024 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_2024_Archives/Clinical_Quality_Key_Measures_2024_Memo.pdf

2024 Clinical Quality Key Measures	Target
Ambulatory Quality Composite Score (Area-specific)	100.0
Proportion of Areas meeting AQC Target	13/13
Carre Coordination	
• Plan All-Cause Readmissions O/E ratio (Medicare members)	1.03*
Staying Healthy	
• HbA1c < 8.0% - Non-Latino Population (18 ≤ 65 y/o)	69.0%*
• HbA1c < 8.0% - Latino Population (18 ≤ 65 y/o)	61.0%*
• Childhood Vaccinations: Combo 10 – Non-AA/Black population	61.0%*
• Childhood Vaccinations: Combo 10 – AA/Black population	43.0%*
• Proportion of Days Covered by Medications: Statins (Ages 18-85) *(new)*	84.0%*

***The targets displayed for these measures reflect the incentive targets for 2024, 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 2024 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 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.

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 non-emergent in-plan 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 practitioners. Additionally, each Medical Center's C&P Committee makes the final credentialing/recredentialing decision for KFHP within its respective 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.

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. This impacts all care settings. 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 PCP 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 PCP. 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 PCP'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 in to 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 PCP's In Basket to facilitate the appropriate intervention.

Regional Outreach is an infrastructure for centrally coordinated, actionable, and standardized outbound mass communications to members to improve clinical quality and outcomes. Outreach modalities include letters, digital notifications through kp.org, automated telephone outreach, and

text messages. The team builds and maintains outreach projects that support the function of Complete Care:

- Clinical Information and 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 includes 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 Care Coordination and Case Management department:

Population Health Management (PHM)
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 members who have needs for home and community-based services. This includes those accessing HCBS waivers, CBAS, and those accessing supports to stay in the home.

- **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.

- **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** ensures members are supported across all settings and delivery systems from discharge planning until they have been successfully connected to all needed services and supports. Care transitions are defined as a member transferring from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports placements (including Sobering Centers, Recuperative Care and Short-Term Post Hospitalization), post-acute care facilities, or long-term care (LTC) settings.

- **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.

Special Needs Plan (D-SNP) is a Senior Advantage Medicare/Medi-Cal Plan that enrolls beneficiaries who are dually eligible for Medicare and full benefits under Medi-Cal. As a Special Needs Plan, 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 and nursing home placements.

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-

[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.

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 to its members. Strategic service priorities are set based on identified 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
- Member Experience Tracking Evaluation and Opinion Research (METEOR)
- Patient Assessment Survey (PAS) of California Provider Organizations
- 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 enrollee, not to exceed 12 months from the contract amendment/termination date or the effective date of the new enrollee'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 enrollee'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 Enrollee's terminated Plan Provider or Plan Provider whose terms of participation have been amended to eliminate previously included services, or a Qualified New Enrollee's Non-Plan Provider within 180 days of the contract amendment/termination date or the effective date of the Qualified New Enrollee's coverage, respectively.
- When the member is receiving inpatient care at a hospital or is institutionalized at a licensed facility.

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 Depression Complete Care (Population Care) Management program focuses on defined populations of patients with common clinical conditions. As part of that effort, the Regional Depression Work Group is a collaborative effort involving representatives from Primary Care, Medical Social Services, Psychiatry and the Regional BHC Department. A Regional Leadership team includes a physician lead from primary care, a physician lead from psychiatry, a member of the Regional BH Services department who serves as the administrative lead for the program and an Assistant Area Medical Director. The program targets members with chronic medical conditions (e.g., cardiovascular diseases) or other medical conditions (e.g., pregnancy) where members are at higher risks for having depression. The program is ever evolving and is designed to proactively identify/screen and treat depression at the earliest stage possible. The program includes depression specialists who are staffed outside of psychiatry to assist members with mild/moderate depression and direct linkage to the Psychiatry Department for more severe depression.

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).
- A visit review 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

KFHP Southern California Region
2024 Quality Program Description

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 2024

Southern California Health Plan Kaiser Permanente

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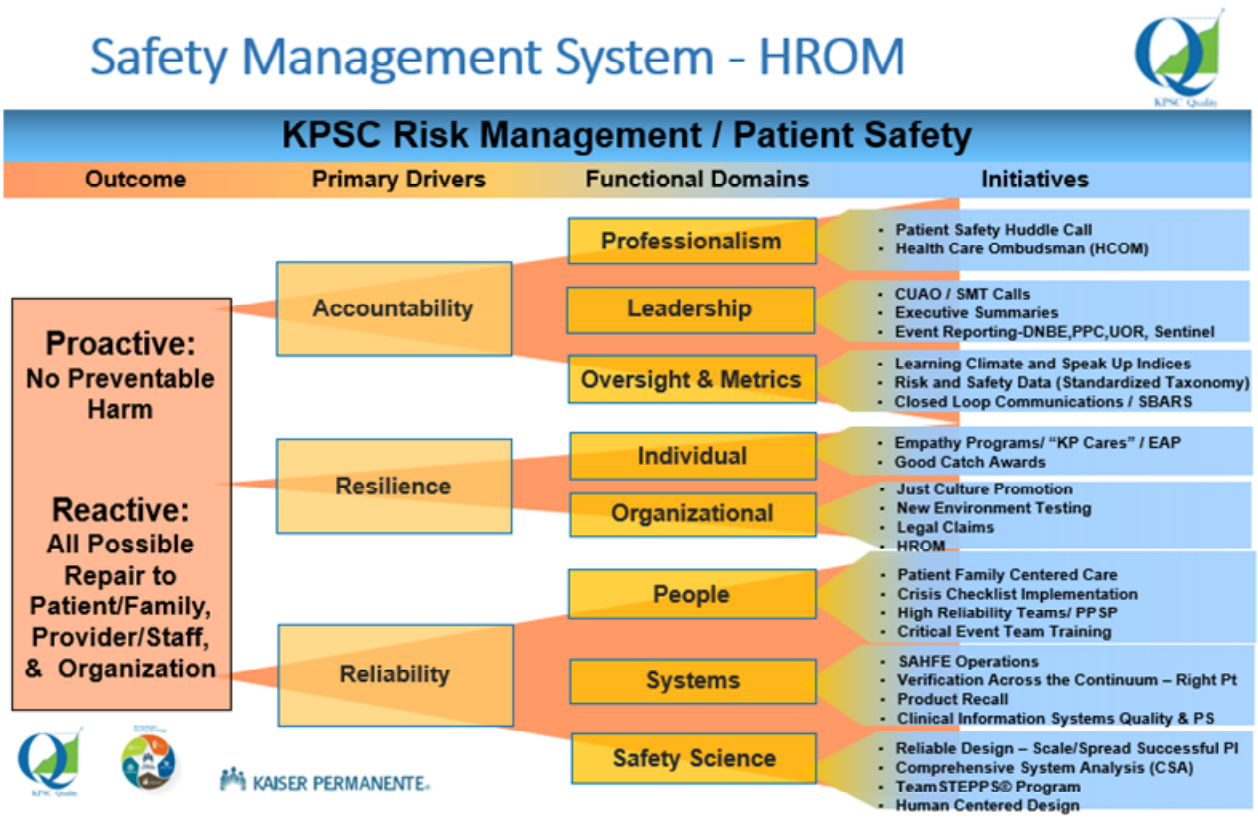
Kaiser Permanente Safety Strategy

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.

2024 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

2024

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.

Attached is an organizational chart of the KPSC Quality Structure demonstrating involvement of Behavioral Health *(Health Plan Quality Oversight Structure for Behavioral Health**: see** appendix 1)*
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. The quality reports include an analysis of selected HEDIS measures including the Anti-Depressant Medication Management (AMM), Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA), and the Initiation & Engagement in Treatment (IET).

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 2024 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 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.

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.
  <u>We group the above Behavioral Health Practitioners into 5 major common types as follows:</u>

  - 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.

- There are no nationally accepted standards of mental health staffing
- 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.

    - KPSC evaluates geographic access at the Substance Use program level.

    - 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 Depression Care Management program is an example:

- KPSC Depression Complete Care Program has the following goals/objectives:
    - Support Primary Care for newly diagnosed patients with depression and follow-up.
    - Maintain/improve HEDIS Antidepressant Medication Management results
    - Improve Antidepressant Medication Management
    - Increase PHQ9 utilization for depression screening and monitoring
    - Develop & monitor standardize staffing model for medical center depression care management programs
    - Implementation of online Cognitive Behavioral Therapy for mild to moderate depression

- 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.

- Depression Care Management Program
    - Depression Care management is an evidence-based collaborative care program for patients with mild-to-moderate depression and anxiety in a primary care setting. The program is administered by trained mid-level providers and licensed clinical social workers that specialize in the treatment of depression. Depression Care Management teams include the following team members: Primary Care and Psychiatry physician champions, treatment specialists, assessment specialists, and support coordinators. Regional staff support the on-going evolution of Depression Care Management and supports local area implementation.

    - Depression Care Management teams also interface with primary care teams to assist with the implementation of evidence-based guidelines for identifying, diagnosing, and treating depression.

    - Primary care teams are encouraged to refer patients to the Depression Care Management program when a patient has mild-to-moderate symptoms of depression as indicated by a total score of 5 or higher on the Patient Health Questionnaire (PHQ9), when a patient has symptoms of anxiety co-occurring with those of depression as indicated by a total score of 5 or more on the 7-item Generalized Anxiety Disorder questionnaire (GAD7), and/or when they feel the patient needs further assessment and in-depth discussions about treatment options for their depression.

    - Initially, assessment specialists who are primary nurses with psychiatric backgrounds or licensed clinical social workers, meet with the patient to have a full assessment of a patient's symptoms to determine severity and clinical need, assess patient readiness for treatment and collaboratively work with patients to develop treatment plan options

including appropriate health education classes, internet-based programs, participation in the local Depression Care Management program or referral to specialty care services in the departments of Psychiatry and/or Addiction Medicine. If Depression Care Management is indicated and acceptable to the patient, the patient is scheduled for a 60-minute initial session with a treatment specialist who is either a mid-level provider or a licensed clinical social worker. It is preferred that this initial treatment session is in person.

- Treatment specialists use a combination of behavioral activation and problem-solving treatment incorporating motivational interviewing techniques and meet with patients in 20 – 40-minute appointments, 2 – 4 times per month for up to 6 months Most visits are done virtually. Changes in symptoms are monitored monthly while in treatment using the PHQ9 and GAD7 as appropriate.

- Discharge is accompanied by a relapse prevention plan and monitoring of depression symptoms for six months and then annually thereafter using secured messaging and automated mailings.

- Patients are tracked throughout their membership with a web-based depression care registry.

- 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 work hand in hand with Primary Care providers at the onset of treatment, in partnership, allowing Pharmacists 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 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.

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

Benefit includes non-specialty, outpatient behavioral health services, labs, and consults. KPSC is responsible for non-Specialty Mental Health Services (NSMHS) for children under age 21 and outpatient mental health services for adult Medi-Cal members with 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).

- KPSC conducts a thorough evaluation to determine if the Medi-Cal member meets “specialty care services” as defined by DHCS. If the member is believed to meet the “specialty care service” definition, KPSC works to ensure that the member is referred to the appropriate County resources for an intake assessment to determine if the member meets their criteria for “specialty care” service. KP and the County share responsibility to ensure all medically necessary BH services are provided in a timely manner to Medi-Cal members.

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’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; and

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. KP 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, KP 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.

KP provides all medically indicated screening services for Medi-Cal beneficiaries under 21 years of age, including any related to AUD/SUD. Further, KP 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.

2024

Utilization Management Program Description

KAISER FOUNDATION HEALTH PLAN
SOUTHERN CALIFORNIA REGION

Utilization Management Program Description 2024

Kaiser Foundation Health Plan, Southern California Region

Table of Contents

I. OVERVIEW

Kaiser Permanente Southern California (KPSC) is an integrated healthcare delivery system composed of three closely aligned organizations, Kaiser Foundation Health Plan (KFHP), Kaiser Foundation Hospitals (KFH) and the Southern California Permanente Medical Group (SCPMG).

Kaiser Foundation Health Plan, Southern California Region, ensures the appropriate use of healthcare services across the continuum through the implementation of a Utilization Management (UM) Program for all KFHP members to include the Drug Utilization Management Program and Prescription Drug Plans (PDP) for KFHP Medicare Advantage members. The scope of the program encompasses Medical and Behavioral Health Care services.

KFHP retains accountability for all utilization management activities and must ensure that the members and practitioners receive full disclosure, timely notice and explanation of UM decisions and appropriate access to UM staff when seeking information about UM processes in compliance with statutory requirements and accreditation standards. KFHP oversees compliance with the Knox- Keene Act (Health and Safety code, Sections 1340 et seq.), Centers for Medicare & Medicaid Services (CMS), the Affordable Care Act (ACA) and the National Committee for Quality Assurance (NCQA) standards.

The Southern California Quality Committee (SCQC), and the Utilization Management Steering Committee (UMSC) provide oversight of utilization management activities performed through SCPMG and KFH in partnership with KFHP.

II. UTILIZATION MANAGEMENT PRINCIPLES

UM Principles

The KFHP UM Program and associated documentation is organized for staff, members, practitioners and others to understand the program structure, scope, processes and oversight.

Utilization Management (UM) is a health plan process that, based in whole or in part on medical necessity, reviews and approves, modifies, delays, or denies a limited pre-determined list of services, requested by providers. The determination of whether a service is medically necessary is based upon criteria that are consistent with and supported by sound clinical principles and processes, which are reviewed and approved annually by the Plan. Please refer to Section VII for the list of services subject to UM as defined.

The KFHP UM Program is subject to direct regulation under the Knox-Keene Act [Section 1367.01 (a) of the Knox Keene Act].

Principles of Decision-Making

Kaiser Permanente (KP) practitioners and health care professionals, using their professional expertise, knowledge, skill and judgment, make patient care decisions based on the member's clinical needs. Kaiser Permanente does not make decisions regarding hiring, promoting, or terminating its practitioners or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits.

KFHP promotes open practitioner-patient communication regarding appropriate treatment alternatives and options without penalizing practitioners for discussing all medically necessary or appropriate care with the member. KFHP does not reward, hire, promote, or terminate practitioners or other individuals for issuing denials of coverage or care.

No financial incentives exist that encourage UM decisions that result in denials or under- utilization, or create barriers to care and services. UM decision making is based only on appropriateness of care and service and existence of coverage.

III. UTILIZATION MANAGEMENT PROGRAM GOALS AND OBJECTIVES

The goal of the KFHP UM program is to ensure the appropriate, high-quality, cost-effective utilization of Medical and Behavioral Health Care services and resources for all members, through:

a. Effective UM program structure, scope, processes and oversight to ensure appropriate, effective, and efficient utilization of resources/services to KP members across the continuum of care in compliance with requirements of state/federal and accrediting entities;
b. Provision of healthcare services at the appropriate level of care (right care at the right setting for the right amount of time);
c. Effective utilization management of targeted member populations, to include Special Needs Program (Medicare), Complex Case Management and Seniors and Persons with Disabilities (Medi-Cal);
d. Feedback from practitioners and members regarding satisfaction with the UM program to guide improvements;
e. Continuous quality improvement of the UM Program;
f. Integration and parity between medical and behavioral health care services;
g. Staff/Provider/Member Education regarding UM policies and processes.

IV. KAISER FOUNDATION HEALTH PLAN UTILIZATION MANAGEMENT LEADERSHIP STRUCTURE

The KFHP UM Program is led by the Health Plan Physician Advisors (HPPA). The program is supported by the SCPMG Regional Physician Director of Behavioral Health Care Clinical Oversight and Coordination, the KFHP Regional Executive Director of Quality Oversight and Regulatory Readiness and the Executive Director of Resource Stewardship These departments work in partnership to oversee and ensure the effective implementation of the KFHP UM program in compliance with statutory requirements and accreditation standards.

Health Plan Physician Advisor (HPPA)

The KFHP Southern California Physician Advisor (HPPA) is accountable to the SCAL Regional Health Plan President for ensuring that KFHP effectively oversees and administers the KFHP UM Program for Medical and Behavioral Health Care services in accordance with UM policies and statutory requirements and accreditation standards.

The HPPA is responsible for oversight and direction of UM activities wherever performed in the Kaiser Permanente SCAL Healthcare delivery system. The activities of the HPPA include, but are not limited to:

a. Guidance and oversight of UM Program daily operations;
b. Oversight of delegated UM functions performed on behalf of the Plan;
c. Development and update of UM policies and for communication of UM decisions to providers and members;
d. Review and update of UM criteria developed in compliance with statutory requirements and accreditation standards at least annually;
e. Development of UM clinical criteria and guidelines by SCPMG providers to ensure that they are consistent with sound clinical principles and professionally recognized standards of care;
f. Evaluation of member and practitioner experience with the UM Program and processes;
- Surveillance of the healthcare delivery system to identify potential UM activities through the review of UM appeals, Independent Medical Review (IMR) cases related to medical necessity denials and

other cases as warranted (e.g. reconstructive surgery);
- Communication with the SCAL Regional Health Plan President and the Southern California Quality Committee regarding the activities and findings of the UM Program at least annually.

Regional Physician Director of Behavioral Health Care Clinical Oversight and Coordination, SCPMG
The SCPMG Regional Physician Director of Psychiatric Utilization Management is the designated behavioral health care practitioner for the KFHP UM Program. This board-certified psychiatrist partners with the HPPA to ensure that UM of behavioral health care services is aligned and in parity with the UM of medical care. Hence, the Regional Director oversees the development and implementation of UM policies and criteria, utilization review and decisions and triage and referral processes for behavioral health care services.

Regional Executive Director, Resource Stewardship, KFHP
The Executive Director of Resource Stewardship is responsible for the collective set of actions KFHP undertakes to ensure the affordability and quality of health care services delivered to its members. Activities focus on prudent and clinically appropriate allocation of resources in the provision of health care services.

Regional Vice President, Quality, Safety & Regulatory Services
The Regional Vice President, Quality, Safety & Regulatory is responsible for the implementation and evaluation of the KFHP UM Program and ensures that KFHP complies with notice requirements which result from a utilization management decision, i.e., all services that require prior authorization. The Regional Vice President with the assistance of the UM Director provides operational and consultative support for UM functions performed by KFHP, KFH and SCPMG across the continuum of care.

V. UTILIZATION MANAGEMENT PROGRAM COMMITTEE STRUCTURE AND ACCOUNTABILITY

KFHP Governing Board
The KFHP Board of Directors promotes, supports and has ultimate accountability, authority and responsibility for a comprehensive and integrated UM program. The Board delegates direct supervision, coordination and oversight of the KFHP UM Program in Southern California to the Southern California Quality Committee (SCQC), sponsored by the KFHP SCAL Regional Health Plan President.

Southern California Quality Committee (SCQC)
The Southern California Quality Committee (SCQC) is responsible to monitor and evaluate the quality and the effectiveness of healthcare services provided to KFHP members across the delivery system in compliance with statutory requirements and accreditation standards. SCQC evaluates the safety and quality of care and services provided to KFHP members and patients in all settings. The Committee recommends policy, identifies strategic opportunities to maintain KFHP as a healthcare leader, and ensures quality priorities are aligned and integrated with key organizational strategic objectives.

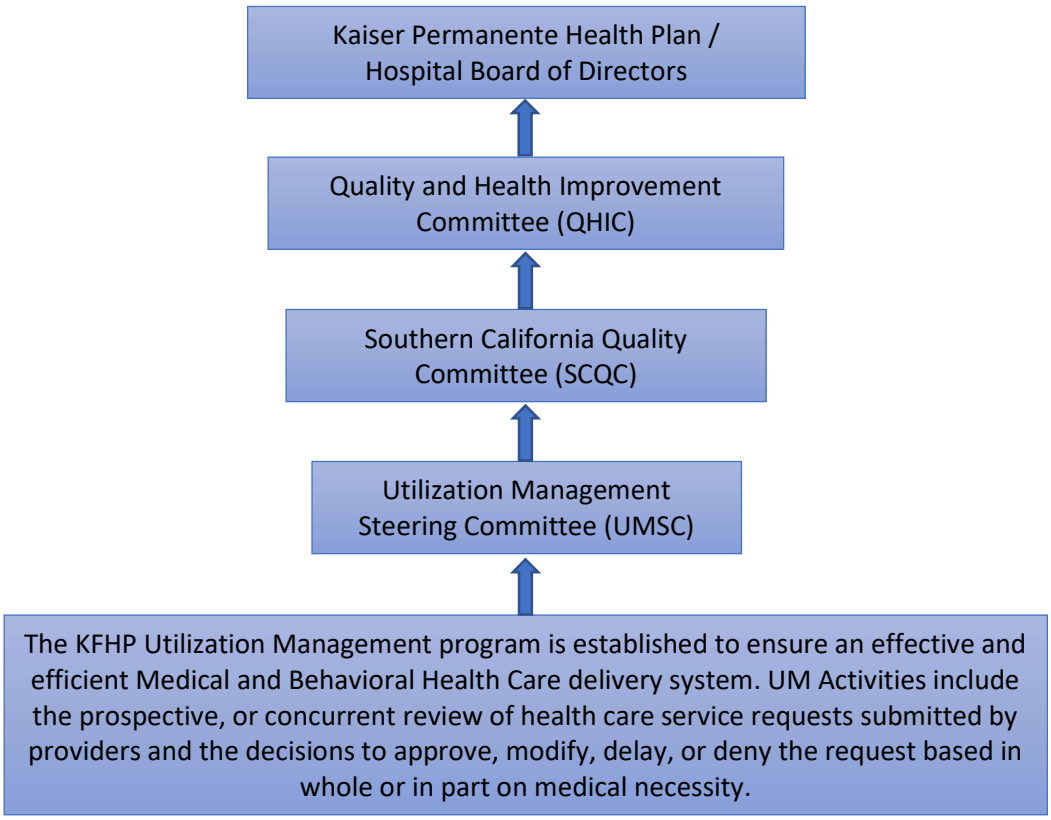
To assist and support its obligations, SCQC has appointed the Utilization Management Steering Committee (UMSC) to ensure the effective oversight of the KFHP UM Program across the continuum of care.

Utilization Management Steering Committee (UMSC)
[REFER TO ADDENDUM 1: UMSC CHARTER]
The Utilization Management Steering Committee (UMSC) is a sub-committee of SCQC that ensures the effective implementation of the UM program across the continuum of care in compliance with statutory requirements and accreditation standards. The committee is chaired by KFHP Health Plan Physician Advisors. The committee members represent a cross-section of KP Leadership to include the SCPMG

Regional Physician Director of Behavioral Health Care Clinical Oversight and Coordination, Health Plan UM, Health Plan Quality Management, Health Plan Membership Services, Enterprise Regulatory Services, SCPMG Physicians and Behavioral Health Care Services.

UMSC oversees utilization management across ambulatory and reviews and resolves operational issues affecting successful UM functions in compliance with statutory requirements and accreditation standards. The Committee establishes UM standards and policy and develops utilization performance targets and goals annually. The Committee makes inquiries and takes action on UM issues as appropriate and recommends UM resource allocation.

Kaiser Foundation Health Plan, Southern California Region
Utilization Management Program Reporting Structure



VI. DECISION MAKING PROCESS FOR PRACTITIONER-REQUESTED SERVICES SUBJECT TO AUTHORIZATION REVIEW

OVERVIEW

KFHP includes, as part of its utilization review function, the prospective or concurrent review, approval, modification, delay or denial of provider requested health care services (based in whole or in part on medical necessity), and shall comply with Section 1367.01 of the Knox-Keene Act. Medical necessity decisions are subject to Health Plan oversight and shall comply with statutory requirements and accreditation standards.

The UM Program plans, monitors, guides and oversees prior authorization of selected services. SCPMG Area Assistant Medical Directors (AAMD) and/or Chiefs of Services (COS) are responsible to oversee utilization decisions for out of plan care and requests for external specialty referrals.

UM notices involving a decision to deny or modify a provider-requested service are processed through the

Regional Utilization Compliance (RUC). RUC is staffed with Registered Nurse Consultants, Project Manager, Analysts, and Administrative Support who ensure that UM decisions are made and communicated timely and that notice letters include a clear and concise reason for the denial, UM criteria to support the decision and a clinical explanation to the member. RUC staff provide telephonic consultation and training to Medical Center-based decision- makers and support staff regarding benefit interpretation, coverage decisions, and denial notification requirements.

Utilization review includes the review of the patient's clinical information collected and evaluated from various sources including KP Health Connect, member or authorized representative, treating practitioners, specialists. Information collected includes:

- Office and hospital records
- History of the presenting problem and clinical exam
- Diagnostic testing results
- Treatment plans and progress notes
- Psychosocial history
- Consults and evaluations from other health care practitioners, including photographs, operative, and pathological reports
- UM medical necessity criteria related to the request
- Information regarding benefits

The review considers individual patient needs and the characteristics of the local delivery system. Based on patient circumstances, applicable UM criteria may be modified to a given instance. The relevant circumstances, described below, are discussed with the physician/practitioner reviewer and requesting physician in order to render an appropriate decision:

- Age
- Comorbidities
- Complications
- Home environment, as appropriate
- Progress toward accomplishing treatment goals
- Family support
- Psychosocial situation and needs
- Benefit structure including coverage for post-acute or home care when needed
- Delivery system capabilities and limitations such as availability of behavioral health care services, skilled nursing facilities, sub-acute care facilities or home care in the service area that supports the patient after discharge
- Local hospitals' ability to provide all recommended services within the estimated length of stay

At Kaiser Permanente, physicians and health care professionals determine whether a service or treatment is clinically appropriate. Care is determined by the treating clinician based on their judgment of clinical appropriateness and not by Health Plan Utilization Management (UM) criteria. The Health Plan does not require prior authorization once members are referred to a service, except for the services listed below.

Practitioner-requested services that require prior and/or concurrent authorization include:
[*REFER TO ADDENDUM 2: REQUESTED SERVICES THAT REQUIRE PRIOR AUTHORIZATION]*

- Acupuncture Services
- Behavioral Health Treatment/Applied Behavioral Analysis (for re-authorization request only)
- Community Based Adult Services (CBAS) Services

- Dental Anesthesia
- Durable Medical Equipment (DME)/Prosthetics and Orthotics (P&O)/Soft Goods
- Home Health Continuous Shift Care and Home Health Shift Care/Private Duty Nursing for Medi-Cal Children (EPSDT)
- External (Out-of-Plan) Referrals
    - Specialty Services
    - Occupational and Physical Therapy Services
    - Speech and Language Therapy Services
- Home Venipuncture
- Plastic Surgery Consultation for Breast Reduction Mammoplasty
- Plastic Surgery Consultation for Panniculectomy
- Spinal Cord Stimulators for the Management of Chronic Pain

UM Decisions

Prior Authorization – Review and Decision

When prior authorization (PA) is required, any practitioner request for a PA listed service must be reviewed and approved by the Plan prior to care being rendered. When the practitioner requested service (either pre-service or concurrent to care) is received (in whole or in part), a trained non-clinical staff or professional licensed staff such as a licensed nurse, rehabilitation therapist, LCSW, and/or substance abuse counselor will screen and approve medical necessity UM requests using approved criteria, guidelines, or other screening tools approved by KFHP. If the service cannot be authorized after application of criteria, guidelines, and other screening tools, the case will be sent to a physician for secondary review. Prior authorization is performed utilizing UM criteria which is developed in accordance with statutory requirements and accreditation standards, and consistent with professional standards of care. Prior authorization reviews are processed according to the urgency of the request.

VII. UTILIZATION MANAGEMENT DECISION TIMEFRAMES

[REFER TO RUM POLICY #16: Utilization Management Denial of Practitioner Requested Services

Decisions to approve, modify, or deny a requested health care service are based on medical necessity and urgency of the request, and are appropriate for the nature of the member's condition.

When the member faces an imminent and serious threat to his or her health, including, but not limited to, potential loss of life, limb, or other major bodily function, decisions to approve, modify or deny requests from provider, shall be made in a timely fashion appropriate for the nature of the member's condition, not to exceed 72 hours after the Plan's receipt of the information reasonably necessary and requested by the Plan to make a determination [Section 1367.01(h) of the Knox-Keene Act].

VIII. UTILIZATION REVIEW CRITERIA

UM Criteria

UM Criteria are used to guide medical necessity decisions to approve, delay, deny or modify practitioner treatment requests subject to utilization review. UM criteria are developed in accordance with Section 1363.5 of the Knox Keene Act and the KFHP UM Workflow process *[REFER TO RUM POLICY #29: HEALTH PLAN REVIEW OF UM PROCESSES*]

KFHP UM criteria are:

- developed with involvement from actively practicing health care providers;
- consistent with sound clinical principles and processes;
- evaluated, and updated if necessary, at least annually;
- When used as the basis of a decision to modify, delay, or deny services in a specified

case under review, are disclosed to the provider and the enrollee in that specified case;
- available to the public upon request.

UM Criteria sets include, but are not limited to:

- Acupuncture Services
- Behavioral Health Treatment
- Dental Anesthesia
- Durable Medical Equipment (DME)/Prosthetics and Orthotics (P&O)/Soft Goods
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Supplemental Shift Nursing Services
- Home Venipuncture
- Occupational and Physical Therapy Services
- Plastic Surgery Consultation for Breast Reduction Mammoplasty
- Plastic Surgery Consultation for Panniculectomy
- Speech and Language Therapy Services
- Spinal Cord Stimulators for the Management of Chronic Pain

KFHP also utilizes commercial criteria sets published by Change Healthcare, American Association of Community Psychiatrists (AACP), American Academy of Child and Adolescent Psychiatry (AACAP), and benefit coverage criteria published by government programs such as Medicare and Medi-Cal to include:

- InterQual® Criteria: Procedures, Imaging, Specialty Referral, Level of care (adult, pediatric), Procedures
- Level of Care Utilization System (LOCUS): Adult Psychiatry
- Child and Adolescent Level of Care Utilization System (CALOCUS)-Child and Adolescent Service Intensity Instrument (CASII) and Early Childhood Service Intensity Instrument (ECSII): Child and Adolescent Psychiatry
- Medicare Coverage Guidelines
- Medi-Cal Coverage Guidelines

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.[1]

At Kaiser Permanente, physicians and health care professionals determine whether a service or treatment is clinically appropriate by using clinical judgment, and where Utilization Review (UR) is required, using the following criteria and guidelines:

[1] Specialty Mental Health Services for Medi-Cal members are available through County Mental Health Plans (MHPs). (APL 22-006) Most alcohol and substance use disorder treatment services for Medi-Cal members are available through the county department responsible for substance use treatment. (APL 21-014)

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-2 Guidelines, as developed by the National Autism Center
Transgender	World Professional Association for Transgender Health (WPATH) Standards of Care

The Plan regularly looks at professional organizations for the purpose of evaluating new guidelines and criteria for the treatment of mental health and substance use disorders. These professional organizations include but are not limited to the various nonprofit professional associations that have developed the currently utilized SB 855 criteria and guidelines listed in APL 21-002. This evaluation process involves frequent collaboration between the Plan and the Medical Groups, including discussion and meetings among the regional mental health administrations, and the chiefs and directors of mental health.

Inter-Rater Reliability
[REFER TO REGIONAL UTILIZATION MANAGEMENT POLICY AND PROCEDURE 8: CONSISTENCY IN UTILIZATION REVIEW CRITERIA / GUIDELINE APPLICATION (INTER-RATER RELIABILITY)]
An Inter-Rater Reliability (IRR) process is deployed to evaluate and ensure that UM criteria are applied consistently for UM decision-making. Annually, both physicians and licensed staff involved with making UM decisions participate in the IRR process.

IX. WRITTEN NOTICES OF UM DECISIONS

When a physician requests a health care service that is subject to prior authorization and the request has been reviewed, denied, delayed, or modified as a result of UM review, the member and provider are provided a written communication that includes the following required elements:

- A clear and concise explanation of the reasons for the Plan's decision;
- A description of the utilization review criteria used, and the clinical reasons for the decision regarding medical necessity;
- Information as to how the member may file a grievance or appeal with the Plan and, in case of Medi-Cal members, information and explanation on how to request an administrative hearing in compliance with Title 22 of the California Code of Regulations;
- Notice of availability of language assistance services;
- Written notice to physicians or other health care providers of a denial, delay, or modification of a request, including the name and telephone number of the health care professional responsible for the decision. The telephone number is a direct number or an extension that allows the physician or health care provider easy access to the professional responsible for the UM decision. UM staff and physicians are available during normal business hours to assist members and physicians with UM concerns;

- Written Notice to the physician and member includes information on Independent Medical Review[1].

Denial notices are issued in accordance with applicable regulations and accreditation standards. The HPPA, Regional UM and Enterprise Regulatory Services Department (ERS) provide direction to and oversight of the process of issuing written notification of non-coverage to KFHP members.

X. DISCLOSURES OF UTILIZATION MANAGEMENT PROGRAM AND CRITERIA

KFHP is responsible to ensure compliance with statutory UM Program disclosure requirements in accordance with Section 1363.5(a) of the Knox Keene Act, and any other statutory requirements and accreditation standards.

The disclosure to regulators and to network providers references the process used to authorize, modify, delay or deny health care services under the benefits provided by the Plan. KFHP includes on its internet website, a summary describing the process by which the Plan reviews and authorizes or approves, modifies, or denies requests for health care services. Enrollees and members of the public may receive a copy of UM Criteria upon verbal or written request to the Member Services Call Center.

[1]Section 1374.30(i) of the Knox Keene Act: No later than January 1, 2001, every health care service plan shall prominently display in every plan member handbook or relevant informational brochure, in every plan contract, on enrollee evidence of coverage forms, on copies of plan procedures for resolving grievances, on letter of denials issued by either the plan or its contracting organization, on grievance forms (Section 1368), and on all written responses to grievances, information concerning the right of an enrollee to request an independent medical review in cases where the enrollee believes that healthcare services have been improperly denied, modified, or delayed by the plan or by one of its contracting providers

The criteria or guidelines used by the Plan, or any entities with which KFHP contracts, that include utilization review to determine whether to authorize, modify, or deny health care services, are disclosed to the provider and the member as appropriate. The criteria/guidelines are available to the public upon request at no cost. The disclosure is accompanied by the following notice:

> *"The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."* [Section 1363.5(c) of the Knox Keene Act]

XI. GRIEVANCE AND APPEALS PROCESSES

Notice of Right to Appeal a UM Decision

When a member receives notice that a provider requested service has been denied or modified through the plan's utilization review process, the member has a right to appeal and is given information on the process to appeal the UM decision through Member Relations. 6.2.1.11.1 [Commercial] 6.2.1.11.2 [Medi-Cal], 6.2.1.11.3 [Federal Employee Health Benefit], 6.2.1.5 [Medicare Part C] and 6.2.1.5 [Health Plan Redetermination].

Appeal Decision Process

If a member, a member's authorized representative, or a provider on the member's behalf disagrees with a UM decision, they may appeal the denial through the Health Plan's appeal process, reviewed by the Joint Regional Appeals Committee (JRAC) or Expedited Review Committee. Practitioners may also request a discussion with the UM physician reviewer regarding the denial determination on behalf of the member. Advisors to the JRAC include

legal counsel, the HPPA and other physicians, in addition to other clinical representatives competent to evaluate the specific clinical issues presented in the request for review. Other representatives include staff from National Benefit Administration and Member Relations. The JRAC is chaired by the Regional Member Relations Grievance Operations Director and is staffed by Regional Grievance Operations Health Plan representatives. Appeals are reviewed, resolved and communicated within applicable statutory and regulatory timeframes and notice requirements**.**

Expedited Review and Expedited Appeals

All KFHP members have the right to ask for an expedited decision on pre-service or concurrent requests for health care services and supplies, and/or expedited review of decisions to terminate health care services. When the case involves an imminent and serious threat to the health of a member, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function, or a member's life, physical or mental health, or ability to regain maximum function could be jeopardized using standard utilization or appeal review time frames, or when a provider familiar with the member's clinical situation states that the need for review is urgent, the appeal is expedited.*6.2.2 [California Statewide Non-Medicare P&Ps], 6.1.6.1 [Medicare Part C Grievance and Appeals P&Ps], 6.1.7 [Medicare Part D Grievance and Appeals P&P*

Independent Medical Review

Commercial and Medi-Cal members can request independent medical review (IMR) whenever health care services have been denied, modified, or delayed by the plan, or by one of the contracting providers, if the decision was based in whole or in part on a finding that the proposed health care services are not medically necessary. The DMHC administers the IMR program in the State of California at no cost to the member in compliance with applicable statutory requirements and accreditation standards. The IMR decision is binding on KFHP.

Medicare Appeals (Part B/C)

Medicare Advantage member grievances and appeals (reconsideration) are processed according to the requirements established by the Centers for Medicare and Medicaid Services (CMS). As part of these requirements, when KFHP affirms in whole or in part its adverse initial determination at the appeal level, or does not provide a resolution within the required timeframe, the Health Plan must auto-forward the disputed health care service/supply/drug for a mandatory review by CMS' designated independent review entity (IRE), MAXIMUS Federal Services, Inc. The IRE decision is binding on KFHP.

All KFHP members have the right to ask for an expedited decision on pre-service or concurrent requests for health care services and supplies, and/or expedited review of decisions to terminate health care services. When the case involves an imminent and serious threat to the health of a member, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function, or a member's life, physical or mental health, or ability to regain maximum function could be jeopardized using standard utilization or appeal review time frames, or when a provider familiar with the member's clinical situation states that the need for review is urgent, the appeal is expedited.

[REFER TO KFHP MEMBER SERVICES [CALIFORNIA STATEWIDE] POLICY AND PROCEDURES: 50-8 URGENT COMMERCIAL; 50-7 URGENT FEHBP; 50-7CSI URGENT CSI; 50-7SF URGENT SELF- FUNDING; 50-2C MEDICARE; 50-2D MEDICARE]

XII. DELEGATION OF UTILIZATION MANAGEMENT FUNCTIONS

KFHP has the discretion to delegate, and the responsibility to oversee, UM functions performed by either SCPMG or KFH in support of the KFHP UM goals and objectives. KFHP, through the Quality Assurance Program Agreement (QAPA) delineates the respective roles, responsibilities and oversight among KFHP, SCPMG, and KFH that support the UM Program. KFHP also has discretion to delegate responsibility, in whole or in part, for UM to contracted affiliated providers. KFHP retains accountability for all delegated Utilization Management activities conducted for members and ensures that delegated UM processes are designed to meet member service and access needs.

UM Delegation to Affiliated Providers

When UM activities are delegated to contract affiliated providers, KFHP, through the SCQC, retains responsibility and oversight of the delegated functions. The delegation is subject to an executed delegation agreement in which UM activities are clearly defined, including:

- Reporting requirements for the delegated entity;
- Reporting requirements for KFHP to the delegated entity;
- Evaluation process of the delegated entity's responsibilities;
- KFHP Approval of the delegated entity's UM program and processes;
- Mechanisms for evaluating the delegated entity's program reports;
- The delegated entity's ability to collect performance data necessary to assess member experience and clinical experience, as applicable;
- KFHP right to revoke and terminate a delegation agreement.

KFHP performs a pre-delegation assessment to ensure the ability and capacity of the delegated entity to perform the UM functions. Based on the pre-delegation assessment and demonstrated ability and capacity to perform certain UM functions, SCQC approves and recommends delegation of UM activities. The final letter of agreement that includes the delegation matrix and the delegation agreement will stipulate specific UM functions as delegated or retained by KFHP.

On an annual basis, KFHP performs a comprehensive assessment of the delegated UM activities to include a UM file review. The entity's annual evaluation of delegated UM functions and assessment summaries of activities are presented to UMSC for review and approval.

Should there be any concerns regarding failure of a delegated entity to carry out delegated activities, the SCQC will determine corrective action plans up to and including revocation of the delegated activities. All submitted corrective action plans are monitored by the UMSC and evaluated until KFHP determines that full correction action has been implemented.

XIII. RESOURCE STEWARDSHIP AND CARE COORDINATION ACTIVITIES

Resource Stewardship and Care Coordination activities focus on the prudent and clinically appropriate utilization and allocation of resources for the provision of health care services. These activities are not subject to direct regulation under the Knox-Keene Act. The appropriateness committee reports are presented to the Utilization Management Steering Committee. The UM Program monitors and provides oversight of coordinated performance related to Utilization/Resource Management across the continuum to include:

- Medication Treatment Appropriateness Committee (MedTAC)
- Laboratory Test Appropriateness Committee (LabTAC)
- Product Utilization Action Team (PUAT)
- Imaging Appropriateness Committee (iMAGAC)
- Molecular Pathology Action Team (MPAT)

Inpatient Quality Management/Care Without Delay

Prior and/or concurrent authorization is not required for services provided in KFH acute medical care hospitals, KFH acute psychiatric care hospitals[2], or in Plan post-acute care services. The KFHP UM Program has established a patient-centered quality function in these facilities for real time intervention to ensure the timely provision of

[2] As indicated in footnote 1 above, Specialty Mental Health Services and most alcohol and substance use disorder treatment services for Medi-Cal members are available through the county MHPs and alcohol and substance use disorder programs.

appropriate Medical and Behavioral Health Care and optimized communication and collaboration amongst the health care team. The core principles of the Care Without Delay model of care include:

- Timeliness of Care (providing the right care at the right time in the right place)
- Real time Peer Review for appropriateness of care
- Real-time escalation
- Communication and Collaboration
- Long View of Care

Management of At-Risk Populations Care/Case Management Programs

KFHP provides Care/Case management programs for coordination of health care and continuity of care across the continuum. These programs are accessible to all members and are typically utilized by members with poorly controlled and/or complex conditions. These programs promote high-quality, cost-effective care and services for members through the proactive provision of services to include care coordination, targeted education, and resource management. Care/Case Management Programs available to KP members include:

Complete Care Management Program*:* A planned and proactive, systems-oriented, and evidence-based approach to health care delivery. It seeks to optimize the member's quality of life across the continuum of health risk by promoting wellness, reducing risk factors, managing chronic conditions, and supporting needs at the end of life.

Case Management services provided through the Behavioral Health Department: There is no prior authorization required for Behavioral Health Services, including Neuropsychological/Psychologic testing, Transcranial Magnetic Stimulation (TMS), office-based Opioid treatment, Electroconvulsive Therapy (ECT), and Transgender services. Case Management services are available to all members with serious and persistent mental health conditions that interfere with their ability to participate in life roles. Typically, patients that benefit from case management are those with a history of frequent psychiatric hospitalizations, diagnosed with addiction diagnoses, and non- adherence to medication/psychiatric follow up.

Complex Case Management: Deployment of strategies to coordinate services for members with poorly controlled or complex conditions to include:

- Southern California Transplant HUB provides case management and care coordination for transplant referrals. Transplant coordinators, in collaboration with specialty physicians and multidisciplinary team members, coordinate the care of the member pre- intra- and post-transplant.
- End Stage Renal Disease (ESRD) Care Management Program is a coordinated team approach to manage the complex needs of Chronic Kidney Disease (CKD) and End Stage Renal Disease (ESRD) patients. The Program provides a systematic approach of proactive and preventive care focused on improved health outcomes.
- Medicare Special Needs Program (SNP) coordinates and helps guide the clinical care management of Medicare members in the SNP program who are frail or high risk for hospitalization.
- Managed Care Medi-Cal provides services to a variety of Medi-Cal members administered by the Medi-Cal Managed Care contracts in the counties of Los Angeles, Orange, San Bernardino, Riverside and San Diego. In order to comply with the various contractual requirements associated with managing the special needs of this population, additional services/coordination may be provided within Plan and out of Plan to ensure that these members receive the services required per the contract and benefit agreements.

- The 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. Patient decisions are based on the fullest understanding of information in the context of a patient's values and preferences.
- Chemical Dependency Recovery Program provides case management, by an interdisciplinary health care team, to members admitted into KP Chemical Dependency programs, which include detoxification, day treatment, crisis residential (TRRS) and outpatient services. The appropriate need for Chemical Dependency Services is determined by SCPMG physicians certified by the American Society of Addiction Medicine (ASAM), who possess a Certificate of Added Qualification (CAQ) in Psychiatry, or have appropriate experience as verified by the Chief of Service (COS), or in their absence, by the Medical Center Area Medical Director or designee.

Out of Plan Resource Management

Emergency Services and Hospital Admissions Out of Plan Screening and Stabilization

KFHP does not require prior authorization for emergency services. Post- service claims review (for out of plan emergency care) considers whether the member reasonably believed they had an emergency medical condition requiring care at the Emergency Department.

Emergency Prospective Review Program (EPRP)

The Emergency Prospective Review Program concurrently tracks and assists in managing the care of KFHP members in non-Plan Emergency Departments. EPRP is staffed 24/7/365 by practicing SCPMG Emergentologists and experienced qualified nurses. EPRP makes post- stabilization care authorization decisions on behalf of KFHP prior to a member's in-patient admission to an outside facility. EPRP arranges ambulance transportation for members who transfer to a KFHP-designated facility as appropriate.

For necessary post-stabilization, medical care received out of network where the Plan fails to approve or disapprove a request for authorization within the federal or state mandated timeframe, the necessary post stabilization medical care shall be deemed authorized.

Post-stabilization

KFHP requires review and authorization for all out of plan post- stabilization care and follows all statutory requirements and accreditation standards in making post- stabilization care authorization decisions.

Outside Utilization Resource Service (OURS)

[REFER TO REGIONAL UTILIZATION MANAGEMENT POLICY AND PROCEDURE 17, OUTSIDE UTILIZATION MANAGEMENT PROCESSES]

OURS is a centralized program that oversees the utilization of services and coordinates the care for KFHP members receiving inpatient or other relevant health care services out of network. OURS is staffed 24/7/365 by qualified nurses with real-time access to dedicated physician advisors. OURS responsibilities include, but are not limited to:

- Post Stabilization Acute Inpatient Medical Care in Non KFH Facilities
- Conducting concurrent reviews for on-going acute hospitalization of members in out of Plan facilities;
- Conducting a review of member care, provided by an outside facility prior to request for authorization from the Plan, for medical necessity;
- Responding to provider requests for inpatient post-stabilization authorizations within the required regulatory timeframes;
- Ensuring that the form and content of all such authorization responses are consistent

with statutory requirements and accreditation standards;
- Offering and arranging stable member transfer to a KFHP-designated facility when continued acute care is still required and transfer is not medically contraindicated.

Second Opinions
Members have a right to a second opinion by a qualified medical professional. An Out of Plan request for second opinion is reviewed to determine whether Kaiser Permanente has appropriately qualified medical professionals with knowledge and expertise in the member's condition who can evaluate the member and provide a second opinion. If so, the member is re-directed in Plan to obtain a second opinion. When an appropriate, qualified physician is not available in Plan, the referral is authorized.

Affiliated Intensivist Network (AIN)
AIN is a program available to both EPRP and OURS to facilitate the care of KFHP members in out of Plan community hospitals. The program uses the services of non SCPMG physicians who are on staff at various community hospitals to manage the care of KFHP members receiving services in those facilities.

AIN services are provided through contracts with vendors who, in turn, contract with physicians on staff at community hospitals in Southern California. An AIN "hospitalist" is officially dispatched primarily by EPRP communicating directly with the call center of the specific vendor. The call center of each vendor is active 24/7.

Organ Transplantation
SCPMG physicians may refer members for Organ Transplantation Evaluation for heart, lung, heart/lung, liver, small bowel, simultaneous kidney pancreas, pancreas alone and blood/marrow (stem cell) transplantation. Members are referred to contracted Centers of Excellence (COE) within Kaiser Permanente's National Transplant Network (NTN). Referrals outside of the NTN are facilitated through an exemption process. The referring specialist may discuss the member's case in an organ specific case conference. The referring specialist and/or other specialists participating in the case conference review the case and determine whether the member is a potential candidate for organ transplant. Once the referring specialist and other relevant specialists have collected and received all the necessary information to facilitate a referral to the Transplant Center of Excellence (COE), the referring physician and patient are notified. At this point, a referral to the appropriate transplant COE is arranged. The COE performs a transplant evaluation and makes the final determination as to whether the member is a suitable candidate for transplantation. The COE notifies the referring physician and/or the member of their decision. If the Member disagrees with the recommended treatment plan, the member may request a second medical opinion and/or may file a grievance with the Health Plan.

Behavioral Health Care (BHC) Clinical Oversight and Coordination
BHC facility-based services do not require health plan prior authorization; however, these services are periodically reviewed for care coordination purposes. The reviews and discussions do not aim to limit days, number of sessions, nor deny services. These reviews focus on the assessment of the patient's presenting problems and current concerns, with the goal of creating a treatment plan addressing those needs. The reviews include benefit coverage discussion and evaluation of clinical issues to assist with the transition of care from one level of care to another. The BHC team uses guidelines from third party, nonprofit professional associations to assist in the provision of BHC services.[3]

[3] As indicated in footnote 1 above, Specialty Mental Health Services and most alcohol and substance use disorder treatment

The program supports the overall KFHP UM program in tracking and managing the coordination of services between medical and mental health services at the appropriate level of care. BHC Clinical Oversight and Coordination provides clinical oversight and care coordination of Kaiser members 7 days per week and is staffed by Registered Nurses (RN) and Licensed Clinical Social Workers (LCSW) who have experience with inpatient psychiatric work. The staff perform periodic clinical reviews, case conferences, or consultations with SCPMG Psychiatrists and treating practitioners to facilitate treatment planning and coordination of care.

Standing Referrals

Within KP's integrated care delivery system, the health plan does not require Primary Care Physicians (PCP) to obtain an authorization to refer a member to a PMG specialist. Furthermore, specialists within the PMGs are not required to seek authorization from the health plan regarding how often or how many times the specialists may see the member. Rather, the PMG specialists determine how to treat the member based on their professional judgment and consultation with the member. In those situations where a member is referred to a non-PMG provider, the referral is made pursuant to a medical necessity determination as approved by KP in consultation with the referring Kaiser physician, the external specialists, and the member.

Completion of Covered Services/Continuity of Care

KFHP, at the request of a member, provides for the completion of covered services by a terminated provider or by a nonparticipating provider. The completion of the covered service shall be provided by a terminated provider to a member who, at the time of the contract's termination, was receiving services to include:

- Acute Condition
- Chronic Condition
- Pregnancy
- Terminal Illness
- Care of a Newborn (between birth and 36 months of age)
- Performance of a surgery or other procedure authorized by the plan as part of a course of treatment
- Mental Health Acute Condition
- Mental Health Serious Chronic Condition

The plan may require a non-participating provider, whose services are continued, to agree in writing to the same contractual terms and conditions that are imposed upon providers under current contract.

XIV. CONFIDENTIALITY STATEMENT

Health Insurance Portability and Accountability Act (HIPAA)

KFHP complies with all applicable HIPAA requirements supported by HIPAA compliance policies. All HIPAA related policies are accessible to UM Physicians and staff on the Kaiser Permanente Intranet compliance site. Ongoing mandatory education is required for all staff.

Confidentiality

To ensure member and practitioner information is held in strict confidence, to safeguard the information received, and to protect against defacement, tampering or use by unauthorized persons or for unauthorized purposes, all member specific information, documents, reports, committee minutes and proceedings are protected from inadvertent release and discovery. All staff members sign a confidentiality statement as a condition of employment. All documentation and information received are confidential and

services for Medi-Cal members are available through the county MHPs and alcohol and substance use disorder programs.

distributed only on a need-to- know basis.

To assure that patient and provider confidentiality is protected, the Regional Utilization Compliance Department maintains all copies of UM related data and documents in a strict confidential manner. Access to this information is restricted to a need-to-know basis. The proceedings and records of the continuous review of the quality of care, performance of medical personnel, utilization of services and facilities and costs are subject to confidential treatment under Health and Safety Code 1370 and Section 1157 of the California Evidence Code.

XV. UTILIZATION MANAGEMENT PROGRAM INTEGRATION WITH KAISER FOUNDATION HEALTH PLAN QUALITY MANAGEMENT PROGRAM

The UM Program is an integral part of the KFHP Quality Management Program and incorporates quality, risk and safety processes and initiatives into prospective, concurrent review. Identification of quality, safety and risk incidents, patterns and trends through UM clinical review are escalated to the appropriate quality department in a timely manner. Results of monitoring and analysis of utilization of care and services, including over- and under-utilization trends, are integrated into the KFHP Quality Program through reports to the Program's Quality Committees. Activities related to the KFHP UM Program are reported to SCQC.

Utilization reports that display metrics across regional, service area, and medical center level performance are collected and analyzed to identify improvement opportunities, ensure consistency, and decrease variation in practice and care delivery. UM reports include:

- Coordination of Care
- UM Decision Notification Timeliness and Content
- Evaluation of Member Experience with the UM Program
- Evaluation of Provider Experience with the UM Program
- Selected Health Plan Effectiveness Data and Information Sets (HEDIS)
- Use of Service measures, including Behavioral Health Utilization
- UM Grievances and Appeals/Independent Medical Review (IMR)

Over- / Under- Utilization

The Plan monitors numerous aspects of under- and over-utilization and continuously looks for opportunities for improvement. Many of the over- and under-utilization measures are Healthcare Effectiveness Data and Information Set (HEDIS) measures. HEDIS measures are reported annually, however, the Plan monitors, analyzes, and acts on such data continuously. Many, if not most, of the HEDIS measures are measures of overuse or underuse, and they are based on evidence as well as recognized "professional standards of practice," as required by Rule 1300.70.

The National Committee for Quality Assurance (NCQA) provides instructive definitions, as follows:

Overutilization: providing clinical services that are not clearly indicated, or providing services in excessive amounts, or in a higher level of setting than is required.

Underutilization: failure to provide appropriate or indicated services, or provisions of an in adequate quantity or lower level of services than required

The UMSC, a subcommittee of the Southern California Quality Committee (SCQC), 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, including but not limited to, review for potential over- and under-utilization of services. Action Teams or Appropriateness Committees will be required to routinely present

utilization reports to the UMSC. The reports will include metric analysis, as well as action items of potential over- and/or under-utilization of services, to ensure professionally recognized standards of practice are maintained.

KFHP participates in the Consumer Assessment of Health Plan Survey (CAHPS) 5.0 Member Satisfaction Survey and utilizes these results in the assessment of member experience with the UM program. Analysis of grievance and appeal data related to UM is also monitored as a part of the member experience review.

XVI. PROGRAM EVALUATION

The Regional UM Program is evaluated annually by the UMSC to ensure that the program policies comply with statutory requirements and accreditation standards and that the program has demonstrated the achievement of UM goals and objectives to ensure the appropriate, high-quality, cost-effective utilization of Medical and Behavioral Health Care services for all members. The annual evaluation includes an assessment of the Program's utilization processes, committee and leadership structure, practitioner participation, and an overview of findings from UM monitoring activities. Based on the findings, goals are established for the subsequent year to improve the effectiveness of the UM Program.

Kaiser Permanente Southern California
Population Health Management Strategic Program Summary – Effective January 1, 2019

Overview

Kaiser Foundation Health Plan of Southern California's mission is to provide high-quality, accessible, and affordable health care services to improve the health status of the members and the communities we serve. The purpose of this 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 as follows:

- 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 includes 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.

Please refer to **Appendix A for Complete Care Focus Areas p. 17-22**

Healthcare Equity

- **Equity, Inclusion & Diversity**
  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.
- **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.

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.

For our diabetes related programs, the disparity in the LatinX population – as opposed to all other diabetic populations – is of great concern. The Centers for Disease Control and Prevention (CDC) emphasizes that

> "Hispanic/Latino Americans make up a diverse group that includes people of Cuban, Mexican, Puerto Rican, South and Central American, and other Spanish cultures, and all races. Each has its own history and traditions, but all are more likely to have type 2 diabetes (17%) than non-Hispanic whites (8%).
>
> But that 17% is just an average for Hispanic/Latino American groups. The chance of having type 2 diabetes is closely tied to background. For example, if your heritage is Puerto Rican, you're about twice as likely to have type 2 diabetes as someone whose background is South American.
>
> Over their lifetime, US adults overall have a 40% chance of developing type 2 diabetes. But if you're a Hispanic/Latino American adult, your chance is more than 50%, and you're likely to develop it at a younger age. Diabetes complications also hit harder: Hispanics/Latinos have higher rates or kidney failure caused by diabetes as well as diabetes-related vision loss and blindness."[1]

Kaiser Permanente internal data also reflects a disparity in the LatinX populations, especially in the under 65-years-of-age comparison. To address the disparity, an emphasis has been put on language concordance (e.g., hiring clinicians QBS II certified for Spanish and pairing patients with preferred spoken language accordingly), emphasizing disparity on regularly distributed metrics such as A1c control and testing rates, extended hours and/or special weekend clinics to allow for better access.

[1] https://www.cdc.gov/diabetes/library/features/hispanic-diabetes.html

Our hypertension programs identified a disparity between African Americans and all other patient populations. According to the U.S. Department of Health and Human Services Office of Minority Health

- In 2018, African Americans were 30 percent more likely to die from heart disease than non-Hispanic whites.
- Although African American adults are 40 percent more likely to have high blood pressure, they are less likely than non-Hispanic whites to have their blood pressure under control.

To address this disparity, we create culturally sensitive outreach and prioritize outreach efforts to the African American population. Utilizing the California Healthy Places Index (HPI), hotspot reports are available to identify zip codes related to the social determinants of health in historically under-served African American and Hispanic/Latino communities.

Outreach efforts include letters with their provider's pictures, outreach from African American providers, and automated outreach. Community access is increased with blood pressure checks in KP Target clinics, intermittent weekend health fairs, and remote patient monitoring is available for eligible patients to securely send health data electronically to their health care providers. Our Center for Healthy Living (CHL) offers an African American Blood Pressure Class, aiming for cultural concordance and featuring African American instructors, imagery, and historical context.

Patient Centered Medical Home

The Patient Centered Medical Home (PCMH) is the fundamental model-of-care that supports PHM program activities across all health care settings and all lines of business (Commercial, Exchange, Medicare, and Medicaid). PCMH focuses on providing personalized, comprehensive, and evidence-based medical care using a physician-led team of professionals. PCMH promotes cohesive coordinated care by integrating 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.

The PCMH model at KPSC requires health care team members to work together to assess patient needs, develop an appropriate plan of care and coordinate services for the patient. Appropriate care coordination depends in large measure on the complexity of needs of each individual patient or population of patients. Factors that increase complexity of care include multiple chronic conditions, acute physical health problems, the social vulnerability of the patient, and many practitioners involved in the patient's care. The medical home team or health care team (HCT), which may consist of nurses, pharmacists, nurse practitioners, physicians, physician assistants, medical assistants, educators, behavioral health therapists, social workers, case managers, and others, are supported in delivering care through the medical home by use of an integrated electronic medical record (EMR), KP HealthConnect (KPHC), where

all HCT members can document information about a patient. HCT members may also use KPHC to send secure messages to each other to coordinate care and proactively identify outreach and in-reach opportunities to provide case management, disease management, and prevention activities.

As part of the PCMH model, practitioners 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. Currently, 107 of KPSC medical offices are NCQA PCMH recognized and manage the health care needs of over 90 percent of the membership in the Commercial, Exchange, and Medicare lines of business.

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 either method of patient/clinician interaction.

Complete Care: Diabetes Disease Management

Offered to diabetic members ages 18 through 74 whose A1c is above goal (usually A1c > 8%).

This interactive program consists of scheduled appointments – usually virtual – with a RN, Pharm D, or Advance Practice provider depending on severity and/or co-morbidities. These clinicians are referred to as a Care Manager. Depending on patient needs, classroom education, wellness coaches, dieticians, or other services may be offered to the patient as part of this program. These licensed Case/Care Managers work within their scope of practice or under protocol to assist in medication, lifestyle, and other aspects of disease management. They are also able to communicate and stage orders for the patient's PCP as needed. Patients also have the option of sending a secure message via kp.org to their Care Management team (Care Manager and support coordinators).

Patients may opt out of the program at any interaction point – telephone or secure message – with any member of the care team.

Patients that also have heart failure may be enrolled under a single Care Manager who will facilitate care for both programs in a single visit.

Complete Care: Heart Failure Transition Program

Offered to members 18 and older with an ejection fraction less than or equal to 40%, or, those who have had hospitalization with primary discharge diagnosis of heart failure in the past 12 months.

This interactive program uses evidence-based learning to improve clinical quality, reduce hospital days/readmission rate, and improve patient quality of life. It consists of inpatient education; a 3-day post-discharge follow-up call; and one or more care management appointments – usually virtual – with a RN, Pharm D, or Advance Practice provider depending on severity and/or co-morbidities. Depending on patient needs, classroom education, wellness coaches, dieticians, or other services may be offered to the patient as part of this program. These licensed Case/Care Managers work within their scope of practice or under protocol to assist in medication, lifestyle, and other aspects of disease management. They are also able to communicate and stage orders for the patient's PCP or Cardiologist as needed. Patients also have the option of sending a secure message via kp.org to their Care Management team (Care Manager and support coordinators).

Patients may opt out of the program at any interaction point – telephone or secure message – with any member of the care team.

Patients that also have diabetes may be enrolled under a single Care Manager who will facilitate care for both programs in a single visit.

Complete Care: Post Hospital Discharge Follow-Up

High risk members discharged with a LACE 11-19 are automatically identified for transitional-care interactive-interventions through decision support built into the electronic medical record. (The LACE score is auto calculated and presented in the EMR for the ward clerks to see and schedule the post hospital appointments.) There is a call in three-days after discharge where a clinician asks a series of questions regarding recovery and will either address any concerns if within scope or escalate to a higher level of care if needed. 7 days after discharge is a visit – which may be virtual – for med reconciliation with a PharmD, APP, or physician. If further care is needed, the clinician may offer additional appointments, health education, wellness coaching, or the like.

Patients may opt out of the program at any interaction point.

Complete Care: SureNet for Gross Hematuria

One of the outpatient SureNet team programs is for Gross Hematuria. All patients who are 50 years and older, with a diagnosis of Gross Hematuria, and who have not had a follow up assessment and diagnostic testing within the last 18 months qualify for the program. (Excludes patients with a dx of Pyelonephritis within 7 days of gross heaturia dx, or an already existing follow up appointment with Urology.)

This interactive program consists of a phone call from an LVN to all in this population (with follow up letters for those unable to be contacted). The LVN utilizes a script to explain the Gross Hematuria diagnosis. Additionally, a questionnaire is administered to determine the need for follow up, along with orders for a CT urogram, cystoscopy, and referral to Urology, to aid with the detection of bladder cancer.

The patient may opt out of the program during the initial call or anytime thereafter by calling member services. However, due to the life-threatening nature, the patient's PCP may decide to contact them outside of the program parameters for follow up.

Support Activities for Complete Care Programs

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. This impacts all care settings. 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 PCP 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 PCP. 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 Office Encounter is also available in virtual visits with recommended instructions/workflows on how patients can proceed to close their gaps in care. Some care gaps were initially deferred during the COVID-19 initial surge to avoid the unnecessary risk of exposing patients. However, a coordinated effort to increase COVID-19-related safety measures and monitor COVID-19 numbers allowed processes to be reinstituted once safe on a location-by-location basis.

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 PCP'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 in to 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 PCP's In Basket to facilitate the appropriate intervention.

Regional Outreach is an infrastructure for centrally coordinated, actionable, and standardized outbound mass communications to members to improve clinical quality and outcomes. Outreach modalities include letters, digital notifications through kp.org, automated telephone outreach, and text messages. The team builds and maintains outreach projects that support the function of Complete Care:

- Clinical Information and 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.

Member Communication

Sharing Available Program Information with Members. KPSC provides its members with a comprehensive website - kp.org - that contains all the necessary information about the programs available to help live a healthy life, manage chronic conditions, and access classes. Most of these programs do not require a referral from the patient's physician or care team. Members can also pick up informational flyers with details about these classes and resources while at the clinic. KPHC has a resource library that care team members can access for managing various conditions. Additionally, most programs reach out to members who qualify for services via phone, secure electronic messages on kp.org, standard mail, or text messages.

Program Availability

KPSC members are informed about programs for which they may be eligible through multiple avenues including the following:

- New member and open enrollment material
- Routine member newsletter and/or annual notification
- Kp.org website
- Practitioner referral
- Prompts in the electronic medical record, which alert front-line support staff to stage referrals to the Center for Healthy Living
- Discharge planner at facilities
- Online communication with practitioner or ancillary department
- In-person encounters with health care team, telephonic, or video practitioner visits
- Written correspondence: Outreach letters, emails, and telephone text messages to members due for preventive services or identified care gaps, i.e., members due for colorectal screenings, immunizations, mammography, diabetes testing, etc.
- Robocalls carried out through telephonic communication

Patients who fall into various populations are picked up by our Complete Care Support Programs Population Engine for contact by our Regional Outreach team. Letters specific to chronic conditions like diabetes or asthma management, how to prevent Kidney Stones reoccurrence, and how to perform an Epley Maneuver at home to relieve the symptoms of vertigo are a few examples of outside-of-the-traditional-preventive-care communications provided. Patients who do not wish to receive a particular contact or any contact from our organization can “Opt-Out” by notifying their panel manager or their local member services department.

Interactive Patient Notification and Opt-Out for Eligible Members

Members who are eligible for the Complete Care programs are Commercial, Exchange, Medicare, and Medicaid members who meet the inclusion criteria for any disease management, case management, or complex case management program. Eligible members may include those who are newly diagnosed or diagnosed with a chronic condition and are new to the health plan, and who meet program-specific registry inclusion criteria for the first time.

Members who are eligible for the program will be notified either via phone call or in-person by a clinician. During the initial notification, patients have the option to opt-out of the program. However, patients can also opt-out at any communication point thereafter, either by sending a secure message through KP.org or via telephone call. Members who are not seen for initial labs/program introduction or members in the program who have not responded may receive a letter or a secure message to schedule follow-up. Periodic messages may be sent unless the member opts out at this time.

- For diabetes and heart failure Care Management programs, eligibility is discussed with the patient when their doctor (or occasionally, an advanced practice provider) – discusses the qualifying lab results in a virtual or in-person visit. Additionally, they will have a follow-up call with a Care Manager who will also give an overview of the program. Patients may opt out at either of these times, on subsequent calls, or through a message to the physician or Care Manager or by calling Member Services.
- For follow-up visits after a qualifying hospital stay, members will be informed of their eligibility either at discharge or through a follow-up call to book a post-discharge appointment. The patient may decline – i.e., opt out of the visit – at either of these times or by calling Member Services.
- For SureNet, patients are initially contacted via phone about the program and will have subsequent visits and testing scheduled. The patient may decline or opt-out at any of these times or by calling Member Services.

Below are examples of encounters and other methods of communication/reminders surrounding the programs.

- *In-person encounters*: Proactive Office Encounter (POE) impacts all health care settings. Appropriate gaps in care are addressed and documented in the member's electronic medical record. All specialties and ancillary departments engage in POE activity by using a Proactive Care Checklist at the point of care. Members with significant care gaps or multiple chronic conditions meeting inclusion criteria are identified and informed of programs to assist in managing their specific condition or given appointments for care gaps, e.g., a member newly diagnosed with diabetes would be referred to a diabetes management care manager and healthy living program.

- *Proactive telephonic outreach to members*: Members with prevention screening needs or chronic conditions care gaps are outreached by the Regional Outreach team, health care practitioners or other members of the health care team.
- *Digital notifications*: Secure emails through kp.org are sent to members due for preventive services or identified care gaps, e.g., members due for diabetes or CHF-related testing. The email includes information on why the screening is important and includes information how to schedule and complete the screening/test.
- *After Visit Summaries*: After a patient's visit or encounter, a summary will either be printed out or sent to their kp.org account. This summary will contain details of any active or newly prescribed medications, any medications that need to be discontinued, patient instructions, education on disease management, lab/procedure orders, and other relevant information.

An example of the above is as follows. A patient is visiting their primary care provider to discuss their A1c test and is told they are considered diabetic. The provider uses motivational interviewing and a shared decision-making process to help the patient understand how to start managing their disease. The provider explains to the patient they will be assisted by Care Managers in the Complete Care program, and that these Care Managers will help with their questions, medication, testing, etc. (Assuming the patient does not opt out at this time, the provider will also have their staff book the patient for classes, discuss use of a glucometer, and other items as needed.)

The patient will be called by the Complete Care department to set up regular phone appointments with a Care Manager. This Care Manager will answer their questions, go over their glucometer results, connect them with resources, titrate medication as needed, etc. They may also enroll them in the Remote Glucose Monitoring program and send them a secure message through the EMR with reminder instructions. (Patients enrolled in secure messaging may also send messages back to their Care Manager and PCP.) If the patient wishes to, they may opt out of the program when they talk with their Care Manager, who will then alert the PCP for follow up.

If the patient misses/cancels appointments, someone in the Complete Care department will outreach to the patient. And, if the patient is not seeing their PCP at least once a year or getting their test, there will be automated outreach calls or letters. The patient may opt out of these automated outreach calls – regardless of whether they stay in the Complete Care Program – by calling member services. If a member previously gave permission for text messages, they may opt out by a return text.

Please refer to **Attachment PHM 1B Member Material** for some examples of member communication materials.

Coordination of Complete Care Programs

The coordination of KPSC's Complete Care programs happens through an electronic medical record (EMR) called KP HealthConnect (KPHC). All members of the healthcare team use the integrated EMR KPHC, which allows them to view the most current patient information and communicate in real-time to support and manage the needs of the patient. Personal doctors or other healthcare team members can refer patients to various programs or services through an electronic referral. The referring practitioner provides information to the case manager regarding the reason for referral and specific concerns to be addressed. Referrals are processed, and the patient's personal doctor is notified of their eligibility and enrollment via electronic messaging in KPHC.

Members of Complete Care programs can communicate between programs and directly with the healthcare team, including practitioners, nursing staff, and non-clinical administrative staff, regarding enrollment and any related needs that are identified during the usual course of care. Reports are created from existing registries that facilitate coordinated member outreach based on enrollment and/or engagement in other Complete Care or Health Education programs.

Data Integration

KPSC uses various means to determine members' needs and eligibility for Complete Care Programs and integrates the following data to utilize for population health management functions:

- Medical and behavioral health encounters
- Pharmacy claims
- Laboratory results
- Electronic health records
- Health services programs

Please refer to **Attachment PHM 2A Data Integration** for example of reports and/or materials.

Member Segmentation/Stratification

A component of the population health management strategy for Complete Care programs including health promotion activities is an annual evaluation of member data from various sources to stratify members into appropriate programs specific to member needs. Each year, KPSC segments or stratifies its entire population into subsets for targeted intervention.

During encounters with members, KPSC routinely collects various information for all age groups, relevant subpopulations (e.g., racial/ethnic groups or transgender members), and members with disabilities or serious and persistent mental illness (SPMI) to

assess the characteristics and needs of the individual members and member groups. The information collected includes, but is not limited to, clinical data (diagnoses, laboratory/diagnostic results, procedures), sociodemographic information (gender, race/ethnicity, age, address), benefits eligibility (copays, coinsurance, medical financial assistance), and social determinants of health (language/literacy needs, access to health care services and/or community resources). The information may be used to trigger a referral for another program or activity or develop a patient-centered care plan that includes individualized goals. At an organizational level, this information may be used to develop and/or expand programs to meet the needs of the population. Every member within Kaiser Permanente will be pulled into one population or another, even if it is just our Healthy Population to ensure preventive screenings, labs, or immunizations are administered as needed.

A member may be included in several programs based on meeting the eligibility criteria, e.g., a member may qualify for both a prevention program (i.e., influenza vaccination, cancer screening) and a disease management program (i.e., diabetes case management). Members may receive one or more program service interventions based on their segmentation and level of risk.

Race and Ethnicity information - collected from the patient - is entered into the EMR and is part of the foundational data exported from and reviewed in determining how to best serve our underused populations. We strive to enter this data for all patients as opposed to relying on claims data. For example, there is race ethnicity data on over 95% of diabetes patients.

In addition to caring for the patient, information is used to adjust for racial bias and increase equity-based decisions when approaching patient populations, such as those with certain chronic diseases. Racial inequities have been identified in multiple chronic conditions and separate reports have been created – and are regularly presented – to track inequities and to drive tests of change. These tests of change include culturally based care events to target the underserved population and communities in which they live (health fairs, programs at churches and places of business, etc.), additional information and outreach campaigns, increasing percentage of care managers who speak the population's preferred language, etc. Examples of patient populations where disparities have been identified include Hispanic/Latino/LatinX diabetic patients and African American/Black hypertension patients.

For inequities based on economic factors, a medical financial assistance (MFA) program is available, and staff/clinicians/physicians have been educated on its availability for patients. Pilot programs are also in development/starting to assist those with lower income. Work is also being done on new reports, attempting to utilize census level data to identify patients in areas of greater economic need and better understand how the complex relationship between ethnic and socio-economic needs influences care outcomes.

KPSC utilizes a query builder within the EMR, which can be used to pull out members of our different populations and provide patient level details. This includes stratifying program patients by race/ethnicity data to look for and address potential inequality in care. For example, 18-64 diabetic Latino/Hispanic patients and African American/Black hypertension patients. Other details may include if the patient needs certain tests, follow-up in specialty departments, etc.

Please refer to **Attachment PHM 2D Member Segmentation Report**.

Practitioner and Provider Support

KFHP participates in an integrated healthcare delivery system with two other separate, yet closely aligned, entities – Kaiser Foundation Hospitals (KFH) and Southern California Permanente Medical Group (SCPMG). The health plan, medical group practitioners, and facilities have access to available guidelines and decision tools in meeting population health/Complete Care goals.

Data sharing: All members of the health care team, including Kaiser hospitals and affiliated hospitals, use the integrated electronic medical record, KP HealthConnect (KPHC), which allows the health care team (practitioners, case managers, discharge planners, hospitalists, etc.) to view the most current patient information and manage the needs of the member. KPHC supports referral processes, documentation of case management and preventive activities, and timely coordination of care. Members of the health care team may access and review the member's electronic medical record from any KPHC enabled computer throughout the KPSC region. The KPHC platform includes alerts that summarizes the member's prevention and chronic conditions care gaps. These alerts are programmed based on evidence-based or consensus-based guidelines that are developed by a governance structure with appropriate content expertise.

Please refer to **Attachment PHM 3A Practitioner Support** for examples of the individualized patient "Care Gaps" found in the EMR, which are addressed as part of the "Proactive Office Encounters".

Evidence-based or certified decision-making aids: Clinical guidelines and decision aids are made readily available to the applicable clinicians, physicians, and managers. They are located on the KP intranet to make them readily accessible when needed.

Additionally, there is shared decision-making information available as patient handouts and printouts from the EMR. KPSC partners with Healthwise, a health content and patient education solutions provider to ensure the most accurate and updated materials are available to practitioners. Healthwise includes a panel of board-certified medical editors and a science advisory board who are involved in planning, product and content development, and the regular and routine review of content written. Please refer to

Attachment PHM 3A Practitioner Support for examples of our Clinical Library portal and a snippet from one of the documents found therein.

Training on equity, cultural competence, bias and diversity. All practitioners are provided cultural competence training upon hire and in-service staff meetings, and ongoing through regular lunch and learns and through the KP Learn website, Diversity Health Video Series presentations, diversity webinars and through the annual Kaiser Permanente Equity, Inclusion & Diversity Conference. Please refer to **Attachment PHM 3A Practitioner Support** for an example of the cultural competency training for practitioners and staff.

Annual Evaluation for Program Effectiveness

KPSC conducts an annual evaluation to determine the impact of targeted activities and interventions to address members' needs. The annual evaluation is a comprehensive analysis to review and update the program strategy, activities, and resources necessary to meet member health care needs. The annual evaluation includes the following:

1. Detailed quantitative and qualitative review of results of clinical, cost/utilization, and experience measures.
2. Comparison of measure results to established goals and benchmarks.
3. Barrier analysis for measures not meeting goals.
4. Identification of specific opportunities for improvement.
5. Development of activities or interventions to address opportunities for improvement.

KPSC uses the results from the annual evaluation to determine if objectives were met and the overall effectiveness of complete care programs. Please refer to **Attachment PHM 6 PHM Annual Assessment Report**.

Appendix A – Complete Care Focus Areas

Informing members of PHM Programs. Patient preferences for communication are documented within KP HealthConnect. As members become eligible for various Complete Care programs, KPSC will contact them by their preferred method to explain their eligibility, details as to how to access the program services, and the benefits of participation.

Each Complete Care program has a tailored communication method based on clinical recommendations for the target population.

Opt-in/opt-out: Any member can opt out of receiving services by contacting member services or their care manager.

Focus Area 1: Keeping Members Healthy

Measure: Annual Influenza Vaccination
Targeted population: All members in all lines of business 18 years and older
Goal: Members report receiving annual influenza vaccination

- Commercial: 60%
- Medicare: 80
- Exchange: 60%

HEDIS benchmark: 90th percentile Commercial 59%; Medicare 80
Opt In/Out: Any member can opt out of receiving flu vaccines for themselves or their children
Program or Service: Health Education/Wellness Program

KPSC Flu Vaccination Program overview:

- Focuses on educating members on the benefits of receiving the flu vaccine, especially for those members with chronic conditions.
- The program strives to make it convenient for the member to receive the vaccine by strategically placing vaccination stations throughout the medical center.
- Data runs weekly to help medical centers track their successful opportunities as well as the flu vaccination penetration in their membership.

Utilizing Services: Members can easily obtain flu shots by making an appointment or walking into a medical center to get a flu shot without making an appointment. Additionally, through kp.org, members can easily locate the closest medical center to obtain the vaccine via flu vaccine location finder. KPSC participates in health fairs where flu vaccines are given to those 18 years or older.

Interventions (both direct/indirect): The Annual Flu Campaign kicks off annually in the 3rd quarter. KPSC sends postcards, kp.org mail, and text messages to our members encouraging them to get vaccinated. Additionally, flu signage is visible in all clinics and medical centers, reminding members to get their flu vaccines early. Members can learn about KPSC flu messaging through broadcasts, social media, and kp.org/app.

Focus Area 2: Managing Members with Emerging Risk

Measure: HbA1c control < 8.0
Targeted population: Adults 18-75 at risk for diabetes, adults 18-75 with controlled diabetes
Goal: Maintain or lower HbA1c < 8.0

- Commercial: 69.5%
- Medicare: 77%
- Exchange: 69.5%

HEDIS benchmark: 90th percentile Commercial 69.67%; Medicare 78.83%, Exchange 69.67%
Opt In/Out: There is no need to opt-in as all eligible members are opted in. Patients may elect to opt-out in-person or over the phone
Program or Service: Complete Care: Diabetes Management

The robust Complete Care program supports diabetes (DM) through many aspects:

- Outreach. In addition to local outreach, there is yearly outreach to DM patients who have not completed their A1c labs. Additionally, there is yearly outreach to patients who have not seen their PCP within a year.
- Consultation, reporting and communication. Two DM physician co-leads from primary care and endocrinology regularly answer clinical questions, visit sites, and host online discussions.
    - A dedicated DM consultant is available to discuss process improvements, answer questions, assess areas of opportunity, and communicate new information and best practices from other areas.
    - A report team continues to iterate and create both outcome reports – to find opportunities for improved patient care – and process reports to help identify process issues/barriers at the physician, staff, and patient level.

  - The Regional Complete Care team engages in regular communication and facilitates communication amongst all thirteen service areas. This includes monthly reports; quarterly calls for medical service areas; generally, at least one annual site-visit a year; and a twice a year, all-region, program meetings (one face-to-face and one online).
- Shared Guidelines and Process Improvement Measures. There is a "playbook" filled with guidelines and best practices for dealing with Diabetes. This includes recommendations for the Complete Care departments (supporting primary care with DM patient follow-up and medication titration), primary care, endocrinology, Center for Healthy Living (DM classes), and soon to also include OB for gestational diabetes.

Focus Area 3: Patient Safety

Measure: Medication reconciliation post-discharge
Targeted population: All adult members discharged from an inpatient admission
Goal: All adult members discharged from an inpatient care facility will have a medication reconciliation documented in the medical record within 30 days of discharge
HEDIS benchmark/thresholds: Medicare 89.29%
Opt In/Out: Patients 18 and above who are able to download an app to a Smart Device from the Google or Apple app store or who have an email and are enrolled on kp.org. To opt-out, patients can simply not visit the portion of app/website
Program or Service: Complete Care: Medication Reconciliation

- POSH appointments – post-hospitalization (POSH) follow-up appointments with primary care practitioner or specialist as appropriate.
- Medication reconciliation as component of POSH appointment.
- Post 72-hour call back program – nurses conduct follow-up telephone calls to members who have been discharged from the hospital. These calls focus on the reasons for hospitalization and confirm the patient has the discharge medications they need, confirm other post-discharge needs, and confirm the follow-up appointment with their PCP or specialist.
- Medication reconciliation is essential to the post-discharge care coordination for all patients taking prescription medications. Patients who have more than one chronic condition are likely to take more medications; therefore, proper medication reconciliation is imperative to preventing unintended complications post-discharge. Nurses review all medications prescribed for patients using the integrated electronic medical record, KP Healthconnect, as part of the care plan during discharge.

Focus Area 4: Managing Multiple Chronic Illnesses

Measure: HEDIS Plan all Cause Readmission (PCR)

Targeted population: Members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission for adult members

Goal: Reduce 30-day readmission rate by 10 percent for members with multiple chronic illnesses

- Commercial: 0.47
- Medicare: 0.85
- Exchange: n/a

HEDIS benchmark/thresholds: Commercial 0.44, Medicare 0.83, Exchange 0.46

Opt In/Out: Patient can elect to opt out simply by refusal to discuss on call or declining a visit

30-day readmission ratio for members with more than one chronic illness, e.g., diabetes, congestive heart failure, and renal failure medication review following a care transition.

a) O/E = observed 30-day readmissions / expected readmissions
b) Target Group: see table below

Factor	Specification
Product Line	Commercial (<65) and Medicare (Medi-Cal is excluded)
Ages	18 years and older as of the Index Discharge Date
Continuous enrollment	365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date
Allowable gap	No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge Date
Anchor date	Index Discharge Date
Event	An acute inpatient discharge on or between the measurement period minus 30 days
Measurement Period	Yearly reporting consists of 11 months of discharges and 1 month to allow for the remaining readmissions.

Program or Service: Complete Care: Care Management

In early 2011, KPSC hospital leaders were given the daunting task of trying to improve readmission rates for more than 40,000 Medicare risk discharges per year at 13 medical centers. KPSC modeled the Kaiser Permanente Northwest (KPNW) innovative work in reducing hospital readmission rates using the "transitional care" bundle.

The program's goal is to design and implement strategies to decrease the 30 days Commercial and Medicare all cause readmission rate. The program consists of a steering committee, project work groups, and local implementation groups. The 13 medical centers and/or each service area has a local readmission reduction team that is responsible for implementation of the key bundle elements. The project work groups focused on developing and refining key bundle elements based on a review of the literature and internal organizational experience. Bundle elements were tested, standardized, and approved by the steering committee.

Leaders from each service area met monthly with regional leaders to review readmission rates and the barriers to successful implementation of key bundle elements at their respective medical center. The graphic below represents the key elements of the transition bundle.

Based on our risk stratification model, the LACE score, we provide interventions to the target group including a follow-up call with a nurse within 3 days of discharge and a provider visit within 7 days of discharge. Other supporting resources include a 24/7 hotline with a hospitalist escalation process, standardized discharge summaries, medication reconciliation at each touch, complex case conferences for high-risk patients, and specialized decision support for the post-hospital provider visit.

Kaiser Permanente Southern California
Population Health Management Strategic Program Summary – Effective January 1, 2019

Lace Score	0-6	7-10	11-19 (Medicine d/c's)	11-19 (General Surgery d/c's)	11-19 (SNF to Home d/c's)	Heart Failure TCP Any Lace
Risk Stratification	✔	✔	✔	✔	✔	✔
Standardized Discharge Summary	✔	✔	✔	✔	✔	✔
Medication Reconciliation	✔	✔	✔	✔		✔
Transition Hotline	✔	✔	✔	✔		
Post Hospital Visit with Physician		≤ 7days	≤ 7 days			≤ 7 days
Phone Call ≤ 72 Hours Post Discharge			✔	✔	✔	
Phone Call ≤ 72 Hours Post Discharge (65+ any LACE, any service)	✔	✔	✔	✔		
Palliative Care Consult (if indicated)			LACE ≥ 15			
Complex Case Conference	✔	✔	✔	✔	✔	✔
Complex Case Management			Lace 18-19			
Home Health Visit						✔
Ongoing Outpatient NP/PharmD/RN follow-up						✔

Member Participation: Members are identified for the transitional care interventions automatically through decision support built into our electronic medical record. The LACE score is auto calculated and presented in the EMR for the ward clerks to see and schedule the POSH appointments. There is an automated patient list the nurse follow-up call teams use to find patients recently discharged from the hospital. Members can opt-out of this program by simply refusing the phone call or the provider visit. Some members prefer a telephone or video visit, which is offered to members who cannot come into the medical center for an in-person visit.

2024 Care at Home (Home Health) (**KPCAH-HH**) Quality Program Description Annual Work Plan

Kaiser Foundation SCAL & Hawaii Markets

Approved:
Kaiser Foundation Regional SCQC Committee on _____ (Date)
Accreditation and QRSS Committee on _____(Date)

2024 SCAL & HI KP CARE AT HOME (HOME HEALTH) QUALITY PROGRAM DESCRIPTION

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2024 SCAL & HI KP CARE AT HOME (HOME HEALTH) QUALITY PROGRAM DESCRIPTION

Section 1 – Quality Program Overview

Purpose

The purpose of this Plan is to provide the mechanism for improving Care at Home (Home Health) Service quality and safety and to ensure that Kaiser Foundation Hospitals (KFH) Board of Directors' Quality and Health Improvement Committee (QHIC), Senior Leaders, Medical Staff, and Home Care Staff demonstrate a consistent and collaborative approach to deliver safe, effective, efficient, equitable, patient centered and timely care within a quality assurance and performance improvement (QAPI) framework. The activities in this plan are essential to achieving the strategic plan of Kaiser Foundation Hospital SCAL & HI Market KP Care at Home Services (**KFH-SCAL & HI KPCAH**). This plan informs the improvement processes for patient outcomes, reducing and preventing medical errors, and applying remediation strategies in response to system or process failures.

KFH-SCAL & HI KPCAH allocates appropriate staff resources to develop and maintain the Quality and Patient Safety Program. The Professional Staff and Home Care operations managers are allocated time, office space, analytical services, and support staff to perform specialized quality roles, which includes participation in process improvement.

The foundational elements of all quality and patient safety initiatives and activities provide a framework that also supports quality improvement processes at **KFH-SCAL & HI KPCAH**. They are:

1. A systems approach, High Reliability Organizations (HRO), human error and human factors.
2. The creation and maintenance of a "Just Culture".
3. Proactive and prioritized performance improvements to prevent failure, mitigate organizational risk, improve systems, and elevate process reliability.
4. Seeking input from and collaborating with patients, families, and caregivers.
5. Assuring compliance with all state and national regulatory, accreditation, and certification standards supporting quality and patient safety.
6. Ongoing identification, sharing, and implementation of successful practices from other parts of internal and external healthcare or non-healthcare organizations.

Note: KP-SCAL "**KPCAH**" consist of Home Health and Hospice Service Lines. Most agencies have joint licensing under Home Health, as opposed to two separate licensed programs. However, operationally, Hospice service lines operate separately from the Home Health program. **HI KPCAH** consist of Home Health and Hospice Service Lines. Therefore, for the duration of this document, **Care at Home "(Home Health)"** will refer to the Home Health program, agency or service being provided.

Mission, Vision, Values

Mission:
Bring our patients home and keep our patients' home.

Vision:
Be the leader of innovative in-home services that delivers exceptional experience through safe, affordable, and highly reliable care.

Values: Commitment, Compassion and Comfort

Guiding Principles/Goals:

- Principle #1: Provide patients, families, and caregivers superior and sustained clinical and non-clinical care, services, and satisfaction across all touch points throughout the Continuum of Care.

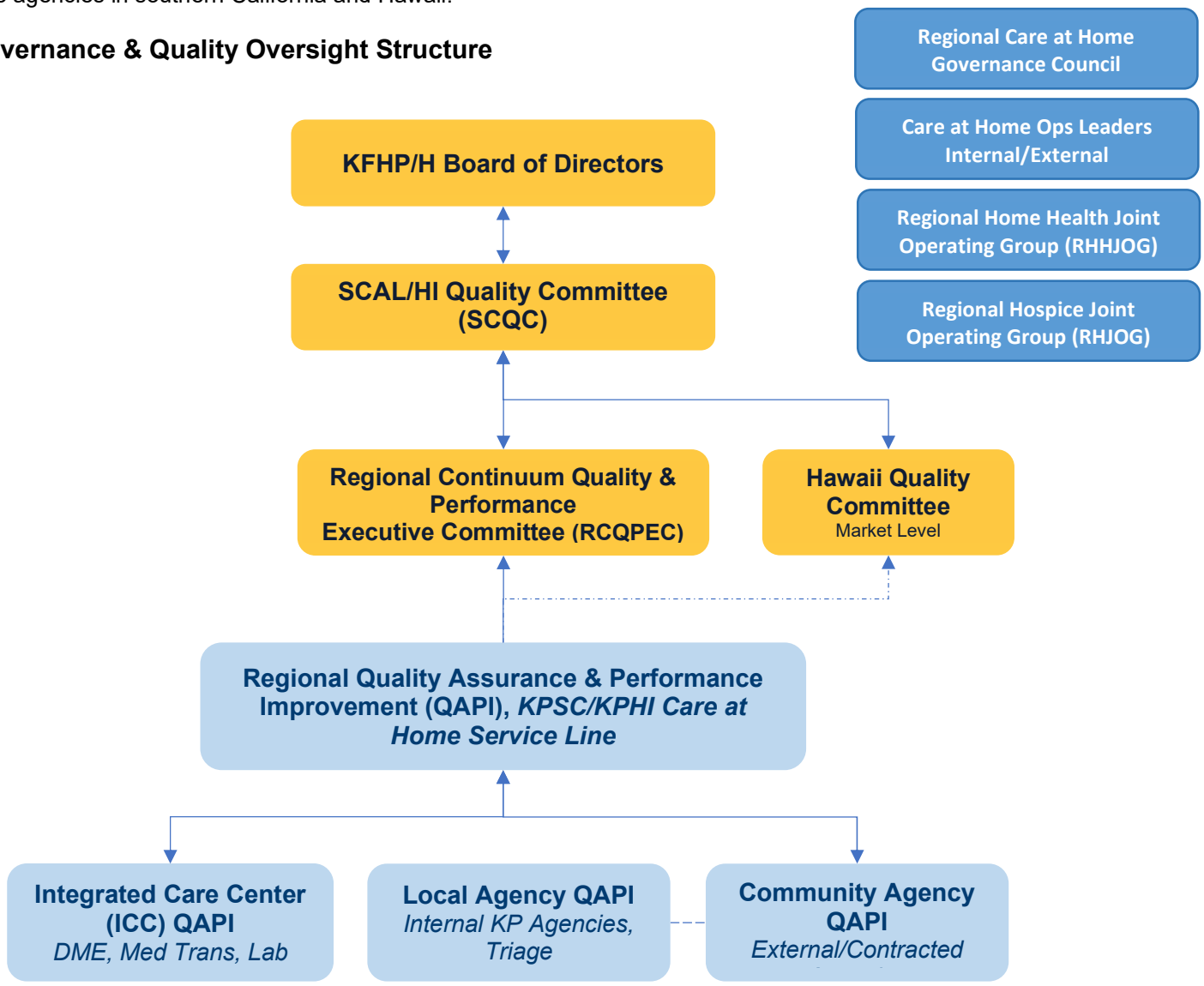
- Principle #2: Drive improvement of clinical operations and sustain quality of care delivery.
- Principle #3: Base decisions on data and input from all stakeholders, including the patient's voice.
- Principle #4: Focus on identification and removal of system and/or process gaps that hinder high-quality care.
- Principle #5: Create a culture of trust where employees are empowered to speak up on errors, system breakdowns and/or opportunities for improvement.
- Principle #6: Encourage staff to support each other and to be accountable for their own professional performance and practice.
- Principle #7: Set performance measure goals using Evidence Based Practice (EBP) and Plan-Do-Study-Act (PDSA) process improvement mediums.
- Principle #8: Monitor reported billing accuracy via our Sarbanes-Oxley (SOX) review program.

2024 SCAL & HI KP CARE AT HOME (HOME HEALTH) QUALITY PROGRAM DESCRIPTION

Program Oversight, Authority, and Care at Home (Home Health) Governance Structure

The objective of **KFH-SCAL & HI KPCAH** Quality Program Management is to provide a leadership driven framework and organizational structure to achieve the mission and strategic goals of the organization. As a distinct and unified service line, Care at Home governance and quality oversight has been simplified under the Regional Continuum Quality & Performance Executive Committee to ensure market wide uniformity of quality and care experience oversight with singular escalation to the Southern California Quality Committee. The integration of local and market wide (regional) quality assurance & performance improvement (QAPI) programs, allows a simplified reporting structure, as well as improved response to accreditation and licensing accountabilities across nine agencies in southern California and Hawaii.

Governance & Quality Oversight Structure



Legend:

- KFH/HP governance meeting or oversight groups
- Care at Home quality governance meetings
- Care at Home operational governance or oversight

QAPI: Quality Assurance and Performance Improvement

** ICC Care Support (transactional) functions will report through ICC QAPI*

***Agency functions centralized at ICC will report up through Local QAPI and ICC QAPI as appropriate*

2024 SCAL & HI KP CARE AT HOME (HOME HEALTH) QUALITY PROGRAM DESCRIPTION

Kaiser Foundation Hospitals Board of Directors *(governing body):*
KFH is a California non-profit, public benefit corporation that owns and operates general acute care hospitals and/or ambulatory facilities, and home care agencies in California, Hawaii, Colorado, Georgia, Washington State, Oregon, and the Mid-Atlantic Region. Each home care agency is licensed by the state in which it is located, certified by CMS, and accredited by The Joint Commission. The KFH Board of Directors, as the governing body, through its Quality and Health Improvement Committee ("QHIC"), oversees each Home Care Agency's Quality and Patient Safety Program through delegation to the CAH Vice President and SCAL and HI Market Quality Department. The QHIC assures each home care agency's executive and Professional Staff leadership develops its care delivery program consistent with the market's Care at Home mission, vision, and values. The agency's executive leadership is accountable to the QHIC to assure the planning and implementation, including establishing priorities for Home Health Quality Management Program (HHQMP) with respect to the delivery of existing services and the implementation of new home care services.

Governing Structure:
The Governance of KP SCAL & HI's Home Health program is made up of four organizational bodies: The Kaiser Foundation Governing Board (via QHIC), Southern California Quality Committee (SCQC), KPCAH Governance Council and the Care at Home Service Line structure.

Purpose of the Governing Body:
The Governing Body provides National, Regional, and local care delivery, management, and leadership oversight of all agencies within SCAL and HI. The Market President sets strategic priorities for Care at Home activities and provides market wide leadership under the Southern California Quality Committee and KPCAH Governance Council framework. Lastly, the governing body assumes full legal authority and responsibility for the operation of Care at Home (Home Health) in accordance with Medicare Conditions of Participation and Health Plan Regulations.

Governing Body Delegation
The KFH Board of Directors has designated the CAH Vice President as the Governing Body of the licensed Home Health Agency. The Care at Home Service Line structure oversees the KFH and Kaiser Foundation Health Plan (KPHP) function as related to home care services and reports quality and experience metrics to the KPCAH Governance Council and SCQC. Additionally, the governing body assumes full legal authority and responsibility for the operation of Care at Home (Home Health) in accordance with Medicare Conditions of Participation.

The CAH Vice President appoints the Divisional Service Line Administrator as leader of their respective agencies. The CAH Vice President has delegated decision-making day-to-day authority for agency operations to the Divisional Service Line Administrator, and support functions to the service line leadership team. Such authority includes but is not limited to approving of policies and procedures, managing fiscal/budgetary matters, monitoring Home Health operations and quality performance and so forth.

Purpose of the Southern California Quality Committee (SCQC):

- Oversee the state of agency administration as outlined with established policies and procedures.
- Ensure an ongoing program for quality improvement and patient safety is defined, implemented, and maintained. This program is to be evaluated annually.
- In accordance with federal *Conditions of Participation* (*COP*), this governing body is to mandate a group of multi-disciplinary professional personnel establish and annually review the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, infection control, clinical records, personnel qualifications, and program evaluation.

- Fulfill agency or branch compliance by conducting meetings at least three times per year with the Quality Assurance Performance Improvement (QAPI) or the Agency fulfils this by conducting an annual review meeting. QAPI minutes and supporting documentation will reflect evidence of compliance with regulations.
- Delegate day-to-day Home Health Quality Management program (HHQMP) oversight and escalation activities to the Continuing Care Quality Department. The Regional Director of Continuing Care Quality, or designee, reports agency performance on established quality indicators to the SPCCQC, QUEST, SCQC, and HI QRSS. The CAH Vice President is accountable to assure valid, reliable monitoring of agency performance on established or evolving quality indicators.

Purpose of the Regional Continuum Quality & Performance Executive Committee (RCQPEC):

- 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.
- Review quality site visits, complaints/grievances, regulatory activities, survey activity/results, service area goals/performance, new compliance initiatives, contract oversight, quality measures, quality oversight of KFH contracted facilities.
- Standardized practices and increase efficiency in each service area.
- Identify and improve quality measures.
- Satisfaction survey program redesign to meet operating trends, efficiency, and quality improvement.
- This committee would meet every other month for 2 hours and report out to SCQC twice a year.

Purpose of the KPCAH Governance Council:

- Joint council of PMG and KFH/HP senior leaders aligning all activities in the Care at Home setting
- Oversees the quality of care and financial performance.
- Guide, review or consult on Home Health strategic plans, including the creation of innovative programs and services.
- Provide direction to the business, property, affairs, and funds of the entity.
- Ensure that the entity functions in the most effective and efficient manner.
- Ensure alignment & integration of Home Care Services across the continuum of care.
- Promote adherence to KP's mission, values, goals, and strategies.
- This council's oversight can be delegated through the Quality oversight function, service line leadership and/or Market Home Joint Operations Group meeting structure as found in attachment 1.

Purpose of the Care at Home Service Line:

In adherence to the Market President's strategic priorities, the CAH Service Line is tasked to provide strategic, operational, and tactical direction of all home health care delivery in the SCAL and HI regions. The CAH service line develops workplans, implements strategic imperatives, conducts process improvement, and oversees clinical/operational performance. Leadership is also responsible for developing and implementing an effective planning process that allows for defining timely and clear goals.

This CAH 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

HHQMP. The CAH Vice President communicates local requirements and inquires with the **KFH-SCAL & HI KPCAH** Divisional Service Line Administrator in collaboration with the Regional Service Line Senior Leadership Team. CAH Vice President provides oversight and functional support for all local agencies and branches access, performance and care delivery quality and experience. Agency level requests of the Regional Service Line Senior Leadership Team, KPCAH Vice President, KPCAH Governance Council, and the Governing Body are made through this established chain of command.

Service Line is responsible for:

- Operating in partnership with Continuing Care leaders/Assistant Medical Center Administrator (AMCA) at each service area to ensure warm handoffs and seamless care transitions across settings.
- Ensuring collaboration with community leaders and organizations to design services to be provided by the hospital that are appropriate to the scope and level of care required by the population served.
- Ensuring communication of the organization's mission, vision, values, goals, objectives, and strategies across the region
- Utilizing situational leadership behaviors to provide appropriate direction and management for all services.
- Ensuring uniform delivery of patient care services provided throughout the region/agencies/branches.
- Ensuring that systems are in place to promote the integration of services, and to support the patient beyond the hospital walls.
- Appointing committees, work groups, performance improvement teams and other forums to ensure multidisciplinary and interdepartmental collaboration on issues of mutual concern.
- Establishing structures and processes that focus on safety and quality, improving the health care safety of patients, and reducing preventable adverse patient events.
- Implementing changes in existing processes to improve the quality of the care provided.
- Establishing quality of care and patient safety metrics, which can be monitored.
- Establishing a learning environment where employee development and continuing education opportunities serve to promote retention of staff and to foster excellence in the delivery of care and support services.
- Providing ongoing patient safety training for all supervisors and field staff
- Promoting a "Just Culture" that recognizes human beings make mistakes, supports reporting, advocates fair treatment, and has intolerance for reckless behavior.
- Ensuring that staffing resources are available, trained, and competent to appropriately meet the needs of the patients served.
- Providing routine (regular) reports and ad-hoc reports, as requested, to the KPCAH Governance Council and the Board of Directors' QHIC

Service Line Agency Management Team

The daily operation of the Care at Home (Home Health) is vested in the Management Team who collectively and individually assume daily responsibility for Agency operations, staff performance and patient care outcomes. The Agency Management Team includes the Care at Home (Home Health) Divisional Service Line Administrator and the Director of Patient Care Service, as well as clinical supervisors. Each member of the Management Team is carefully selected and qualified through credentialing, education, and experience for their level of supervision and managerial leadership.

The following describes the Management Team:

1. **Divisional Service Line Administrator (DSLA)** - appointed in writing by the CAH Vice President as delegated by the governing body of the Care at Home (Home Health) Agency to organize and direct the services and ongoing functions of the Agency. (See Home Health Policy 4-006 Appointment of Divisional Service Line Administrator). The DSLA also annually approves the list of indicators that measure the quality of care, services delivered, appropriateness of the service, and regulatory readiness. Indicators are selected based on regulatory requirements, high risk or problem prone areas or significant trends

identified in data collection results. These indicators will provide the basis for the quality program at each Agency and reflect the means to report on the aggregate status of all agencies throughout the Region.

2. **Director of Patient Care Services (DPCS) -** the clinical lead for day-to-day clinical needs in collaboration with internal and external departments and/or agencies. The DPCS oversees the clinical managers and supervisors and all field staff providing direct patient care.

3. **Continuing Care Quality Sr. Director**– functions as service line subject matter expert in regulations, accreditation, quality, performance improvement, survey readiness for regulatory & accreditation surveys, not limited to including compliance audits. Provides guidance and council for operations both clinical and administrative functions to improve performance at all levels. Augments education and training, interprets regulations for assessment of compliance. May serve as Improvement Advisors in the PI process. Oversees and co-partners in the development of the quality plan, designing tools for problem identification/resolution, compliance monitoring, standards development, inter-rater reliability (IRR) and recommendation and collaboration with corrective action plans. Lastly, supports CAH agencies on all aspects of the Quality Program including performance improvement, quality outcomes, patient experience, and service delivery as appropriate.

4. **Service Line Nurse Consultant –** Service Line Nurse Consultant provides clinical expertise for areas of compliance, education and training which involve medical necessity and/or quality concerns. Utilizes clinical expertise to conduct investigations and seeks input from other clinical professionals as required. Responsible for reviewing and analyzing audit related reports and providing consultation on non-compliance. They support both internal and external agencies as appropriate.

5. **Clinical, Rehab and/or Administrative Supervisors/Managers -** These positions provide direct supervision over-all front-line field staff (direct care and coordination) and/or office staff (. e.g., intake and scheduling).

6. **Quality Coordinator –** Registered Nurse who coordinate**s** and report**s** quality outcome information related to identified important aspects of care, patient occurrences, patient satisfaction surveys, infection control and other outcome data. Monitor**s** clinical performance improvement activities to ensure compliance with agency policies and procedures and standards established by accreditation and regulatory bodies and assist**s** with the development of corrective action plans, where needed. Report**s** trends in documentation and patient care management to clinical management and subsequently develop**s** educational programs to address deficits.

7. Quality Analyst – support position that gathers data, processes reports, and provides ready-to-validate packages of quality information to the quality coordinator. The quality analyst works under the direction of the quality coordinator.

8. Quality Assurance Performance Improvement – see QAPI section below.

9. **Medical Staff:** The Southern California Permanente Medical Group (SCPMG) and the Hawaii Permanente Medical Group (HPMG) is organized, directed, and administered as a separate entity from KFH and KFHP.

Regional Level: The Medical Directors of SCPMG and HPMG are responsible for the executive level decisions made regarding SCPMG issues.

Facility Based Medical Staff Positions: SCPMG and HPMG Home Health Medical Director: provides consultation and acts as a liaison to the area Medical Director and Regional Departments. The responsibilities of the Medical Director shall include but are not limited to:

- direct access to the Care at Home (Home Health) management/staff members

- participation in standards approval, quality management, utilization review and meetings (e.g., QAPI/ Case Conference/IDT, etc.),
- assist with conflict resolution.
- lead provision of direct medical home care
- designate alternative MD in his/her absence.

Attending Physician: Patients admitted to Care at Home (Home Health) are attended by their primary physician. Responsibilities include, but are not limited to:

- authorize and sign the plan of care in a timely manner.
- review and modify the plan of care as required.
- participate during the Care at Home (Home Health) case conferences/interdisciplinary teams.
- provide necessary medical examination and care.

KPCAH Regional Quality Assurance & Performance Improvement Plan (*QAPI*) KPCAH Governance Council and the Regional QAPI Committee - has oversight responsibility for the quality activity in the Care at Home (Home Health) Agency. The KPCAH Governance Council and the Regional QAPI Committee will review and approve the Home Health Program Descriptions as well as the agency's Annual Home Health Work Plan and Home Health Program Evaluation. The Divisional Service Line Administrator of Care at Home (Home Health) or designee reports to the KPCAH Governance Council and the Regional QAPI Committee. Frequency of reporting is determined by the KPCAH Governance Council and the Regional QAPI Committee. The KPCAH Governance Council and the Regional QAPI Committee reviews all key quality monitors. This Committee serves as the committee to implement, monitor, and enhance operational systems to ensure quality improvement, performance improvement and patient safety for home care. The Institute for Health Care Improvement (IHI) Model for Improvement as well as other performance improvement models (e.g., Plan-Do-Study-Act) and tools are utilized to organize efforts that improve the quality of health care delivered and the processes that support quality care for KPCAH.

Regional QAPI facilitates the preparation of reports related to the local agency's quality assurance, performance improvement, and patient safety activities to be submitted to the Board of Directors' QHIC on an annual basis or upon request.

Other committees:
Coordination and integration of the QM activities occurs through formal or informal relationships at the medical center, regional and program levels. This includes other operational, clinical, professional practice or departmental committees/workgroups tasked by leadership to develop, implement, and monitor performance effectiveness for the services and processes within their scope, one being Regional Joint Operations Group. These committees and work groups report up through the quality structure.

Section 2 – Performance Improvement

Performance Measure Overview

Performance measures are based on the strategic objectives each year. Process, outcome, and balancing measures ** are selected to reflect important aspects of care at the hospital, department and unit level and align with the organizational program goals for Home Health. The Board of Directors' QHIC sets outcome measures for the safe quality care delivered to our patients. The Board of Directors' QHIC has also set an expectation that all Care at Home Agencies will plan for and implement processes needed to meet these outcome measures.

The Board of Directors' QHIC has set an expectation that the Home Care Divisional Service Line Administrator, in partnership with the Home Health Agency Medical Director's designee will identify, prioritize, and remedy quality and safe patient care issues as they occur, consistent with the parameters of the quality plan. This is accomplished in part through the collaboration with the KPCAH Governance Council. Care at Home service line

leadership shall report these issues and their remediation on an annual basis in the Agency's annual quality and patient safety evaluation.

**Definitions:

- Outcome measures are high level metrics taken to improve the patients' health and wellbeing.
- Process measures are the specific steps taken to measure how the systems are performing.
- Balancing measures are metrics to ensure an improvement in one area is not negatively impacting another area or to provide a measure that, in isolation, lacks context.

SCOPE

Care at Home (Home Health) use 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 process
- Compliance with applicable laws, regulations, and accreditation body standards
- Outsourced agency (contract) services
- Publicly reported data monitoring of performance improvement and service quality

Quality Oversight & Linkage

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

Quality Assurance Performance Improvement *(QAPI):* Each Care at Home (Home Health) Agency has a local QAPI Committee which meets at a minimum of three times a year and may also have a QAPI workgroup which meets as needed to work on projects for improvement. This group advises agency and service line leadership on professional and performance improvement opportunities. The local agency QAPI team partners with the service area or medical center to enable seamless care transitions, address challenges, improve quality outcomes throughout the continuum of care.

Local QAPI and/or Quality Membership: The membership shall include at least one physician, one registered nurse and appropriate representation from other professional disciplines. At least one member of the group shall be neither an owner nor an employee of the agency.

Local QAPI and/or Quality Duties:

- This committee Meets at a minimum three times a year.
- Director of Patient Care Services and the Divisional Service Line Administrator jointly manage it.
- Annually review the Agency policies regarding scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluations.
- Review quality outcome measures and quality improvement activity and make recommendations.
- Analyze data, evaluate results of analysis, institute QI activities as needed and ensure follow up as appropriate.
- Meet frequently to advise the agency on professional issues.
- Maintain dated meeting minutes of the proceedings.

- QAPI minutes reflect all committee decisions & actions and recommendations and are dated and signed. These are reported to the CAH Vice President, or designee at least twice per year, quarterly preferred.
- Other duties, as deemed appropriate.

These committees will address quality issues, monitor agency performance for improvement activities, and track progress on action plans. It also analyzes data, evaluates results of analysis and institutes QI activities as needed and ensures follow-up as appropriate. QAPI focuses on high risk and high-volume measures that affect quality standards. See Section below.

KPCAH Service Line Quality Team and SCAL & HI Regional Leadership (Home Health) Leaders:
The Divisional Service Line Administrator and the Regional Service Line Senior Leadership Team, along with KPCAH Service Line Quality Team meet routinely and are responsible for overseeing the following QM activities:

- Structure, process, and outcome standards development
- Organize compliance monitoring of structure, processes, and outcome standards.
- Aggregate collation of area statistics
- Oversee the development of data sources for problem identification.
- Monitor and resolve the effectiveness of problem identification methods.
- Identify opportunities for improving systems, programs, and patient care.
- Identify teams to pursue corrective action and improvement activities.

Regional QAPI Committee: The Care at Home (Home Health) designated quality coordinators from each Agency meet at least nine times per year with the Regional QAPI committee. The Regional QAPI Committee directs the quality assessment and quality improvement efforts for Care at Home and coordinates quality improvement activities for each agency. This committee exists to identify opportunities for improvement and consistency, and to conduct benchmark among the agencies. The committee coordinates and implements improvement initiatives, best practice opportunities and consistent education and training with the agency leaders and quality management staff. The Regional Home Health Operating Group (RHHJOG) meetings will be merged with the Regional QAPI committee, reporting Quarterly on program updates, services, regulatory requirements, and service line changes impacting Quality, Care Experience, and outcomes.

The regional QAPI committee with agency members that meets monthly to review trends, regulatory compliance issues, set regional policy and procedures. This group will meet the second Thursday of each month virtually or in a designated place. This group will include the Sr Director of Quality and Safety, Regional Sr. Director of Continuing Care, Regional Sr. Director Clinical Excellence for **KPCAH** (Home Health), Regional Sr. Director for **KPCAH (**Home Health), Regional Quality Managers, assigned Agency Quality Coordinators, Quality Analysts, Ad Hoc or Subject Matter Experts (SME) will be invited as needed. Physician leaders, DPCS delegates and Supervisor delegates will be invited to the quarterly RHHJOG report outs.

Duties:

- Establish policies governing the day-to-day provision of home health care and services.
- Review Home Health policies annually regarding scope of services offered, admission discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluations.
- Review quality outcome measures and quality improvement activities and make recommendations.
- Analyze data, evaluate results of analysis and institute QI activities as needed.
- Ensure follow up of outliers or discrepancies as appropriate.
- Meet frequently to advise on the professional, clinical or outcome issues.
- Maintain dated meeting minutes of the proceedings.
- Meeting minutes reflect all committee decisions & actions and recommendations and are dated and signed.
- Other duties, as deemed appropriate.

2024 SCAL & HI KP CARE AT HOME (HOME HEALTH) QUALITY PROGRAM DESCRIPTION

Care at Home (Home Health) Quality Assurance and Performance Improvement Program

The QAPI program will be integrated in services that impact Care at Home (Home Health) Agency services, including Durable Medical Equipment (DME), Integrated Care Center (ICC), Long Term Care Services (LTC), Ambulance and Transportation and Long-Term Support Services (LTSS) services to our members in Southern California and Hawaii. The QAPI program will support improvements in outcomes by measuring, analyzing, and tracking quality indicators, including adverse events reports (AER) and other performance indicators. The QAPI program will identify gaps in systems and processes, accessing all available data sources to look at the bigger picture to identify potential problem areas. The QAPI program will trend outcomes for tracking of monitored indicators such as medication management, medical device reporting, OSHA reporting, infections, unusual occurrences/significant events, e.g., falls, patient complaints and grievance logs.

QAPI Goals:

- Address compliance/regulatory requirements outlined by Center for Medicare & Medicaid Services (CMS)
- Collect, monitor, review, compare, and interpret data from various sources - IQIES, Care Compare, HHCAHPS, HHQI, vendors, and chart audits, etc.
- Ensure *safe, effective, appropriate, and affordable care* as we manage through efficacy, availability, timeliness, continuity, safety, respect, and care.
- Incorporate PI methodologies to address clinical and psychosocial issues.
- Assess, measure, analyze and evaluate systematically quality of care and service provided to patients.
- Ensure continuity and coordination of care and service to members.
- Assure credentialing policies and procedures meet expectations are implemented and maintained.
- Promote communication and feedback of quality findings and targeted improvement efforts.
- Identify areas to improve processes, patterns, and outcomes of care.
- Assure compliance with internal and external accrediting and regulatory standards.
- Each Care at Home (Home Health) Agency establishes goals as described in each QAPI Plan

Program Activities, Scope, and Focus: *(including but not limited to...)*

- QAPI Program will gather input from focus groups, process mapping to identify areas of improvements. It will consolidate, and prioritize, considering if the area is a high-risk problem versus an opportunity for improvement. The program will look for alignment to other current quality indicators that measure outcomes and key indicator to determine if standards have been met.
- Leverage Member/Stakeholders Needs, Expectations, and Satisfaction
- Adhere to all Quality Management Project Model scopes found in this document.
- Target high-risk, high volume, or problem prone areas of service, considering the incidence, prevalence, and severity of problems in those areas. The goal is to correct any immediate problem that directly or potentially threatens the health and safety of our patients.
- Track and analyze unusual occurrences and complaints utilizing MIDAS so that the agency can implement preventative actions and sustainable measures.
- Use Critical Event Analysis (CEA) or Inter-Rater Reliability (IRR) to identify contributing causal factors that leads to variations in performance.
- Reference any regulatory and clinical performance standards to identify deviations; implement changes or corrective actions that will result in improvement, testing small pilots before rolling out to entire region; review QAPI plan every year (continuing to show improvement)
- Access online QAPI courses at National Association for Healthcare Quality (NAHQ) and the California Association of Health Services at Home (CAHSAH) to stay versed in Care at Home (Home Health) QAPI, topic specific courses related to Performance Improvement, Data Interpretation and Reliability, and Clinical Improvement Outcome

- Comply with regulatory and accreditation review requirements, including Centers for Medicare and Medicaid Services, California Department of Public Health Medi-Cal, California Department of Managed Health Care, Hawaii Department of Public Health Medicaid, and The Joint Commission
- Support Patient Safety and Behavioral Health Care Programs
- The program will foster sharing state-of-the-art QA&I practices and strategies that widely support the Continuum of Care improvement efforts.
- Set QA&I activity priorities to support Strategic Goal achievement.
- Incorporate member expectations into standards of care and service.
- Support Continuum of Care management activities development

Methodology for Improving Performance:

A. Plan – Do – Study/Check - Act

The research method followed to assess, monitor, and continuously improve Care at Home (Home Health) processes and performance is the Plan – Do – Study/Check – Act (PDS/CA) cycle for performance improvement. Each performance improvement initiative and indicator managed by the Agency QI Team has improvement activities that follow or align with the PDS/CA Cycle. Local Agency performance improvement activities may follow methods like PDS/CA as approved by the Regional Quality Committee.

B. Statistical Processes and Tools

Statistical Process Control (SPC) tools e.g., Pareto analyses, trending data, use of control charts, and other performance improvement tools are used to analyze and display data and applied to determine whether an indicator or a process is stable and functional within acceptable variation or customer and stakeholder needs.

Patient Safety

To permeate responsibility and mutual accountability for patient safety throughout our organization, KP will continue to implement activities broadly aimed at becoming a highly reliable organization by achieving the following six strategic themes:

Core Theme	Description
Safe Care	Ensure the actual and potential hazards associated with high-risk procedures, processes, and patient care populations are identified, assessed, and controlled in a way that demonstrates continuous improvement and moves the organization toward high reliability and the ultimate objective of ensuring our patients are free from unnecessary harm.
Safe Culture	Create and maintain a strong, unified patient safety culture at KP, with patient safety and error reduction embraced as shared organizational values and acknowledged pre-requisites of "quality you can trust."
Safe Staff	Ensure staff possesses the knowledge and competence to safely perform required duties, improve system safety performance, and reduce workplace injuries. Develop new knowledge and provide ongoing education on patient and workplace safety for individuals and teams throughout the organization.
Safe Patients	Engage the patient and their family, as appropriate, as a partner in safety and in reducing medical errors improving system safety performance, and actively participating in their own safe care. Strive for collaborative relationships with patients and families in all aspects of the organization.

2024 SCAL & HI KP CARE AT HOME (HOME HEALTH) QUALITY PROGRAM DESCRIPTION

Core Theme	Description
Safe Place	Design, construct, operate, and maintain a safe environment of care as well as evaluate, purchase, and utilize equipment and products in a way that promotes the efficiency and effectiveness with which safe healthcare is provided.
Safe Systems	Identify, implement, and maintain support systems that provide the right information, to the right people, at the right time. This includes knowledge sharing networks, responsible reporting, and meaningful measures of risk and safety.

Annual Quality and Patient Safety Program Evaluation

Annually, management and staff will evaluate each component of the Quality and Patient Safety Program, including performance against targets and develop work plans for the ensuing year. The evaluation specifically:

- Targets the effectiveness of activities and actions taken in the previous year.
- Draws conclusions from those activities and actions.
- Performs an analysis of the barriers.
- Identifies priorities for improvement based upon evaluation and other data available.

Basic Home Safety - All patients/caregivers are given written information on basic safety including fire safety and environmental tips. Situations identified as unsafe related to the environment (fire, electrical, mobility, bathroom, etc.) are pointed out to the patient/caregiver. Instruction/training is provided to improve the situation. It is the patient's choice and responsibility to remedy identified (actual or potential) safety hazards. Ultimately, the home environment must be a safe and appropriate setting for meeting the patient's needs if the patient is to remain eligible for Home Health services.

Employee training is conducted on patient safety, e.g., precautions to prevent/control infections, medication, medical equipment, rehabilitation techniques, identification, handling and disposal of hazardous materials and wastes, etc.

Behavioral Health Care
Behavioral Health Care (BHC) is integrated into the Care at Home (Home Health) quality program. Licensed Medical/Clinical Social Workers (LCSW/MSW) are employees of the Care at Home (Home Health) Agency and provide psychosocial/spiritual counseling regarding death/dying and referrals for community assistance and/or financial resources to patients, patient's family, and care providers. The Social Worker is a member of the QAPI Committee and has the resources available to them from Psychiatry and Psychology.

Resources
The Care at Home (Home Health) Quality Teams will have access to adequate resources and work closely with regional, medical center or local partners. The following are examples of partner access.

- Regional Service Line Senior Leadership Team (e.g., KPCAH Vice President, KPCAH Sr. Director Clinical Excellence, KPCAH Senior Director of Home Health Operations and Senior Director of Finance, etc.)
- Divisional Service Line Administrator of Home Care
- Regional Director of Quality Continuing Care and Quality Team
- Regional Home Care Nurse Consultants and Sr. Managers
- Director of Patient Care Services (DPCS)
- Clinical Supervisors/Managers
- Patient Care and Clerical Staff
- Medical Center Quality Department Leader or designee

Components of Care at Home (Home Health) Quality Plan:

- Continuing education and professional development

- Professional credentialing, assessment for competency and ongoing performance appraisal
- Patient perception surveys and complaint monitoring
- Risk management, including unusual occurrence tracking, safety, and infection control monitoring.
- Active processes for problem identification
- Compliance to applicable laws and regulations
- Quality Assessment and Performance Improvement (QAPI)
- Outsourced Agency (Contract) oversight
- CMS STAR Rating for Quality and Service
- Analysis of OASIS data – Potentially Avoidable Event Reports (PAE); Internet Quality Improvement and Evaluation System (iQIES) Reports, CMS Care Compare Reports and HHCAHPs Reports.

Section 3 Credentialing, Privileging, and Peer Review

The KP-SCAL & HI Regional Care at Home (Home Health) Quality Management Program includes the methods for assessing and continuously improving the care delivered to hospital patients through the review of practitioner performance. Credentialing, privileging, and peer review are considered integral to the development and implementation of quality improvement, patient safety, resource utilization and risk management strategies.

The KPCAH Governance Council oversight of the Professional Staff includes reviews and recommendations of practitioners seeking privileges, and acts on results of focused practitioner performance evaluation (FPPE) and ongoing practitioners' performance evaluation (OPPE), and trends identified by peer review.

Credentialing and Privileges

Credentialing and privileging activities are conducted in accordance with written policies and procedures for credentialing, re-credentialing, privileging, appointment, reappointment, proctoring, and ongoing practitioner performance evaluation (OPPE). Recommendations for Professional Staff membership and/or clinical privileges are made by the KPCAH Governance Council for Medical and Licensed Social Workers (MSW/LCSW) and the physician will under the MEC associated with their medical center whose recommendations are further submitted to the KFH Board of Directors' QHIC for final approval consistent with the process delineated in the Professional Staff Bylaws.

The processes for renewal of clinical privileges and/or reappointment to the Professional Staff incorporate data from quality of care, professional conduct, quality assessment, peer review, professional liability experience, resource utilization, patient satisfaction, patient complaints, and the six general competencies (patient care, medical knowledge, practice-based learning and improvement, interpersonal communication skills, professionalism, and systems-based practice). A separate confidential quality file is maintained for each practitioner. Credentials and quality files are available to individual practitioners, chiefs of service, peer reviewers, and the MEC and KPCAH Governance Council at each step of the credentials and privilege processes.

Peer Review

Peer Review is an ethical and legal cornerstone of the medical profession and the process by which a practitioner's clinical performance is examined and critiqued by one or more individuals who have comparable professional education, training, knowledge, and experience. Peer review is conducted in accordance with written policies and procedures which are approved by the KPCAH Governance Council and MEC as appropriate to each discipline on behalf of the Professional Staff. All medical staff departments establish an ongoing and consistent quality program that includes peer review.

The objective of Peer Review is to:

- Assess and improve the care provided to patients.
- Determine if standards of care are met; evaluate and improve individual performance.
- Determine education and training needs to improve skills and outcomes.
- Identify and prioritize areas for systems improvement.
- Monitor trends through aggregate data.
- Promote a "Just Culture," in which practitioners and the organization learn from unanticipated outcomes.

The primary information used to identify issues requiring peer review include sentinel and other serious adverse events (actual or close call), department-specific monitoring, electronic monitoring of complication reports, mortality reports, infection control data, risk and utilization management data, contract management, customer service (patient concerns), and regulatory findings. Supplemental focused reviews are conducted as necessary to provide greater detail and empirical support regarding an area of practice and practitioner performance. Focused reviews may lead to the development or refinement of standards of practice or processes that can be used to improve clinical performance and as well to evaluate clinical competence.

The Agency's Medical Director, or designee, based on peer review findings may recommend activities to improve performance that include but are not limited to:

- Education programs
- Proctoring or Focused Professional Practice Evaluation (FPPE)
- Patient safety education or strategies
- Interdepartmental collaboration
- New protocols/guidelines or modification of existing protocols
- Modification of measures for review
- Acquisition and use of new equipment/technology
- Individual counseling of a practitioner
- Additional data collection and trending
- Performance improvement plans for individual providers.

Peer review data and information is considered by the KPCAH Governance Council and Medical Executive Committee in carrying out the functions of credentialing and privileging and in the assessment of the competency of the Professional Staff.

Outsourced Agency (Contract) Evaluation and Oversight

At least annually, **KFH-SCAL & HI KPCAH** Community Agency Division (CAD) assesses the quality monitoring of the agencies, organizations, and individuals with which it contracts for the provision of care, treatment, and services provided to the Care at Home (Home Health) patients. The outsourced agency Care at Home (Home Health) contract list will be reviewed annually based on quality and performance data, and if applicable elevated to the KPCAH Governance Council.

KFH-SCAL & HI KPCAH leaders will select and develop the best methods to oversee the quality and safety of services provided through contractual agreement. Examples of sources of information that may be used for evaluating contracted services include, but are not limited to the following:

- Review of information about the contractor's Joint Commission accreditation or certification status
- Direct observation of the provision of care
- Audit of documentation, including medical records
- Review of incident reports
- Review of periodic input from patient, family members or staff reports regarding performance/outcomes.
- Collect data that address the efficacy of the contracted service.
- Review of performance reports based on indicators and contractual expectations.
- Review of patient satisfaction studies

- Review of results of risk management activities

If contracted services do not meet expectations, leaders are expected to take appropriate steps to improve care, treatment, and services.

Outsourced Agency (Contract) Oversight

Contracted Services - All Certified Home Health Agencies with whom contracts are maintained are credentialed, prior to contracting, and re-credentialed to ensure that each provider is qualified and competent to provide care to KP patients and families. KP has access to member's medical records to extent permitted by state and federal law.

Section 4 Confidentiality

All Quality and Patient Safety Program data, committee minutes, reports, recommendations, memoranda, and documented actions created under the auspices of the Home Care agency's Quality and Patient Safety Program and its peer review processes are considered quality assurance documents and, therefore, subject to the protection of laws governing the confidentiality of peer review and/or quality assurance information. These documents are maintained in accordance with applicable confidentiality policies and procedures.

HIPAA: All KP physicians, employees, contractors, students, and volunteers are trained about the HIPAA of 1996. HIPAA is a federal law that established new standards for the privacy and security of protected health information.

Contract Services: KP requires its business associates to safeguard protected health information (PHI) that KP discloses to them, or that is created or received by them or behalf of KP. (HIPPA Policy for Business Associates)

Identification of Member/Stakeholders Needs, Expectations and Satisfaction
Member or stakeholder input is key to quality management. Each Care at Home (Home Health) will have methods in place to obtain input to help direct quality management efforts. Care at Home (Home Health) customers and or stakeholders include patients, their families and caregivers, physicians, agency staff and volunteers, and referring parties such as Hospitals/Alliance Facilities, Skilled Nursing Facilities, Discharge Planner's, and Physicians. Other stakeholders include departments that provide services including the Pharmacy, After Hours Advice, DME companies, and Contracted Agencies. The KP organization (e.g., Health Plan, Utilization Management, Resources, Quality, etc.), regulatory agencies, and the community in which services are provided are also customers/stakeholders of Home Health. Care at Home (Home Health) monitors to identify member/stakeholders' needs, expectations, and satisfaction.

Member Rights

A. **Accessibility:** clinical care/services 7 days/week, 365 days/year. The agency office hours are from 8:30 A.M. to 5:00 P.M. Care at Home (Home Health) office hours may vary across KP-SCAL/HI. After hours assistance, physician services and drugs and biologicals are routinely available on a 24 hour-basis.

   Care at Home (Home Health) meets the needs of homebound individuals for care that is skilled, intermittent, reasonable, and necessary.

B. **Phone Accessibility:** A nurse is available 7 days/week, 24 hours/day to respond to all calls from Care at Home (Home Health) patients and families. All other covered services are available on a 24-hour basis to the extent necessary to meet the needs of homebound individuals for care that is skilled, intermittent, reasonable, and necessary. Provisions of these services are in a manner consistent with accepted standards After-hours advice care is available for patients when unexpected situations arise. Individual patient needs are met by processes specific to each agency.

C. **Complaint Management:** Upon admission to service patients/families are provided with a Guide to Home

Health that includes Home Health Patient Rights, and they are encouraged to discuss all concerns and complaints with the Care at Home (Home Health) staff member or supervisor. The Guide to Home Health provides the patients/families with phone numbers for Member Service Call Center, Care at Home (Home Health), state toll-free "hotline" and The Joint Commission. Complaints can be received from many different areas, e.g., Member Services, phone interviews, patient satisfaction surveys. All complaints are investigated, and the findings and resolution are documented. Trends are identified, and action is taken based analysis of trend results.

D. **Employee/staff satisfaction:** Feedback from staff/employee is encouraged through many different sources, e.g., suggestion boxes, agency employee satisfaction surveys, participative labor/management partnership meetings, and the organization's employee satisfaction survey process (People Pulse), etc. Based on feedback changes are made, e.g., policies and procedures are revised or developed, performance improvement teams are formed with multidisciplinary team members.

E. **Privacy/Confidentiality:** The maintenance of patient privacy is a right of all patients. All field staff makes every effort to ensure patient privacy. All staff makes every effort to ensure confidentiality. These measures may include discussing patient issues only with authorized persons; discretion in discussing patient specifics when unauthorized persons may be able to hear; protecting sensitive written patient information from unauthorized disclosure. The patient has the right to confidentiality of the clinical records maintained by the Agency. The agency advises the patient of the policies and procedures regarding disclosure of clinical records during the admission process.

Medical Record
The Care at Home (Home Health) Agency medical record is the legal record used in documenting and communicating patient information and care. The content, availability, retention, and protection of the Home Health medical record meets all regulatory guidelines, e.g., Title 22 California, Title 11 Hawaii, Medicare Conditions of Participation, etc. See Member Rights above regarding confidentiality of medical record.

Continuum of Care
It is the objective of Home Health to provide all patients with continuity of care across the continuum from all three service lanes: Inpatient, Ambulatory and Home.

2024 SCAL & HI KP CARE AT HOME (HOME HEALTH) QUALITY PROGRAM DESCRIPTION

Regional Indicators

Domains of Quality	Home Health and Home Health with Palliative Pathway Quality Management Indicators	Frequency of Data Collection	Frequency of Reporting
Satisfaction	• CMS Home Health Patient Survey Star Rating • HHCAHPS for Home Health includes: • Summary Star Rating domains: • Rate of Agency • Communication	Monthly	Quarterly
Clinical Quality	• Potentially Avoidable Events – Monitoring occurs based as directed by CMS 1. Increase in # of Pressure Ulcers 2. Clinical Care issues 3. Documentation errors • CMS Care Compare Report • CMS Home Health Quality of Patient Care Star Ratings • Re-hospitalization Rate within 30 days from episode start of care (SHP data)	Quarterly Monthly Quarterly Monthly	Quarterly Quarterly Quarterly Quarterly
Infection Control	• Rate of Home Care acquired UTI w/Foley catheter • Rate of Central Line Associated Bloodstream Infections • Rate of GI infections • Rate of Genitourinary infections, excluding catheters • Rate of compliance with Hand Hygiene and Bag Technique by observation	Quarterly Monthly	Quarterly Quarterly
Access	• 48-hour admission timeliness	Monthly	Quarterly
Regulatory Compliance	• Accuracy of NOMNC for Home Health • Timeliness – Provided at least 48 hours prior to discharge • Accurate Content - Per CMS requirements • Contract agency NOMNC compliance • CHHA supervision • MD Face to Face visit • Home Health Certification/POC signed appropriately and timely by Physician • Home Health documentation supports medical necessity • Oasis error report compliance (Reports #909, #935, and #3330) • Language Assistance SB853 Compliance •	Monthly	Quarterly
Contract Oversight	• Home Health outside vendor contract a) Annual contract oversight for credentialing/recredentialing b) Monitoring of complaints/dissatisfaction c) Monitoring of unusual occurrences • Shift Care outside vendor contract	Monthly, Quarterly, Annual	Quarterly, Annual

	a) Annual contract oversight for credentialing/recredentialing b) Monitoring of complaints/dissatisfaction c) Monitoring of unusual occurrences • d) Shift care contract agreement agency oversight tool – shifts ordered vs shifts completed • e) Billing reconciliation compares shifts provided vs shifts ordered billing cycle		

2024 SCAL & HI KP CARE AT HOME (HOME HEALTH) QUALITY PROGRAM DESCRIPTION

Southern California Region & Hawaii
Health Plan Contract Oversight Procedure
Utilization Management of Shift Care Cases

SCAL & HI Regional Community Agency Division (CAD) provides oversight and responsibility for all contracted services under KPCAH. SCAL & HI Regional Quality provides consultative services to ensure quality of care for members in outside agencies and compliance with regulatory requirements including contractual obligations.

Purpose
Define a process for monitoring and evaluating the care and services provided by contract vendors to members that require shift care.

Procedure

Kaiser Permanente Responsibility

1. At the beginning of each shift care case the KPCAH (Home Health) will provide to the contract vendor the following information:
   a) provider type
   b) the number of hours per day, week, or month ordered by the physician on the Plan of Care (POC).
2. The clinical manager/designee will monitor the care and service provided by the contract vendor by the following:
   a) Contacts and informs the patient/family of the complaint procedures.
   b) Contacts, assesses, and documents patient/family satisfaction with care at least once every two-month period and as indicated by patient/family complaints or concerns identified by the contract vendor.
   c) Contacts vendor on a weekly basis to address problems and identify solutions up to and including patterns of missed shifts and finding alternate contract vendor to provide care if needed**. Director of Patient Care Services (DPCS)** and attending physician are notified when unable to resolve any identified problem with the contract agency.
   d) Completes the "Shift Care Contract/Agreement Agency Oversight Tool" as calls are made and received regarding missed shifts. Summarize form on a weekly basis until staffing appears stable and at least every 60 days thereafter.
   e) Compares shifts provided against shifts ordered during each billing cycle to determine that the contract vendor is notifying Kaiser each time the hours of care cannot be met according to the Plan of Care.
   f) Responds to and tracks member complaints regarding shift care coverage.
3. The **DPCS or designee** will monitor the adequacy of coverage and the development, implementation and resolution of action plans developed by the contract agency to correct identified problems.
4. When action plans developed and implemented by the contract agency fail to resolve identified problems, the **DPCS** or designee will develop an internal action plan designed to correct the identified problems up to and including interviewing and obtaining an alternate provider. The physician approving the patient's plan of care will be included in the development of the action plan and informed of its resolution.
5. The results of all contract oversight activities are reported at least annually and as needed to the Governing Board per local mechanisms.

Contract Vendor Responsibility

- Diligently seek coverage for open shifts and documents such attempts. Provides documentation to Kaiser when requested. Notifies Kaiser when shifts are canceled by patient/caregiver or when shifts are cancelled by contract vendor due to inability to staff and the number of shifts/hours/range fall below the shifts/hours/range specified on the POC. This notification must occur as soon as possible once known on the next business day.
- When unable to meet the hours ordered in the POC, assesses, and documents the patient/family's need for an Alternate level of care. Contacts and works with Kaiser when the patient/family requests an alternate level of care.
- Notify attending physician when unable to meet the POC orders.
- Cooperate with Kaiser in resolving identified problems.

- Develops and implements actions plans to correct identified problems. Keeps Kaiser informed on resolution of the action plans.
- Contract Agency notifies Kaiser of changes to the POC regarding the provider type and the number of hours per day, week, or month.
- Submit copies of the visit notes with each billing cycle when requested.
- Submit copy of POC and the RN visit note for each new patient and each recertification.

2024 KP Care at Home (Hospice) (**KPCAH-HO**) Quality Program Description Annual Work Plan

Kaiser Foundation SCAL & HI Region

Approved:
Kaiser Foundation Regional SCQC Committee on _____ (Date)
Accreditation and QRSS Committee on _____ (Date)

2024 SCAL & HI KP CARE AT HOME (HOSPICE) QUALITY PROGRAM DESCRIPTION

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2024 SCAL & HI KP CARE AT HOME (HOSPICE) QUALITY PROGRAM DESCRIPTION

Section 1 – Quality Program Overview

Purpose

The purpose of this Plan is to provide the mechanism for improving Kaiser Permanente Care at Home **KPCAH** (Hospice) Service quality and safety and to ensure that Kaiser Foundation Hospitals (KFH) Board of Directors' Quality and Health Improvement Committee (QHIC), Senior Leaders, Hospice Medical Staff, and Hospice Staff demonstrate a consistent and collaborative approach to deliver safe, effective, efficient, equitable, patient centered and timely care within a quality assurance and performance improvement (QAPI) framework. The activities in this plan are essential to achieving the strategic plan of Kaiser Foundation Hospital SCAL & Hawaii (HI) Regional KP Care at Home Services (**KFH-SCAL KPCAH**). This plan informs the improvement processes for patient outcomes, reducing and preventing medical errors, and applying remediation strategies in response to system or process failures.

KFH-SCAL & HI KPCAH allocates appropriate staff resources to develop and maintain the Quality and Patient Safety Program. The Professional Staff and Hospice operations managers are allocated time, office space, analytical services, and support staff to perform specialized quality roles, which includes participation in process improvement.

The foundational elements of all quality and patient safety initiatives and activities provide a framework that also supports quality improvement processes at **KFH-SCAL & HI KPCAH**. They are:

1. A systems approach, High Reliability Organizations (HRO), human error and human factors.
2. The creation and maintenance of a "Just Culture"
3. Proactive and prioritized performance improvements to prevent failure, mitigate organizational risk, improve systems, and elevate process reliability.
4. Seeking input from and collaborating with patients, families, and caregivers.
5. Assuring compliance with all state and national regulatory, accreditation, and certification standards supporting quality and patient safety.
6. Ongoing identification, sharing, and implementation of successful practices from other parts of internal and external healthcare or non-healthcare organizations.

Note: **KPCAH** "Kaiser Permanente Care at Home" consists of Home Health and Hospice Service Lines. Most agencies have joint licensing under Home Health, as opposed to two separate licensed programs. However, operationally, Hospice service lines may have their own Hospice license or operate under the license of the Home Health program. Therefore, for the duration of this document, **KPCAH** (Hospice)" will refer to the Hospice program, agency or service being provided.

Mission, Vision, Values, Guiding Principles & Goals

Mission:
Bring our patients home and keep our patients' home

Vision:
Be the leader of innovative in-home services that delivers exceptional experience through safe, affordable, and highly reliable care

Values: Commitment, Compassion and Comfort

2024 SCAL & HI KP CARE AT HOME (HOSPICE) QUALITY PROGRAM DESCRIPTION

Guiding Principles/Goals:

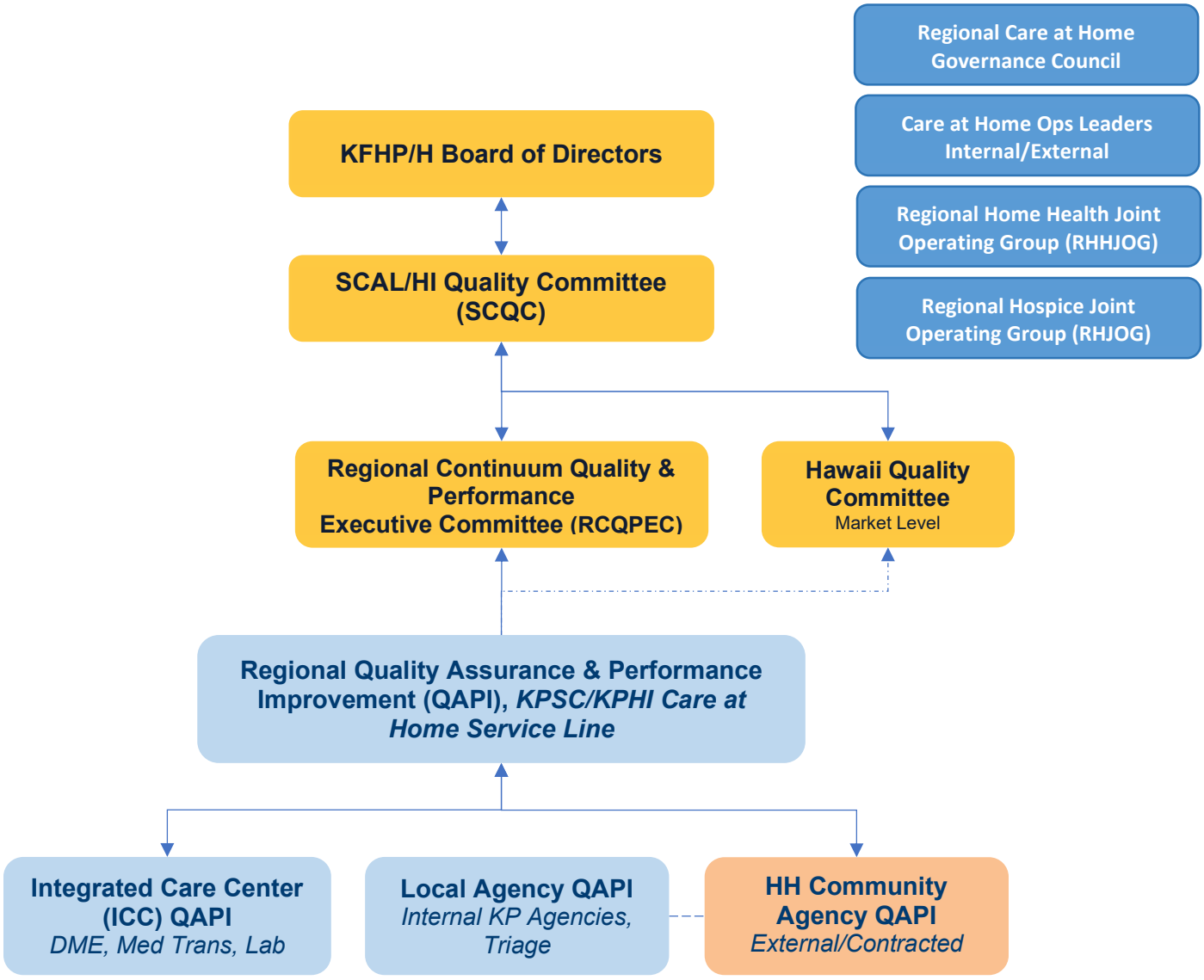
- Principle #1: Provide patients, families, and caregivers superior and sustained clinical and non-clinical care, services, and satisfaction across all touch points throughout the Continuum of Care.
- Principle #2: Drive improvement of clinical operations and sustain quality of care delivery.
- Principle #3: Create a culture of trust where employees are empowered to speak up on errors, system breakdowns and/or opportunities for improvement.
- Principle #4: Focus on identification and removal of system and process gaps, as opposed to individuals.
- Principle #5: Base decisions on data and input from all stakeholders, including the patient's voice.
- Principle #6: Set performance measure goals using Evidence Based Practice (EBP) and Plan-Do-Study-Act (PDSA) process improvement mediums.
- Principle #7: Encourage staff to support each other and to be accountable for their own professional performance and practice.
- Principle #8: Monitor reported billing accuracy via our Sarbanes-Oxley (SOX) review program.

2024 SCAL & HI KP CARE AT HOME (HOSPICE) QUALITY PROGRAM DESCRIPTION

Program Oversight, Authority, and KPCAH (Hospice) Governance Structure

The objective of **KFH-SCAL & HI KPCAH** Quality Program Management is to provide a leadership driven framework and organizational structure to achieve the mission and strategic goals of the organization. The Quality and Patient Safety Program structure and oversight ensures that consistent and systematic efforts are maintained to continually measure, assess, and improve processes and outcomes related to services provided.

Governance and Quality Oversight Structure



Legend:

- KFH/HP governance meeting or oversight groups
- Care at Home quality governance meetings
- Care at Home operational governance or oversight

QAPI: Quality Assurance and Performance Improvement

** ICC Care Support (transactional) functions will report through ICC QAPI*

***Agency functions centralized at ICC will report up through Local QAPI and ICC QAPI as appropriate*

2024 SCAL & HI KP CARE AT HOME (HOSPICE) QUALITY PROGRAM DESCRIPTION

Kaiser Foundation Hospitals Board of Directors:
KFH is a California non-profit, public benefit corporation that owns and operates general acute care hospitals and/or ambulatory facilities, and hospice home care agencies in California, Hawaii, Colorado, Georgia, Washington State, Oregon, and the Mid-Atlantic Region. Each hospice home care agency is licensed by the state in which it is located, certified by CMS, and accredited by The Joint Commission. KPCAH Governance Council, Regional Service Line Senior Leadership Team, the governing body, through its Quality and Health Improvement Committee ("QHIC"), oversees each KPAH Agency's Quality and Patient Safety Program through the KPCAH Vice President and SCAL & HI Regional Quality Director of Continuing Care. The QHIC assures each KPCAH agency's executive and Professional Staff leadership develops the KPAH Agency's program consistent with the KPAH's mission, vision, and values. The Agency's executive leadership is accountable to the QHIC to assure the planning and implementation, including establishing priorities for **KFH-SCAL & HI KPCAH** Quality and Program Management with respect to the delivery of existing services and the implementation of new KPCAH services. A KPCAH Agency consists of Home Health, Hospice and Home-Based Palliative Care Services. For the duration of this document will be referred to as **KPCAH** "(Hospice)".

Governing Structure:
The Governance of the **KP SCAL and HI** (Hospice) is made up of four organizational bodies, The Kaiser Foundation Governing Board, (via QHIC, Southern California Quality Committee, (SCQC), KPCAH Governance Council and the Care at Home Service Line structure.

Purpose of the Governing Body:
The Governing Body provides National, Regional, and local care delivery, management, and leadership oversight of all agencies within SCAL and HI. The Market President sets strategic priorities for Care at Home activities and provides market wide leadership under the Southern California Quality Committee and KPCAH Governance Council framework. Lastly, the governing body assumes full legal authority and responsibility for the operations of Care at Home (Hospice) in accordance with Medicare Conditions of Participation and Health Plan Regulations.

Governing Body Delegation:

The KFH Board of Directors has designated the CAH Vice President as the Governing Body of the licensed Home Health Agency. The Care at Home Service Line structure oversees the KFH and Kaiser Foundation Health Plan (KPHP) function as related to home care services and reports quality and experience metrics to the KPCAH Governance Council and SCQC. Additionally, the governing body assumes full legal authority and responsibility for the operation of Care at Home (Hospice) in accordance with Medicare Conditions of Participation.

The CAH Vice President appoints the Service Line Administrator as leader of their respective agencies. The CAH Vice President has delegated decision-making day-to-day authority for agency operations to the Senior Director of Hospice and Palliative Care and Service Line Administrators, and support functions to the service line leadership team. Such authority includes but is not limited to approving of policies and procedures, managing fiscal/budgetary matters, monitoring Hospice operations and quality performance and so forth.

Purpose of the Southern California Quality Committee (SCQC)

- Oversee the state of agency administration as outlined with established policies and procedures.
- Serve as a consulting partner to the KPCAH Governance Council to assume full legal authority and responsibility for the Service Line Operation of KPCAH (Hospice) in accordance with Medicare Conditions of Participation
- Ensure an ongoing program for quality improvement and patient safety is defined, implemented, and maintained. This program is to be evaluated annually.

- In accordance with federal *Conditions of Participation* (*COP*), this governing body is to mandate a group of multi-disciplinary professional personnel establish and annually review the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, infection control, clinical records, personnel qualifications, and program evaluation.
- Fulfill agency or branch compliance by conducting meetings at least three times per year with the Quality Assurance Performance Improvement (QAPI) or the Agency fulfils this by conducting an annual review meeting. QAPI minutes and supporting documentation will reflect evidence of compliance with regulations.
- Delegate day-to-day Hospice Quality Management program (HHQMP) oversight and escalation activities to the Continuing Care Quality Department. The Regional Director of Continuing Care Quality, or designee, reports agency performance on established quality indicators to the SPCCQC, QUEST, SCQC, and HI QRSS. The CAH Vice President is accountable to assure valid, reliable monitoring of agency performance on established or evolving quality indicators.

Purpose of the Regional Continuum Quality & Performance Executive Committee:

- 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.
- Review quality site visits, complaints/grievances, regulatory activities, survey activity/results, service area goals/performance, new compliance initiatives, contract oversight, quality measures, quality oversight of KFH contracted facilities.
- Standardized practices and increase efficiency in each service area.
- Identify and improve quality measures.
- Satisfaction survey program redesign to meet operating trends, efficiency, and quality improvement.
- This committee would meet every other month for 2 hours and report out to SCQC twice a year.

Purpose of KPCAH Governance Council:

- Joint council of PMG and KFH/HP senior leaders aligning all activities in the Care at Home setting
- Oversees the quality of care and financial performance
- Guide, review or consult on Hospice strategic plans, including the creation of new programs and services
- Provide direction to the business, property, affairs, and funds of the entity
- Ensure that the entity functions in the most effective and efficient manner
- Ensure alignment & integration of **KPCAH** Services across the continuum of care
- Promote adherence to KP's mission, values, goals, and strategies
- This council's oversight can be delegated through the Quality oversight function, service line leadership and/or Market Home Joint Operations Group meeting structure as found in attachment 1.

Regional Quality & KPCAH

Quality Management activities and oversight occur at varying levels in the Region. The Regional Hospice Quality Management Program describes minimum requirements for quality management activities across the Region**.** The Regional Director of Continuing Care Quality, or designee, reports agency performance on established quality indicators to the Southern California Continuing Care Quality Committee, Quality Evaluation and Support Team (QUEST) and Southern California Quality Committee (SCQC). The KPCAH Vice President is accountable to assure valid, reliable monitoring of agency performance on established or evolving quality indicators.

2024 SCAL & HI KP CARE AT HOME (HOSPICE) QUALITY PROGRAM DESCRIPTION

Kaiser Permanente Care at Home Service Line:
In adherence to the Market President's strategic priorities, the CAH Service Line is tasked to provide strategic, operational, and tactical direction of all home health care delivery in the SCAL and HI regions. The CAH service line develops workplans, implements strategic imperatives, conducts process improvement, and oversees clinical/operational performance. Leadership is also responsible for developing and implementing an effective planning process that allows for defining timely and clear goals.

This CAH service line sets priorities, organizes best practices/regional implementations, and collaborates with all partners on the physician, network agency or other departments to ensure adherence to the HOQMP. The CAH Vice President communicates local requirements and inquires with the **KFH-SCAL and HI KPCAH** Service Line Administrator in collaboration with the Regional Service Line Senior Leadership Team. CAH Vice President provides oversight and functional support for all local agencies and branches access, performance and care delivery quality and experience. Agency level requests of the Regional Service Line Senior Leadership Team, KPCAH Vice President, KPCAH Governance Council, and the Governing Body are made through this established chain of command.

Service Line is responsible for:

- Operating in partnership with Continuing Care leaders/Assistant Medical Center Administrator (AMCA) at each service area to ensure warm handoffs and seamless care transitions across settings.
- Ensuring collaboration with community leaders and organizations to design services to be provided by the hospital that are appropriate to the scope and level of care required by the population served
- Ensuring communication of the organization's mission, vision, values, goals, objectives, and strategies across the region
- Utilizing situational leadership behaviors to provide appropriate direction and management for all services
- Ensuring uniform delivery of patient care services provided throughout the region/agencies/branches
- Ensuring that systems are in place to promote the integration of services, and to support the patient beyond the hospital walls
- Appointing committees, work groups, performance improvement teams and other forums to ensure multidisciplinary and interdepartmental collaboration on issues of mutual concern
- Establishing structures and processes that focus on safety and quality, improving the health care safety of patients, and reducing preventable adverse patient events
- Implementing changes in existing processes to improve the quality of the care provided
- Establishing quality of care and patient safety metrics, which can be monitored
- Establishing a learning environment where employee development and continuing education opportunities serve to promote retention of staff and to foster excellence in the delivery of care and support services
- Providing ongoing patient safety training for all supervisors and field staff
- Promoting a "Just Culture" that recognizes human beings make mistakes, supports reporting, advocates fair treatment, and has intolerance for reckless behavior
- Ensuring that staffing resources are available, trained, and competent to appropriately meet the needs of the patients served
- Providing routine regular reports and ad-hoc reports as requested to the KPCAH Governance Council and the Board of Directors' QHIC

Service Line Agency Management Team
The daily operation of the KPCAH (Hospice) is vested in the Management Team who collectively and individually assume daily responsibility for Agency operations, staff performance and patient care outcomes. The Agency Management Team includes the Service Line Administrator and the Director of Patient Care Service, as well as clinical supervisors and may also include individuals who perform operational coordination roles. The Senior Director of Hospice and Palliative Care oversees the Agency Management Team and each member of the Management Team is carefully selected and qualified through credentialing, education, and experience for their level of supervision and managerial leadership.

2024 SCAL & HI KP CARE AT HOME (HOSPICE) QUALITY PROGRAM DESCRIPTION

The following describes the Management Team:

1. Service Line Administrator (SLA) appointed in writing by the KPCAH Vice President as delegated by the governing body of the KPCAH (Hospice) Agency to organize and direct the services and ongoing functions of the Agency. (See Hospice Policy 4-007 Appointment of Area Administrator). The Service Line Administrator (SLA) also annually approves the list of indicators that measure the quality of care, services delivered, appropriateness of the service, and regulatory readiness. Indicators are selected based on regulatory requirements, high risk or problem prone areas or significant trends identified in data collection results. These indicators will provide the basis for the quality program at each Agency and reflect the means to report on the aggregate status of all agencies throughout the Region.

2. **Director of Patient Care Services (DPCS) -** the clinical lead for day-to-day clinical needs in collaboration with internal and external departments and/or agencies. The DPCS oversees the clinical managers and supervisors and all field staff providing direct patient care.

3. **Continuing Care Quality Manager/Director-** functions as service line subject matter expert in regulations, accreditation, quality, performance improvement, survey readiness for regulatory & accreditation surveys, not limited to including compliance audits. Provides guidance and council for operations both clinical and administrative functions to improve performance at all levels. Augments education and training, interprets regulations for assessment of compliance. May serve as Improvement Advisors in the PI process.

4. **Service Line Nurse Consultant-** The Regional Home Care Nurse Consultant provides clinical expertise for areas of compliance, education, and training, which involve medical necessity and/or quality concerns. Utilizes clinical expertise to conduct investigations and seeks input from other clinical professionals as required. Responsible for reviewing and analyzing audit related reports and providing consultation on non-compliance. They support both internal and external agencies as appropriate.

5. **Clinical Supervisors, Administrative staff, Supervisors/Managers** -These positions provide direct supervision over-all front-line field staff (direct care and coordination) and/or office staff (. e.g., intake and scheduling). exist for the management/supervision of the direct patient care functions and agency operations.

6. Quality Coordinator – Registered Nurse who coordinates and reports quality outcome information related to identified important aspects of care, patient occurrences, patient satisfaction surveys, infection control and other outcome data. Monitors clinical performance improvement activities to ensure compliance with agency policies and procedures and standards established by accreditation and regulatory bodies and assist with the development of corrective action plans, where needed. Reports trends in documentation and patient care management to clinical management and subsequently develops educational programs to address deficits.

7. Quality Analyst – support position that gathers data, processes reports, and provides ready-to-validate packages of quality information to the quality coordinator. The quality analyst works under the direction of the quality coordinator.

8. **Medical Staff:** The Southern California Permanente Medical Group (SCPMG) and Hawaii Permanente Medical Group (HPMG) are organized, directed, and administered as a separate entity from KFH and KFHP.

9. **Regional Level**: The Medical Directors of SCPMG and HPMG are responsible for the executive level decisions made regarding SCPMG and HPMG issues.

Facility Based Medical Staff Positions:

- SCPMG or HPMG **(Hospice) Medical Director:** provides consultation and acts as a liaison to the

area Medical Director and Regional Departments. The responsibilities of the Medical Director shall include but are not limited to:

- direct access to the Care at Home (Hospice) management/staff members.
- participation in standards approval, quality management, utilization review and meetings (e.g., QAPI/IDG/, etc.),
- assist with conflict resolution.
- lead provision of direct medical home care
- designate alternative MD in his/her absence

Hospice Elected Physician: Patients admitted to KPCAH (Hospice) are attended by their Hospice elected physician. Responsibilities include, but are not limited to:

- authorize and sign the plan of care in a timely manner
- completing the Hospice Face to Face visit and attestation timely and accurately completing written Certification of Terminal Illness documents timely and accurately in accordance with the Center of Medicare and Medicaid Services, (CMS) regulations
- review and modify the plan of care as required
- participant in the KPCAH (Hospice) interdisciplinary teams
- provide necessary medical examination and care

KPCAH Governance Council is responsible to ensure the proper functioning of all departments, committees, and other activities of the Professional Staff. The KPCAH Governance Council oversees Professional Staff effectiveness, quality of care, patient safety practices and overall performance. The KPCAH Governance Council is responsible for the organization of the performance improvement, as well as the mechanisms used to conduct, evaluate, and revise such activities.

KPCAH **Regional Quality Assurance & Performance Improvement Plan (**QAPI**)** Committee serves as the committee to implement, monitor, and enhance operational systems to ensure quality improvement, performance improvement and patient safety for **KPCAH**. The Institute for Health Care Improvement (IHI) Model for Improvement as well as other performance improvement models (e.g., Plan-Do-Study-Act) and tools are utilized to organize efforts that improve the quality of health care delivered and the processes that support quality care for KPCAH.

Regional QAPI facilitates the preparation of reports related to the local **KPCAH** (Hospice) Agency's quality assurance, performance improvement, and patient safety activities to be submitted to the Board of Directors' QHIC through the on an annual basis and upon request.

Other committees: Coordination and integration of the QM activities occurs through formal or informal relationships at the medical center, regional and program levels. This includes other operational, clinical, professional practice or departmental committees/workgroups tasked by leadership to develop, implement, and monitor performance effectiveness for the services and processes within their scope. Regional Hospice Joint Operations Group is one such committee. These committees and work groups report up through the quality structure.

Section 2 – Performance Improvement

Performance Measure Overview

Performance measures are based on the strategic objectives each year. Process, outcome, and balancing measures are selected to reflect important aspects of care at the hospital, department and unit level and align

with the organizational program goals for Hospice. The Board of Directors' QHIC sets outcome measures for the safe quality care delivered to our patients. The Board of Directors' QHIC has also set an expectation that all **KPCAH** Agencies will plan for and implement processes needed to meet these outcome measures.

The Board of Directors' QHIC has set an expectation that the Hospice Service Line Administrator, in partnership with the Hospice Agency Medical Director will identify, prioritize, and remedy quality and safe patient care issues as they occur, consistent with the parameters of the quality plan. This is accomplished in part through the collaboration with the KPCAH Governance Council. Hospice leadership shall report these issues and their remediation on an annual basis in the Agency's annual quality and patient safety evaluation.

**Definitions:

- Outcome measures are high level metrics taken to improve the patients' health and wellbeing
- Process measures are the specific steps taken to measure how the systems are performing
- Balancing measures are metrics to ensure an improvement in one area is not negatively impacting another area or to provide a measure that, in isolation, lacks context

SCOPE

KPCAH (Hospice) use 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 process
- Compliance with applicable laws, regulations, and accreditation body standards
- Outsourced agency (contract) services
- Publicly reported data monitoring of performance improvement and service quality

Quality Oversight & Linkage

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

KPCAH Governance Council and the Regional QAPI Committee has oversight responsibility for the quality activity in the Hospice. The KPCAH Governance Council and the Regional QAPI Committee will review and approve the KPCAH Hospice Program Descriptions as well as the agency's Annual Work Plan and Program Evaluation. The Area Administrator or designee reports to the KPCAH Governance Council and the Regional QAPI Committee. Frequency of reporting is determined by the KPCAH Governance Council and the Regional QAPI Committee. The KPCAH Governance Council and the Regional QAPI Committee reviews all key quality monitors.

Quality Assurance Performance Improvement (QAPI)- Each Care at Home (Hospice) Agency has local minimum QAPI Committee which meets at a minimum of three times a year and may also have a QAPI workgroup which meets as needed to work on projects for improvement. This group advises agency and service line leadership on professional and performance improvement opportunities. The local agency QAPI team partners with the service area or medical center to enable seamless care transitions, address challenges, improve quality outcomes throughout the continuum of care.

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QAPI and/or Quality Membership: The membership shall include at least one physician, one registered nurse and appropriate representation from other professional disciplines. At least one member of the group shall be neither an owner nor an employee of the agency.

Local QAPI and/or Quality Duties:

- Meets at a minimum three times a year.
- Annually review the Agency policies regarding scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluations.
- Review quality outcome measures and quality improvement activity and make recommendations.
- Analyzes data, evaluates results of analysis and institutes QI activities as needed and ensures follow up as appropriate.
- Meet frequently to advise the Agency on professional issues.
- Maintain dated meeting minutes of the proceedings.
- QAPI minutes reflect all committee decisions & actions and recommendations and are dated and signed. These are reported to the KPCAH Vice President at least twice per year, quarterly preferred.
- Other duties, as deemed appropriate.

These committees will address quality issues, monitor agency performance for improvement activities, and track progress on action plans. This committee, under the leadership of the Director of Patient Care Services or designee analyzes data, evaluates results of analysis and institutes QI activities as needed and ensures follow-up as appropriate. QAPI focuses on high risk and high-volume measures that affect quality standards. Each Home Care (Hospice) will have a QAPI program. See Section below.

Interdisciplinary Group and/or Team (IDG): Each KPCAH (Hospice) has an interdisciplinary group or groups composed of individuals who provide or supervise the care and services offered by the hospice.

IDG Function: The IDG is a committee of professional personnel who are available to meet weekly or ad hoc basis to advise the KPCAH Hospice Leadership on professional, clinical, or miscellaneous issues related to patient care.

IDG Membership: The membership includes the following KPCAH Hospice employees or partners: at least one physician, one registered nurse, a social worker, and a pastoral or other counselor. Other clinical and administrative team members may attend such as, Volunteer Coordinators, Bereavement Coordinators, Home Health Aides, supervisors, Quality Coordinators, and Pharmacists. These members are not required to attend but may attend as applicable and as available.

IDG Duties:

- Participates in the establishment of the plan of care
- Provision or supervision of hospice care and services
- Periodic review and/or updating of the plan of care of patient's receiving hospice
- Evaluates on-going terminal decline for Hospice eligibility

IDG goals are to address quality of care issues, continued Hospice eligibility, plan of care update, performance improvement and action plan as related to patient care and service delivery.

KPCAH Service Line Quality Team and SCAL & HI Regional Leadership (Hospice) Leaders:
The Service Line Administrators and the Regional Service Line Senior Leadership Team, along with KPCAH Service Line Quality Team meet routinely and are responsible for overseeing the following QM activities:

- Structure, process, and outcome standards development
- Organize compliance monitoring of structure, processes, and outcome standards

- Aggregate collation of area statistics.
- Oversee the development of data sources for problem identification
- Monitor and resolve the effectiveness of problem identification methods
- Identify opportunities for improving systems, programs, and patient care; and
- Identify teams to pursue corrective action and improvement activities

Regional QAPI Committee: The KP Care at Home (Hospice) designated quality coordinators from each Agency meet at least 9 times per year with the Regional QAPI committee. The Regional QAPI Committee directs the quality assessment and quality improvement efforts for KP Care at Home (Hospice) and coordinates quality improvement activities for each agency. This committee exists to identify opportunities for improvement and consistency, and to conduct benchmark among the agencies. The committee coordinates and implements improvement initiatives, best practice opportunities and consistent education and training with the agency leaders and quality management staff. The Regional Hospice Operating Group (RHJOG) meetings will be merged with the Regional QAPI committee, reporting Quarterly on program updates, services, regulatory requirements, and service line changes impacting Quality, Care Experience, and outcomes.

The regional QAPI committee with agency members that meets monthly to review trends, regulatory compliance issues, set regional policy and procedures. This group will meet the second Thursday of each month virtually or in a designated place each month. This group will include the l Senior Director of Quality and Safety, Regional Practice Leader, Regional Clinical Director for **KPCAH (**Hospice), Regional Quality Managers and assigned Agency Quality Coordinators, Quality Analysts, Ad Hoc or Subject Matter Experts (SME) will be invited as needed. Physician leaders, DPCS delegates and Supervisor delegates will be invited to the quarterly Regional Hospice Joint Operating Group report outs.

Duties:

- Establish policies governing the day-today provision of hospice care and services
- Review Hospice policies annually regarding scope of services offered, admission discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluations
- Review quality outcome measures and quality improvement activities and make recommendations.
- Analyze data, evaluate results of analysis and institute QI activities as needed
- Ensure follow up of outliers or discrepancies as appropriate
- Meet frequently to advise on professional, clinical or outcome issues
- Maintain dated meeting minutes of the proceedings
- Meeting minutes reflect all committee decisions & actions and recommendations and are dated and signed
- Other duties, as deemed appropriate

Home Care (Home Health) Quality Assurance and Performance Improvement Program
The KPCAH (Hospice) has a Quality Assurance Performance Improvement (QAPI) Committee, who participate in the evaluation of the Agency's program**.** The QAPI committee also assists the Agency in maintaining liaison with other Health Care providers in the community, as well as with the Agency's community information program. This committee exists to identify opportunities for improvement and consistency, and to conduct benchmark among the agencies. The committee coordinates and implements improvement initiatives, best practice opportunities and consistent education and training with the agency leaders and quality management staff. *Local QAPI Membership:* the following Hospice (or organizations) employees: at least one physician, one registered nurse, a social worker, and a pastoral or other counselor(chaplain).

2024 SCAL & HI KP CARE AT HOME (HOSPICE) QUALITY PROGRAM DESCRIPTION

Hospice Quality Assurance and Performance Improvement Program (QAPI)
The QAPI program will be integrated in services that impact **KPCAH** (Hospice) Agency services, including Durable Medical Equipment (DME), Long Term Care Services (LTC), Ambulance and Transportation and Long-Term Support Services (LTSS) services to our members in Southern California. The QAPI program will support improvements in outcomes by measuring, analyzing, and tracking quality indicators, including adverse events reports (AER) and other performance indicators. The QAPI program will identify gaps in systems and processes, accessing all available data sources to look at the bigger picture to identify potential problem areas. The QAPI program will trend outcomes for tracking of monitored indicators such as medication management, medical device reporting, OSHA reporting, infections, unusual occurrences/significant events, i.e., falls, patient complaints and grievance logs.

QAPI Goals:

- Address compliance/regulatory requirements outlined by Center for Medicare & Medicaid Services (CMS)
- Collect, monitor, review, compare, and interpret data from various sources-CASPER, QIES, PEPPER, Care Compare, Hospice CAHPS, vendors, and chart audits, etc.
- Ensure *safe, effective, appropriate, and affordable care* as we manage through efficacy, availability, timeliness, continuity, safety, respect, and care
- Incorporate PI methodologies to address clinical and psychosocial issues
- Assess, measure, analyze and evaluate systematically quality of care and service provided to patients
- Ensure continuity and coordination of care and service to members
- Assure credentialing policies and procedures meet expectations, are implemented, and maintained
- Promote communication and feedback of quality findings and targeted improvement efforts
- Identify areas to improve processes, patterns, and outcomes of care
- Assure compliance with internal and external accrediting and regulatory standards
- Each KPCAH (Hospice) Agency establishes goals as described in each QI Plan

Program Activities, Scope and Focus: *(including but not limited to...)*

- QAPI Program will gather input from focus groups, process mapping to identify areas of improvements. It will consolidate, and prioritize, considering if the area is a high-risk problem versus an opportunity for improvement. The program will look for alignment to other current quality indicators that measure outcomes and key indicator to determine if standards have been met
- Leverage of Member/Stakeholders Needs, Expectations and Satisfaction
- Adhere to all Quality Management Project Model scopes found in this document
- Target high-risk, high volume, or problem prone areas of service, considering the incidence, prevalence, and severity of problems in those areas. The goal is to correct any immediate problem that directly or potentially threatens the health and safety of our patients
- Track and analyze unusual occurrences and complaints utilizing Midas so that the agency can implement preventative actions and sustainable measures
- Use Critical Event Analysis (CEA) or Inter-Rater Reliability (IRR) to identify contributing causal factors that leads to variations in performance
- Reference any regulatory and clinical performance standards to identify deviations; implement changes or corrective actions that will result in improvement, testing small pilots before rolling out to entire region; review QAPI plan every year (continuing to show improvement)
- Access online QAPI courses at National Association for Healthcare Quality (NAHQ), National Hospice and Palliative Care Organization (NHPCO), and the California Association of Health Services at Home (CAHSAH) to stay versed in- Home Care (Hospice) QAPI, topic specific courses related Performance Improvement, Data Interpretation and Reliability, and Clinical Improvement Outcome
- Comply with regulatory and accreditation review requirements, including Centers for Medicare and

Medicaid Services, California Department Public Health-, Medi-Cal and Medicaid, California Department of Managed Health Care and The Joint Commission
- Support Patient Safety and Behavioral Health Care Programs
- The program will foster sharing state-of-the-art QA&I practices and strategies that widely support the Continuum of Care improvement efforts
- Set QA&I activity priorities to support Strategic Goal achievement
- Incorporate member expectations into standards of care and service
- Support Continuum of Care management activities development

Methodology for Structured Performance Improvement:

A. Plan – Do – Study/Check - Act

The research method followed to assess, monitor, and continuously improve **KPCAH** (Hospice) processes and performance is the Plan – Do – Study/Check – Act (PDS/CA) cycle for performance improvement. Each performance improvement initiative and indicator managed by the Agency QI Team has improvement activities that follow or align with the PDS/CA Cycle. Local Agency performance improvement activities may follow methods similar to PDS/CA as approved by the Regional Quality Committee.

B. Statistical Processes and Tools

Statistical Process Control (SPC) tools e.g., Pareto analyses, trending data, use of control charts, and other performance improvement tools are used to analyze and display data and applied to determine whether an indicator or a process is stable and functional within acceptable variation or customer and stakeholder needs.

Patient Safety

To permeate responsibility and mutual accountability for patient safety throughout our organization, KP will continue to implement activities broadly aimed at becoming a highly reliable organization by achieving the following six strategic themes:

Core Theme	Description
Safe Care	Ensure the actual and potential hazards associated with high-risk procedures, processes, and patient care populations are identified, assessed, and controlled in a way that demonstrates continuous improvement and moves the organization toward high reliability and the ultimate objective of ensuring our patients are free from unnecessary harm.
Safe Culture	Create and maintain a strong, unified patient safety culture at KP, with patient safety and error reduction embraced as shared organizational values and acknowledged pre-requisites of "quality you can trust."
Safe Staff	Ensure staff possesses the knowledge and competence to safely perform required duties, improve system safety performance, and reduce workplace injuries. Develop new knowledge and provide ongoing education on patient and workplace safety for individuals and teams throughout the organization.
Safe Patients	Engage the patient and their family, as appropriate, as a partner in safety and in reducing medical errors improving system safety performance, and actively participating in their own safe care. Strive for collaborative relationships with patients and families in all aspects of the organization.
Safe Place	Design, construct, operate, and maintain a safe environment of care as well as evaluate, purchase, and utilize equipment and products in a way that promotes the efficiency and effectiveness with which safe healthcare is provided.

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Core Theme	Description
Safe Systems	Identify, implement, and maintain support systems that provide the right information, to the right people, at the right time. This includes knowledge sharing networks, responsible reporting, and meaningful measures of risk and safety.

Annual Quality and Patient Safety Program Evaluation

Annually, management and staff will evaluate each component of the Quality and Patient Safety Program, including performance against targets and develop work plans for the ensuing year. The evaluation specifically:

- Targets the effectiveness of activities and actions taken in the previous year
- Draws conclusions from those activities and actions
- Performs an analysis of the barriers
- Identifies priorities for improvement based upon evaluation and other data available

Basic Home Safety
All patients/caregivers are given written information on basic safety including fire safety and environmental tips. Situations identified as unsafe related to the environment (fire, electrical, mobility, bathroom, etc.) are pointed out the patient/caregiver. Instruction/training is provided to improve the situation. It is the patient's choice and responsibility to remedy identified (actual or potential) safety hazards. Ultimately, the home environment must be a safe and appropriate setting for meeting the patient's needs if the patient is to remain eligible for KPCAH Hospice services.

Employee training is conducted on patient safety, e.g., precautions to prevent/control infections, medication, medical equipment, rehabilitation techniques, identification, handling and disposal of hazardous materials and wastes, etc.

Behavioral Health Care
Behavioral Health Care (BHC) is integrated into the KPCAH (Hospice) quality program. Licensed Medical/Clinical Social Workers (LCSW/MSW) are employees of the KPCAH (Hospice) and provide psychosocial/spiritual counseling regarding death/dying, bereavement and referrals for community assistance and/or financial resources to patients, patient's family, and care providers. The LCSW/MSW is a member of the IDG Committee and has the resources available to them from Psychiatry and Psychology.

Resources
The KPCAH (Hospice) Quality Team's will have access to adequate resources and work closely with regional, medical center or local partners. The following are examples of partner access

- Regional Service Line Senior Leadership Team (e.g., KPCAH Vice President, Senior Director of Clinical Excellence, KPCAH Senior Director of Hospice and Palliative Care, Senior Director of Finance, etc.)
- Divisional Service Line Administrator of Home Care (Hospice)
- Senior Director of Quality and Safety and team
- Regional Home Care Nurse Consultants and Senior Managers
- Director of Patient Care Services (DPCS)
- Clinical Supervisors/Managers
- Patient Care and Clerical Staff
- Medical Center Quality Department Leader or designee

Components of KPCAH **(Hospice) Quality Plan:**

- Continuing education and professional development
- Professional credentialing, assessment for competency and ongoing performance appraisal

- Patient perception surveys and complaint monitoring
- Risk management, including unusual occurrence tracking, safety, and infection control monitoring
- Active processes for problem identification
- Compliance to applicable laws and regulations
- Quality Assessment and Performance Improvement (QAPI) CMS
- Outsourced Agency (Contract) oversight
- CMS Hospice CAHPS for Quality and Service
- PEPPER reports
- Bi-annual SOX Audit and Review
- Hospice Item Set and Internet Quality Improvement and Evaluation System (QIES) Reports

Section 3 Credentialing, Privileging and Peer Review

The KP-SCAL **KPCAH** (Hospice) Quality Management Program includes the methods for assessing and continuously improving the care delivered to hospital patients through the review of practitioner performance. Credentialing, privileging, and peer review are considered integral to the development and implementation of quality improvement, patient safety, resource utilization and risk management strategies.

The KPCAH Governance Council oversight of the Professional Staff includes reviews and recommendations of practitioners seeking privileges, and acts on results of focused practitioner performance evaluation (FPPE) and ongoing practitioners' performance evaluation (OPPE), and trends identified by peer review.

Credentialing and Privileges

Credentialing and privileging activities are conducted in accordance with written policies and procedures for credentialing, re-credentialing, privileging, appointment, reappointment, proctoring, and ongoing practitioner performance evaluation (OPPE). Recommendations for Professional Staff membership and/or clinical privileges are made by the KPCAH Governance Council for Medical and Licensed Social Workers (MSW/LCSW) and the physician will under the MEC associated with their medical center whose recommendations are further submitted to the KFH Board of Directors' QHIC for final approval consistent with the process delineated in the Professional Staff Bylaws.

The processes for renewal of clinical privileges and/or reappointment to the Professional Staff incorporate data from quality of care, professional conduct, quality assessment, peer review, professional liability experience, resource utilization, patient satisfaction, patient complaints, and the six general competencies (patient care, medical knowledge, practice-based learning and improvement, interpersonal communication skills, professionalism, and systems-based practice). A separate confidential quality file is maintained for each practitioner. Credentials and quality files are available to individual practitioners, chiefs of service, peer reviewers, and the KPCAH Governance Council at each step of the credentials and privilege processes.

Peer Review

Peer Review is an ethical and legal cornerstone of the medical profession and the process by which a practitioner's clinical performance is examined and critiqued by one or more individuals who have comparable professional education, training, knowledge, and experience. Peer review is conducted in accordance with written policies and procedures which are approved by the KPCAH Governance Council, and MEC as appropriate to each discipline on behalf of the Professional Staff. All medical staff departments establish an ongoing and consistent quality program that includes peer review.

The objective of Peer Review is to:

- Assess and improve the care provided to patients
- Determine if standards of care are met; evaluate and improve individual performance
- Determine education and training needs to improve skills and outcomes
- Identify and prioritize areas for systems improvement
- Monitor trends through aggregate data
- Promote a "Just Culture", in which practitioners and the organization learn from unanticipated outcomes

The primary information used to identify issues requiring peer review include sentinel and other serious adverse events (actual or close call), department-specific monitoring, electronic monitoring of complication reports, mortality reports, infection control data, risk and utilization management data, contract management, customer service (patient concerns), and regulatory findings. Supplemental focused reviews are conducted as necessary to provide greater detail and empirical support regarding an area of practice and practitioner performance. Focused reviews may lead to the development or refinement of standards of practice or processes that can be used to improve clinical performance and as well to evaluate clinical competence.

The Agency's Medical Director, or designee, based on peer review findings may recommend activities to improve performance that include but are not limited to:

- Education programs
- Proctoring or Focused Professional Practice Evaluation (FPPE)
- Patient safety education or strategies
- Interdepartmental collaboration
- New protocols/guidelines or modification of existing protocols
- Modification of measures for review
- Acquisition and use of new equipment/technology
- Individual counseling of a practitioner
- Additional data collection and trending
- Performance improvement plans for individual providers

Peer review data and information is considered by the KPCAH Governance Council and Medical executive Committee in carrying out the functions of credentialing and privileging and in the assessment of the competency of the Professional Staff.

Outsourced Agency (Contract) Evaluation and Oversight

At least annually, **KFH-SCAL and HI KPCAH** Community Agency Division (CAD) assesses the quality monitoring of the agencies, organizations, and individuals with which it contracts for the provision of care, treatment, and services provided to the **KPCAH** (hospice) patients. The outsourced agency **KPCAH** (hospice) contract list will be reviewed annually based on quality and performance data, and if applicable elevated to the KPCAH Governance Council or **KPCAH** Governance Committee.

KFH-SCAL and HI KPCAH leaders will select and develop the best methods to oversee the quality and safety of services provided through contractual agreement. Examples of sources of information that may be used for evaluating contracted services include, but are not limited to the following:

- Review of information about the contractor's Joint Commission accreditation or certification status
- Direct observation of the provision of care
- Audit of documentation, including medical records
- Review of incident reports
- Review of periodic input from patient, family members or staff reports regarding performance/outcomes
- Collect data that address the efficacy of the contracted service
- Review of performance reports based on indicators and contractual expectations

- Review of patient satisfaction studies
- Review of results of risk management activities

If contracted services do not meet expectations, leaders are expected to take appropriate steps to improve care, treatment, and services.

Outsourced Agency (Contract) Oversight

Contracted Services - All Certified Hospice Agencies with whom contracts are maintained are credentialed, prior to contracting, and re-credentialed to ensure that each provider is qualified and competent to provide care to KP patients and families. KP has access to member's medical records to extent permitted by state and federal law.

Section 4 Confidentiality

All Quality and Patient Safety Program data, committee minutes, reports, recommendations, memoranda, and documented actions created under the auspices of the Hospice agency's Quality and Patient Safety Program and its peer review processes are considered quality assurance documents and, therefore, subject to the protection of laws governing the confidentiality of peer review and/or quality assurance information. These documents are maintained in accordance with applicable confidentiality policies and procedures.

HIPAA: All KP physicians, employees, contractors, students, and volunteers are trained about the HIPAA of 1996. HIPAA is a federal law that established new standards for the privacy and security of protected health information.

Contract Services: KP requires its business associates to safeguard protected health information (PHI) that KP discloses to them, or that is created or received by them or behalf of KP. (HIPPA Policy for Business Associates)

Identification of Member/Stakeholders Needs, Expectations and Satisfaction
Member or stakeholder input is key to quality management. Each KPCAH (Hospice) will have methods in place to obtain input to help direct quality management efforts. KPCAH (Hospice) customers and or stakeholders include patients, their families and caregivers, physicians, agency staff and volunteers, and referring parties such as Hospitals/Alliance Facilities, Skilled Nursing Facilities, Discharge Planner's, and Physicians. Other stakeholders include departments that provide services including the Pharmacy, After Hours Advice, DME companies, and Contracted Agencies. The KP organization (e.g., Health Plan, Utilization Management, Resources, Quality, etc.), regulatory agencies, and the community in which services are provided are also customers/stakeholders of KPCAH Hospice. KPCAH (Hospice) monitors to identify member/stakeholders' needs, expectations, and satisfaction.

Member Rights

A. Accessibility - clinical care/services 7 days/week, 365 days/year. The agency office hours are generally from 8:30 A.M. to 5:00 P.M. KPCAH (Hospice) office hours may vary across KP-SCAL and HI KPCAH. Nursing services, physician services and drugs and biologicals are routinely available on a 24 hour-basis.

KPCAH (Hospice) meets the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illnesses and related conditions. KPCAH Hospice provides 4 levels of care: (1) routine home care; (2) continuous home care; (3) inpatient respite care; and (4) general inpatient care.

B. Phone Accessibility: A triage nurse is available 7 days/week, 24 hours/day to respond to all calls from KPCAH (Hospice) patients and families. All other covered services are available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions. Provisions of these services are in a

manner consistent with accepted standards. After-hours advice care is available for patients when unexpected situations arise. Individual patient needs are met by processes specific to each agency.

C. **Complaint Management:** Upon admission to service patients/families are provided with a Guide to Hospice that includes KPCAH Hospice Patient Rights, and they are encouraged to discuss all concerns and complaints with the KPCAH (Hospice) staff member or supervisor. The Guide to Hospice provides the patients/families with phone numbers for Member Service Call Center, KPCAH (Hospice), state toll-free "hotline" and The Joint Commission. Complaints can be received from many different areas, e.g., Member Services, phone interviews, patient satisfaction surveys. All complaints are investigated, and the findings and resolution are documented. Trends are identified and action is taken based analysis of trend results.

D. **Employee/staff satisfaction:** Feedback from staff/employee is encouraged through many different sources, e.g., suggestion boxes, agency employee satisfaction surveys, participative labor/management partnership meetings, and the organization's employee satisfaction survey process (People Pulse), etc. Based on feedback changes are made, e.g., policies and procedures are revised or developed, performance improvement teams are formed with multidisciplinary team members.

E. **Privacy/Confidentiality:** The maintenance of patient privacy is a right of all patients. All field staff makes every effort to ensure patient privacy. All staff makes every effort to ensure confidentiality. These measures may include discussing patient issues only with authorized persons; discretion in discussing patient specifics when unauthorized persons may be able to hear; protecting sensitive written patient information from unauthorized disclosure. The patient has the right to confidentiality of the clinical records maintained by the Agency. The agency advises the patient of the policies and procedures regarding disclosure of clinical records during the admission process.

Medical Record

KPCAH (Hospice) medical record is the legal record used in documenting and communicating patient information and care. The content, availability, retention, and protection of the KPCAH (Hospice) medical record meet all regulatory guidelines, e.g., Title 22, Medicare Conditions of Participation, etc. See Member Rights above regarding confidentiality of medical record.

Continuum of Care

It is the objective of KPCAH (Hospice) to provide all patients with continuity of care across the continuum from all three service lanes: Inpatient, Ambulatory and Home.

2024 SCAL & HI KP CARE AT HOME (HOSPICE) QUALITY PROGRAM DESCRIPTION

Regional Hospice Indicators

	Hospice Quality Management Indicators	Frequency of Data Collection	Frequency of Reporting

Satisfaction	• Satisfaction survey data monitoring KPCAH (Hospice) CAHPS data through NCEA
	  • Rating of Patient Care from This Hospice
	  • #35 Hospice Team Listened Carefully to Caregiver
	  • #14 Hospice Team Listened Carefully about Problems with Care
	  • #7 Received help as soon as wanted
	•
		Monthly	Quarterly

Access	• 24-hour admission timeliness		
Clinical Quality	• Record Review of Hospice Care: ○ Terminality/LLOS	Monthly	Quarterly
Infection Control	• Rate of **Hospice** acquired UTI w/Foley catheter • Rate of compliance with Hand Hygiene observation	Quarterly Monthly	Quarterly Quarterly
Regulatory Compliance	• Hospice Aide supervision • MD Face to Face visit • Hospice benefit election form completed accurately • Hospice CTI accurate and timely • Hospice medical record documentation supports terminal illness criteria • Hospice SB853 Language Assistance compliance • HIS Completion and Transmission • SOX billing compliance	Monthly Monthly	Quarterly Monthly

2024
Regional Virtual Medical Center
Quality and Patient Safety
Program Description
Annual Work Plan and Evaluation

Approved by the _____ Medical Executive Committee on _____ (Date)

2024
REGIONAL VIRTUAL MEDICAL CENTER
QUALITY AND PATIENT SAFETY
PROGRAM DESCRIPTION

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REGIONAL VIRTUAL MEDICAL CENTER
QUALITY AND PATIENT SAFETY
PROGRAM DESCRIPTION

Section 1 – Quality and Patient Safety Program Overview

Purpose

The purpose of this Plan is to provide the mechanism for improving the Regional Virtual Medical Center ("RVMC") quality and safety and to ensure that Southern California Permanente Medical Group ("SCPMG") and Kaiser Foundation Hospitals Board of Directors' Southern California Quality Committee ("SCQC"), Senior Leaders, Medical Staff, and Hospital Staff demonstrate a consistent and collaborative approach to deliver safe, effective, efficient, equitable, patient centered and timely care within a quality assurance and performance improvement (QAPI) framework. The activities in this plan are essential to achieving the strategic plan of Kaiser Foundation Hospital and SCPMG – Regional Virtual Medical Center. This plan informs the improvement processes for patient outcomes, reducing and preventing medical errors, and applying remediation strategies in response to system or process failures.

SCPMG and Kaiser Foundation Health Plan allocates appropriate staff resources to develop and maintain the Regional Virtual Medical Center Quality and Patient Safety Program. SCPMG and Kaiser Foundation Health Plan operations managers are allocated time, office space, analytical services, and support staff to perform specialized quality roles, which includes participation in process improvement.

The foundational elements of all quality and patient safety initiatives and activities provide a framework that also supports quality improvement processes at SCPMG and Kaiser Foundation Health Plan. They are:

1. An understanding of systems thinking, High Reliability Organizations (HRO), human error and human factors.
2. The creation and maintenance of a culture in which reporting takes place in a "Just Culture"
3. Proactive and prioritized performance improvements to prevent failure, mitigate hazards, and improve systems and process reliability.
4. Seeking input from and collaborating with patients and families.
5. Assuring compliance with all state and national regulatory, accreditation, and certification standards supporting quality and patient safety.
6. Ongoing identification, sharing, and appropriate implementation of successful practices from other parts of the organization, other healthcare organizations, and organizations outside of healthcare.

Mission, Vision, Values

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

Vision:
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.

RVMC Vision:
The KPSC Regional Virtual Medical Center enables convenience and high-quality care for our patients, promotes wellness for our care teams and employs a cost-effective operating model that ensures a sustainable business. We operationalize the care delivery models of tomorrow.

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Values:
In carrying out our mission and goals, we maintain core values of respect, scientific discipline, integrity, pioneering spirit, and stewardship.

Program Oversight, Authority, and Governance Structure

The objective of the Regional Virtual Medical Center's Quality and Patient Safety Program is to provide a leadership driven framework and organizational structure to achieve the mission and strategic goals of the organization. The structure and oversight ensures that consistent and systematic efforts are maintained to continually measure, assess, and improve processes and outcomes related to services provided.

AUTHORITY AND STRUCTURE

Khang Nguyen, MD
Care Transformation
Asst Executive Medical Director

Alan Evans, MD
Regional Physician Director of Business Services,
Clinical Delivery

Patrick Springob, MD
Regional Physician Director of Business Services
RVMC Core Operations

Jin Chang, MD
Regional Physician Director,
Business Services, Clinical Delivery

Yvonne Bach, MD
Regional Physician Director of Business Services,
Pan Permanente Initiatives, Pediatrics and Education

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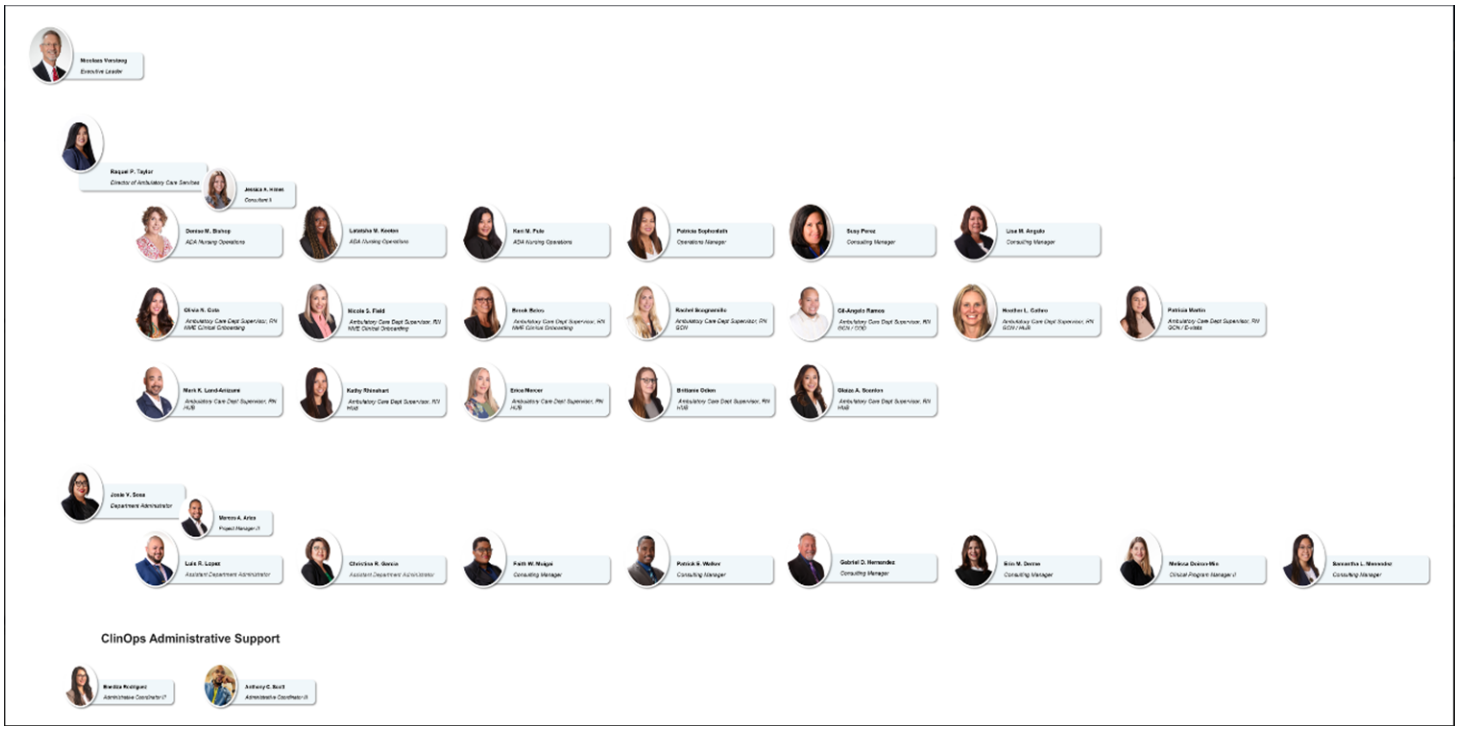

Permanente Medical Group:
Permanente Medicine is physician-led health care delivered to Kaiser Permanente patients and members with compassion and respect, by physicians and allied health providers who are called to practice medicine.

In partnership with Kaiser Foundation Health Plan and Hospitals, the Permanente Medical Groups are dedicated to the mission of improving health of our patients and communities.

Regional Virtual Medical Center Leadership:
The RVMC Clinical Operations is managed by the Asst Admin Ops & CNO SCPMG, who serves as the Administrator and works in collaboration with the SCPMG Regional Virtual Medical Center Physician Director. Leadership is responsible for providing a framework for the delivery of quality care and services provided by the Regional Virtual Medical Center based on SCPMG and Health Plan's mission, SCQC, and identified opportunities for improvement. Leadership is also responsible for developing and implementing an effective planning process that allows for defining timely and clear goals.
The RVMC Asst Admin Ops & CNO SCPMG, Regional Associate Medical Group Administrator, SCPMG Virtual Medical Center Physician Director, and Assistant Physician Medical Director collaborate with the Regional VMC Administrator for Quality and Patient Safety as well as other members of the leadership team on implementing the quality and patient safety program.

Leadership is responsible for:

- Ensuring collaboration with community leaders and organizations to design services to be provided by the RVMC that are appropriate to the scope and level of care required by the population served;
- Ensuring communication of the organization's mission, vision, values, goals, objectives and strategies across the facility;
- Utilizing situational leadership behaviors to provide appropriate direction and management for all services and/or departments;

- Ensuring uniform delivery of patient care services provided through the RVMC;
- Ensuring that systems are in place to promote the integration of services, and to support the patient beyond the RVMC
- Appointing committees, work groups, performance improvement teams and other forums to ensure multidisciplinary and interdepartmental collaboration on issues of mutual concern;
- Establishing structures and processes that focus on safety and quality, improving the health care safety of patients, and reducing preventable adverse patient events;
- Implementing changes in existing processes to improve the quality of the care provided ;
- Establishing quality of care and patient safety metrics, which can be monitored through the RVMC's plan;
- Establishing a learning environment where employee development and continuing education opportunities serve to promote retention of staff and to foster excellence in the delivery of care and support services;
- Providing ongoing patient safety training for Physicians, Advanced Practice Providers, Registered Nurses, Licensed Vocational Nurses and RVMC staff;
- Promoting a "Just Culture" that recognizes human beings make mistakes, supports reporting, advocates fair treatment, and has intolerance for reckless behavior;
- Ensuring that staffing resources are available, trained and competent to appropriately meet the needs of the patients served;
- Ensuring the Medical Executive Committee submits reports to the Board of Directors' SCQC regularly and as requested; and
- Providing routine reporting and special reports as requested to the Board of Directors' SCQC

Southern California Quality Committee (SCQC) serves as the committee to implement, monitor and enhance operational systems to ensure quality improvement, performance improvement and patient safety for the RVMC. The Institute for Health Care Improvement (IHI) Model for Improvement as well as other performance improvement models (e.g. Plan-Do-Study-Act) and tools are utilized to organize efforts that improve the quality of health care delivered and the processes that support quality care.

Section 2 – Performance Improvement

Performance Measure Overview

Performance measures are based on the strategic objectives each year. Process, outcome, and balancing measures* are selected to reflect important aspects of care at the RVMC and align with the organizational (i.e., SCPMG) program goals for RVMC. The Board of Directors' SCQC sets outcome measures for the safe quality care delivered to our patients. The Board of Directors' SCQC has also set an expectation that this program will plan for and implement processes needed to meet these outcome measures.

The Board of Directors' SCQC has set an expectation that the Regional Virtual Medical Center administrator in partnership with the SCPMG Regional Virtual Medical Center Physician Director will identify, prioritize and remedy quality and safe patient care issues as they occur, consistent with the parameters of the quality plan. This is accomplished in part through the collaboration of the RVMC Administrators and Physician Leaders.

Process measures are the specific steps taken to improve outcomes.
Outcome measures are high level metrics that reflect the overall care provided.
Balancing measures are metrics to ensure an improvement in one area isn't negatively impacting another area.

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Patient Safety

To permeate responsibility and mutual accountability for patient safety throughout our organization, SCPMG will continue to implement activities broadly aimed at becoming a highly reliable organization by achieving the following six strategic themes

Core Theme	Description
Safe Care	Ensure the actual and potential hazards associated with high risk procedures, processes, and patient care populations are identified, assessed, and controlled in a way that demonstrates continuous improvement and moves the organization toward high reliability and the ultimate objective of ensuring our patients are free from unnecessary harm.
Safe Culture	Create and maintain a strong, unified patient safety culture at SCPMG and Kaiser Permanente, with patient safety and error reduction embraced as shared organizational values and acknowledged pre-requisites of "quality you can trust."
Safe Staff	Ensure staff possesses the knowledge and competence to safely perform required duties, improve system safety performance, and reduce workplace injuries. Develop new knowledge and provide ongoing education on patient and workplace safety for individuals and teams throughout the organization.
Safe Patients	Engage the patient and their family, as appropriate, as a partner in safety and in reducing medical errors improving system safety performance, and actively participating in their own safe care. Strive for collaborative relationships with patients/members/families in all aspects of the organization.
Safe Place	Design, construct, operate, and maintain a safe environment of care as well as evaluate, purchase, and utilize equipment and products in a way that promotes the efficiency and effectiveness with which safe healthcare is provided.
Safe Systems	Identify, implement, and maintain support systems that provide the right information, to the right people, at the right time. This includes knowledge sharing networks, responsible reporting, and meaningful measures of risk and safety.

Annual Quality and Patient Safety Program Evaluation

Bi-annually, responsible Regional Virtual Medical Center quality and administrative leaders evaluate each component of the Quality and Patient Safety Program, evaluate performance against targets and develop work plans for the ensuing year. The evaluation specifically:

- Evaluates the effectiveness of activities and actions taken in the previous year;
- Draws conclusions from those activities and actions;
- Performs an analysis of the barriers; and
- Identifies priorities for improvement based upon evaluation and other data available.

Section 3 Credentialing and Peer Review

The Regional Virtual Medical Center's Quality and Patient Safety Program includes the methods for assessing and continuously improving the virtual or telephonic care delivered to patients through the review of practitioner performance. Credentialing, privileging, and peer review are considered integral to the development and implementation of quality improvement, patient safety, resource utilization and risk management strategies.

2024
REGIONAL VIRTUAL MEDICAL CENTER
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Credentialing

Credentialing activities are conducted in accordance with written policies and procedures for credentialing, re-credentialing, appointment, reappointment, proctoring, and ongoing practitioner performance evaluation.

The processes for renewal of credentialing incorporate data from quality of care, professional conduct, quality assessment, peer review, professional liability experience, resource utilization, patient satisfaction, patient complaints, and the six general competencies (patient care, medical knowledge, practice-based learning and improvement, interpersonal communication skills, professionalism and systems-based practice). A separate confidential quality file is maintained for each practitioner. Credentials and quality files are available to individual practitioners, RVMC Physician Leaders and peer reviewers at each step of the credentials processes.

Peer Review

Review is an ethical and legal cornerstone of the medical profession and the process by which a practitioner's clinical performance is examined and critiqued by one or more individuals who have comparable professional education, training, knowledge and experience. Peer review is conducted in accordance with written policies and procedures which are approved by the SCPMG. All medical staff departments establish an ongoing and consistent quality program that includes peer review.

The objective of the Peer Review Program is to:

- Assess and improve the care provided to patients
- Determine if standards of care are met; evaluate and improve individual performance
- Determine education and training needs to improve skills and outcomes
- Identify and prioritize areas for systems improvement
- Monitor trends through aggregate data
- Promote a "Just Culture", in which practitioners and the organization learn from unanticipated outcomes

The primary information used to identify issues requiring peer review include sentinel and other serious adverse events (actual or close call), department-specific monitoring, electronic monitoring of complication reports, mortality reports, infection control data, risk and utilization management data, contract management, customer service (patient concerns), and regulatory findings. Supplemental focused reviews are conducted as necessary to provide greater detail and empirical support regarding a particular area of practice and practitioner performance. Focused reviews may lead to the development or refinement of standards of practice or processes that can be used to improve clinical performance and as well to evaluate clinical competence.

The RVMC Physician Leaders and credentialing committee(s), and Regional Virtual Medical Center physicians based on peer review findings may recommend activities to improve performance that include but are not limited to:

- Education programs
- Proctoring or Focused Professional Practice Evaluation (FPPE)
- Patient safety education or strategies
- Interdepartmental collaboration
- New protocols/guidelines or modification of existing protocols
- Modification of measures for review
- Acquisition and use of new equipment/technology
- Individual counseling of a practitioner
- Additional data collection and trending
- Performance improvement plans for individual providers

Peer review data and information is considered by the RVMC Physician Leaders in carrying out the functions of credentialing and in the assessment of the competency of the Professional Staff.

Section 4 Confidentiality

All Quality and Patient Safety Program data, committee minutes, reports, recommendations, memoranda, and documented actions created under the auspices of the RVMC's Quality and Patient Safety Program and its peer review processes are considered quality assurance documents and, therefore, subject to the protection of laws governing the confidentiality of peer review and/or quality assurance information. These documents are maintained in accordance with applicable confidentiality policies and procedures.

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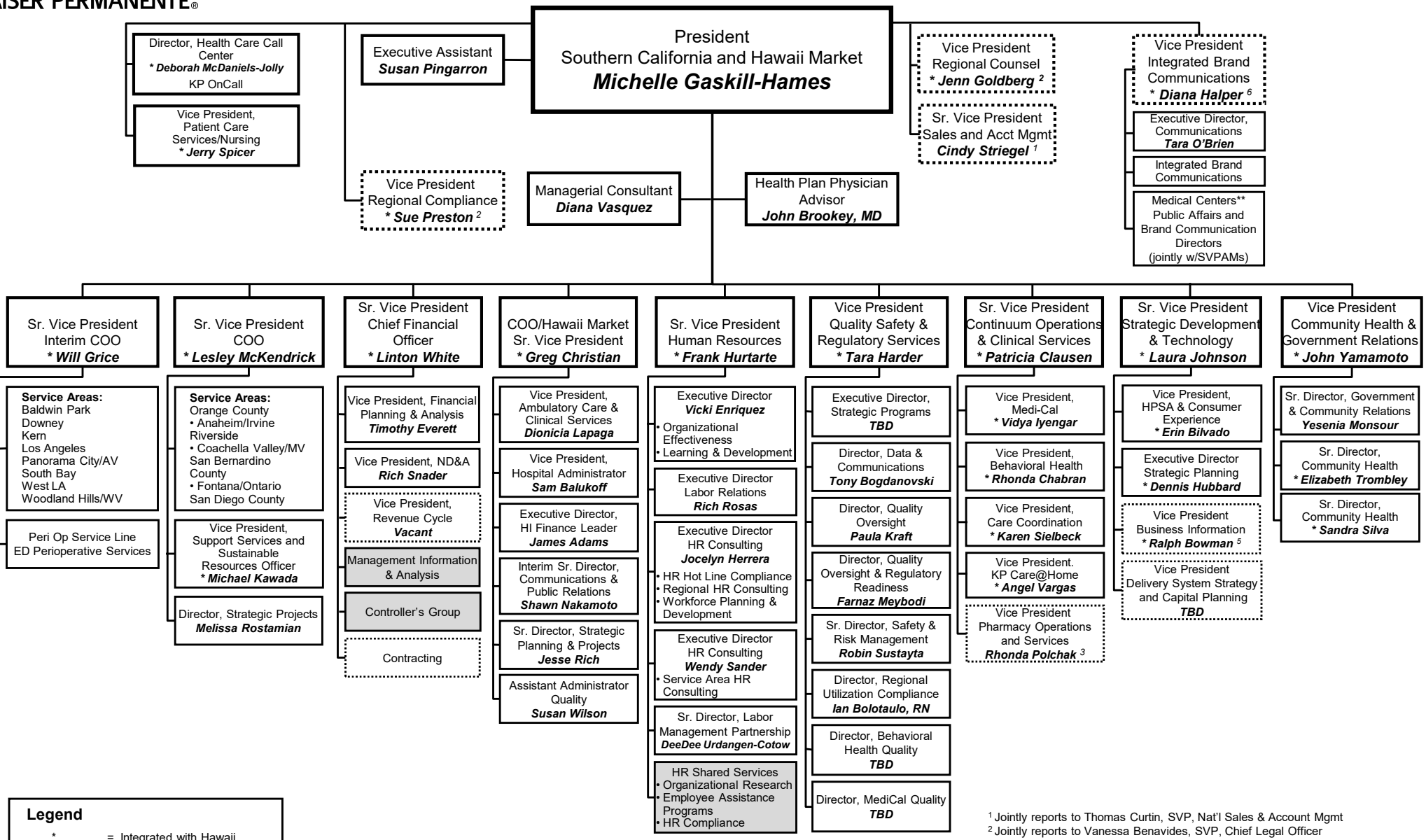
Kaiser Foundation Health Plan, Inc. / Kaiser Foundation Hospitals
SOUTHERN CALIFORNIA REGIONAL LEADERSHIP

2/2024



Legend

* = Integrated with Hawaii

** = Reports jointly to SCPMG

= California Shared Service

= National Shared Service

[1] Jointly reports to Thomas Curtin, SVP, Nat'l Sales & Account Mgmt
[2] Jointly reports to Vanessa Benavides, SVP, Chief Legal Officer
[3] Jointly reports to Kathy Brown, SVP & COO, Pharmacy Market Operations
[4] Jointly reports to TBD, SVP, Nat'l Delivery Sys Strategy, Plng & Design
[5] Jointly reports to Desiree Gandrup-Dupre, SVP for Care Delivery Technology Svcs
[6] Jointly reports to Catherine Hernandez, Nat'l VP, Public Relations & Comm

KFHP, Inc.
KFHP of the Northwest
KFHP of Colorado
KFHP of the MAS

QUALITY AND HEALTH IMPROVEMENT COMMITTEE (QHIC) CHARTER

A. Composition

The Quality and Health Improvement Committee shall consist of three (3) or more Directors, who shall be selected by the Board of Directors, and who shall continue as members of the committee at the pleasure of the Board.

B. Authority and Duties

The Quality and Health Improvement Committee is created to: (1) provide strategic direction for quality assurance and improvement systems; (2) provide oversight of systems designed to monitor on behalf of the Board of Directors that quality care and services are provided at a comparable level to all members and patients throughout the Program across the continuum of care; and (3) provide oversight of the Program's quality assurance and improvement systems and organizational accreditation and credentialing.

The committee will review and, as appropriate, provide direction in the following areas:

1. Quality Assurance

a. Overseeing quality systems, including quality goals, objectives, and performance measures;

b. Identifying and addressing deficiencies in quality;

c. Reviewing, and as appropriate approving, standards for the global member experience including standards for quality assurance, quality of care, patient safety, service quality, utilization, and risk management; and

d. Reviewing and addressing the results of internal and external system audits.

2. Quality and Health Improvement

   a. Promoting progress in member health improvement, including health policy direction, disease prevention activity, reduction of health disparities among population groups and the development and dissemination of evidence based medicine;

   b. Approving annual targets for health improvement, including HEDIS and improvement in members' health that contributes to community well being;

   c. Approving annual targets for service quality including access to services, the care experience and overall member, patient, and purchaser satisfaction;

   d. Monitoring and assessing performance against targets of the care delivery system, including clinical performance and member satisfaction with the care experience; and

   e. Evaluating results of quality improvement activities including recommended actions and follow-up.

3. Organizational Accreditation & Credentialing

   a. Reviewing accreditation and licensing processes and reports, such as those of the National Committee on Quality Assurance, the Centers for Medicare & Medicaid Services, and state agencies; and

   b. Reviewing the integrity of systems relating to the selection, credentialing and competence of physicians and other health care practitioners, including systems for granting or terminating clinical privileges, professional staff or medical staff or clinical staff membership, peer review, proctoring and continuing education.

   c. Approving applications for appointments/reappointments to the medical or provider staff, clinical privileges, and other actions related to medical staff or provider staff membership and ambulatory surgery center clinical privileges that require governing body approval.

   d. Approving medical staff or provider staff Bylaws and Rules and Regulations and amendments thereto.

e. Approving ambulatory center Bylaws and amendments thereto.

f. Recommending the appointment of the ambulatory surgery center administrator and approving the appointment of the ambulatory surgery center medical director.

g. Approving ambulatory surgery center policies and procedures, when governing body approval is required.

The committee shall report its decisions, actions and recommendations to the Board of Directors.

KAISER PERMANENTE
2024 Southern California Quality Committee (SCQC) Charter

Mission: To provide leadership and oversight in regulatory, publicly recognized and member focused quality and safety activities.

Authority and Scope: The SCQC serves as the quality oversight committee for Kaiser Foundation Health Plan, Inc.- Southern California Region (KFHP)., and Kaiser Foundation Hospitals (KFH) in the Southern California Region. The SCQC is established by the KFHP/KFH- Southern California Regional President and 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, who is appointed by the KFHP President, and the SCPMG Regional Physician Director for Quality and Risk Management, who is appointed by the Regional Medical Director as the key senior leaders** administratively responsible for the leadership and direction of the quality program. The co-chairs of the SCQC are accountable to the KFHP President and the SCPMG Regional Medical Director, delegates of the KFHP/KFH Board of Directors, who in turn hold them accountable for quality oversight of processes and initiatives.

Performance expectations are established collaboratively among relevant services, departments, teams, and individuals. Every senior leader, physician, manager, supervisor, nurse, and administrative or front- line employee is responsible for contributing to the achievement of performance targets for quality and safety initiatives.

The SCQC has authority to speak and act on behalf of KFH, KFHP, and SCPMG senior leadership on quality improvement issues including, but not limited to, the following:

- Regional metrics, including Clinical Effectiveness, Clinical Risk Management, Safety, Service, and Resource Stewardship.
- Review of facility-specific performance metrics.
- Evaluation of the quality of clinical care and service across all settings for the full spectrum of services provided.
- Making recommendations to senior leadership for actions to improve clinical quality and service quality.
- Identifying opportunities for improvement and establishing priorities among them.
- Communicating quality priorities, findings, conclusions and recommendations to appropriate leadership and stakeholder groups.
- Providing and documenting region-wide clinical and service quality oversight as required by regulatory and accrediting agencies, purchasers, the Board of Directors Quality Health Improvement Committee (QHIC) and the KP National Quality Committee (KPNQC).
- Approving data prepared for the QHIC and oversight of required follow-up.
- Functioning as the formal quality and service intermediary between the Regional Senior Leaders and the Medical Centers.
- Determining accountability and ensuring quality issues are investigated and resolved.
- Serving as the final decision-making body on impasse issues and policy decisions.
- Committing the organization to action and monitoring progress relative to the action plan.

The Purpose of the SCQC is to:

- 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 processes and outcomes.
- 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.

Reporting Structure: The Southern California Quality Committee (SCQC) **is accountable to** the Kaiser Foundation Health Plan and Hospitals, Inc., Boards of Directors.

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 the Quality and Health Improvement Committee (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 workplans, and program evaluations.

Meeting Process: SCQC will meet monthly, for no less than ten months of the year. Membership includes representatives from KFH, KFHP, and SCPMG. The quorum is a simple majority of the voting members. Co-chair leadership is shared with at least one co-chair from KFHP. SCQC actions and decisions are documented in contemporaneous minutes of the meetings proceedings. In the event that SCQC is unable to meet in person or via telepresence, members will review quality reports, minutes, and associated documents and vote on approval offline.

SCQC Membership: Voting members of SCQC are expected to routinely attend committee meetings and engage in informed discussions about the topics presented as well as review any offline documents assigned by the committee and provide actionable feedback.

Voting membership is determined by the ability to impact resource allocations and prioritization of the quality and safety agenda. **The membership of SCQC also includes two Patient Advisors, who are non-voting members.**

VOTING MEMBERS
Co-Chair: SCPMG Regional Physician Director of Quality, Risk Management, Regulatory & Safety
Co-Chair: KFHP/KFH Vice President, Quality, Safety & Regulatory Services
President, KFHP/KFH
Regional Medical Director of Quality & Clinical Analysis, SCPMG
Chief Nursing Officer, SCPMG
Assistant Medical Director of Quality & Clinical Analysis, SCPMG
Chairperson, Regional Credentialing Committee
Chief Quality Officer, Quality & Systems of Care, SCPMG
Vice President – Care Coordination
Vice President - Regional Patient Care Services
SCAL Health Plan Physician Advisor
Senior Counsel - Legal
Kaiser Affiliated Hospital Council Tri-Chair
Senior Vice President / COO - KFH/HP
Assistant Regional Medical Director – Care Experience & Chair of Regional Member Concerns Committee
Chairperson, Regional Medication Safety Oversight Committee
SCAL Regional Bioethics Program Director

VOTING MEMBERS
Regional Vice President of Compliance
Chairperson, Regional Systems and Peer Review Oversight Committee (RSPROC)
Chairperson, Surgical Quality Oversight Committee
Chairperson, Regional Behavioral Health Oversight Committee
Vice President, Health Plan Service Administration & Care Experience
Sr. Director, Member Relations & Member Service Contact Center
Senior Vice President & Area Manager – KFH/HP – South Bay
Senior Vice President / COO – KFH/HP
Vice President, Behavioral Health & Wellness

Confidentiality: The SCQC is a peer review body, and all of its subcommittee minutes, reports, recommendations, memoranda, and documented actions are confidential and protected under all applicable protections, including, but not limited to CA H&S code 1370 and 1370.1 and CA Evidence Code 1157.

All records are maintained in a manner that preserves their integrity in order to assure that patient and practitioner confidentiality is protected.

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

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

Local Service Area Quality Structure: 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 Regional Executive Medical Director, through the Kaiser Foundation Health Plan/ Hospitals Medical Center Senior Vice President/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 improvement in their respective medical center and service area.

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, managers, 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 quality structures, programs, resources, and systems, and appoint at least one physician quality leader (SCPMG) and one administrative quality leader (KFHP/H) who are accountable for the quality program in the medical center. Annually, the medical center quality program description, workplan and evaluation is 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.

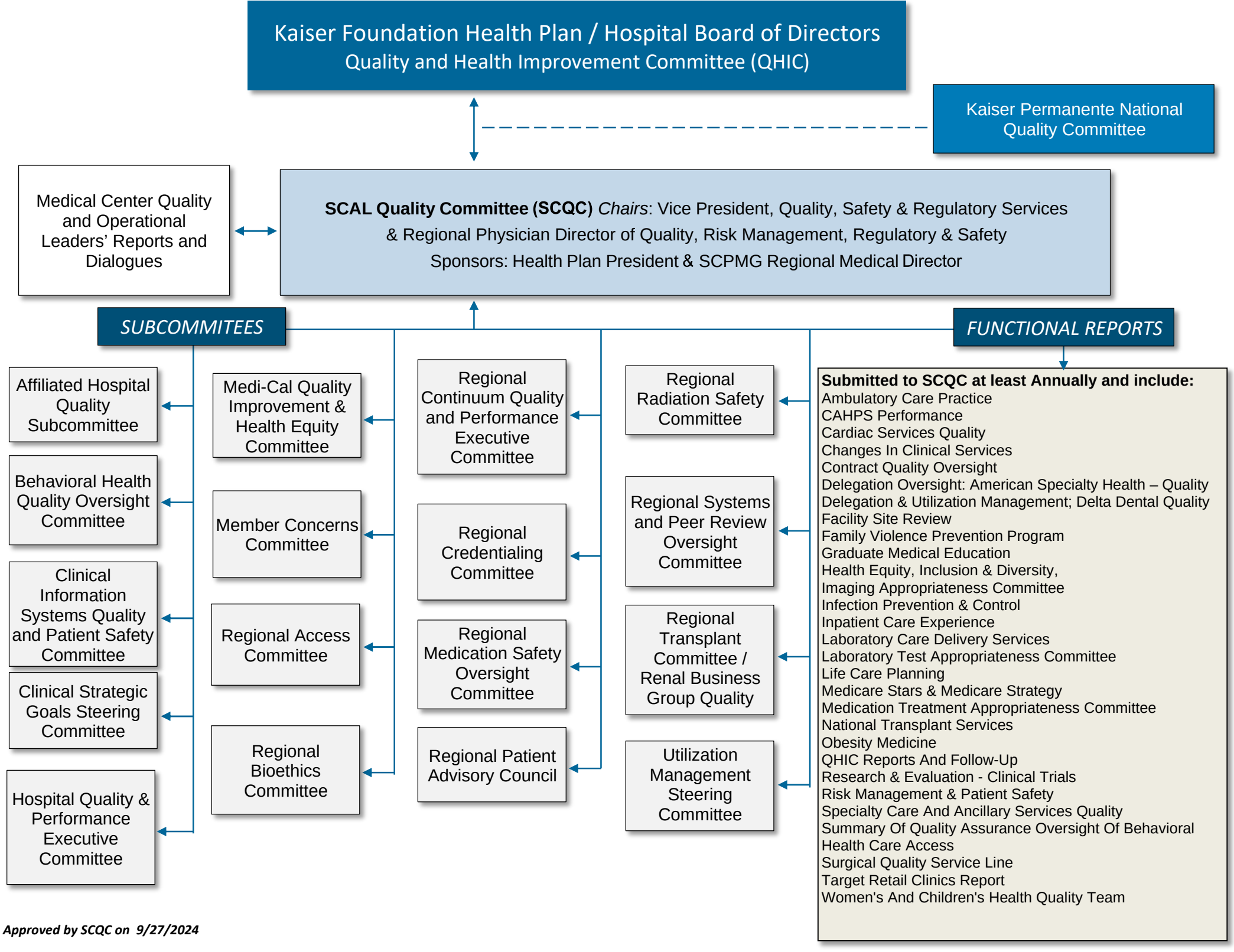
The Health Plan provides oversight of the local medical center quality/operational functions. The KFHP leaders receive regular reports on local performance of all quality and regulatory issues.

KFHP & KFH Continuous Readiness

Continuous readiness assessments are conducted by a team of internal consultants reporting to the KFHP Vice President for Quality, Safety and Regulatory Services and the SCPMG Regional Physician Director for Quality, Regulatory and Risk Management. This team conducts scheduled site visits to each medical center, monitoring against regulatory standards and quality vulnerabilities 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 on-going sustained improvement of corrective action plans, identification of new high-risk vulnerabilities and on-going accrediting and regulatory readiness.

SCQC Subcommittees – Accountabilities

The SCQC assigns certain responsibilities to subcommittees that are required to report to SCQC at least annually, or more often as necessary. The Charters for each subcommittee are updated annually and include group composition, responsibilities, and activities. SCQC membership and subcommittee membership is reviewed annually. The subcommittees of the SCQC are listed below:



Approved by SCQC on 9/27/2024

Attachment A: Current Membership & Physician Specialties

SCQC VOTING MEMBERS	CURRENT MEMBERSHIP	PHYSICIAN SPECIALTIES
Co-Chair: SCPMG Regional Physician Director of Quality, Risk Management, Regulatory & Safety	Deepak Sonthalia, MD	Anesthesiology
Co-Chair: KFHP/KFH Vice President, Quality, Safety & Regulatory Services	Tara Harder	
President, KFHP/KFH	Michelle Gaskill-Hames	
Regional Medical Director of Quality & Clinical Analysis, SCPMG	Nancy Gin, MD	Internal Medicine
Chief Nursing Officer, SCPMG	Aileen D Oh, RN	
Assistant Medical Director of Quality & Clinical Analysis, SCPMG	Benjamin I. Broder, MD	Family Medicine Clinical Informatics
Chairperson, Regional Credentialing Committee	Christopher Distasio, MD	Neurology
Chief Quality Officer, Quality & Systems of Care, SCPMG	Giselle H Willick	
Vice President – Care Coordination	Karen Sielbeck	
Vice President - Regional Patient Care Services	Jerry E Spicer, RN	
SCAL Health Plan Physician Advisor	John M. Brookey, MD	Pediatrics
Senior Counsel - Legal	Jennifer Goldberg	
Kaiser Affiliated Hospital Council Tri-Chair	Dan N Huynh, MD	Internal Medicine
Senior Vice President / COO - KFH/HP	Lesley A. McKendrick, RN	
Assistant Regional Medical Director – Care Experience & Chair of Regional Member Concerns Committee	Wadie L Marcos, MD	Family Medicine
Chairperson, Regional Medication Safety Oversight Committee	Sarah J Matsumoto	
SCAL Regional Bioethics Program Director	Alain Durocher	
Regional Vice President of Compliance	Sue M Preston	
Chairperson, Regional Systems and Peer Review Oversight Committee (RSPROC)	William D. Geis, MD	Obstetrics and Gynecology
Chairperson, Surgical Quality Oversight Committee	Andrew DiFronzo, MD	Surgery
Chairperson, Regional Behavioral Health Oversight Committee	Erika Aguirre-Miyamoto	
Vice President, Health Plan Service Administration & Care Experience	Erin Bilvado	
Sr. Director, Member Relations & Member Service Contact Center	Rashida Tobor / Irene Nora	
Senior Vice President & Area Manager – KFH/HP – South Bay	Margie Harrier	
Senior Vice President / COO – KFH/HP	TBD	
Vice President, Behavioral Health & Wellness	Rhonda Chabran	

AFFILIATED HOSPITAL QUALITY SUBCOMMITTEE CHARTER

CHARTER NAME	Affiliated Hospital Quality Subcommittee
MISSION STATEMENT	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.
GOALS	The Subcommittee's goals include: • Developing and maintaining appropriate quality metrics and performance standards. • Ensure 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 technical definitions. • Ensure efficiency and avoid 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.
COLLABORATION & MEMBERSHIP	The Workgroup will provide: A platform for communication between all Affiliated Hospitals and KP for Quality Oversight. Membership includes, but is not limited to, representatives from; Affiliated Hospitals, Service Area Quality Leaders with an Affiliated Hospital, Regional Quality Data & Communications, Network Development and Administration, and the Patient Advisory Council.
MEETING STRUCTURE	The Committee meets quarterly. A quorum consists of at least 1/3 of membership of mixed representation from the Membership roster. Members are asked to identify a designee who is kept informed of quality metrics and activities. The Committee's actions and tasks will be documented in meeting summaries that reflect ongoing actions and reporting.

Reviewed by the Affiliated Hospital Quality Subcommittee, July 19, 2024
Pending Approval by SCQC

AFFILIATED HOSPITAL QUALITY SUBCOMMITTEE CHARTER

CONFIDENTIALITY	The Committee activities necessitate the access to privileged or otherwise confidential information. The confidentiality of such information is vital to the free and candid communications necessary to fulfill the oversight functions of the Committee. Committee members agree to adhere to all KPSC confidentiality policies and procedures. As a condition of membership, members of the Committee explicitly agree to: 1. Respect and maintain the confidentiality of all discussions and information. 2. Make no voluntary disclosures of discussions and information except to persons authorized to receive it in the conduct of activities. 3. Notify a Co-Chair if any person or entity seeks to compel disclosure of privileged or confidential information. 4. Not create or retain any copies or reproductions of discussions or information except as required for participation.
ACCOUNTABILITY	The Affiliated Hospital Quality Subcommittee reports to the Southern California Quality Committee (SCQC)
TRI-CHAIRS (SCAL Regional Oversight)	Paula Kraft Juan-Pablo (JP) Larrea Kim Hawkins
Executive Leaders	Tara Harder, KFHP Jonathan Truong, MD SCPMG

AFFILIATED HOSPITAL QUALITY SUBCOMMITTEE CHARTER

STANDING MEMBERS	**Kaiser Permanente Regional Representatives** ◊ Kim Hawkins, Nurse Consultant, Quality Oversight ◊ Juan Pablo (JP) Larrea, Manager Data & Consulting, Quality Data & Communications ◊ Paula Kraft, Regional Director, Quality Oversight ◊ Lei Caine, Sr. Managerial Consultant, ND&A ◊ Ron Cali, KP Member Advisor **Quality Directors/Liaisons for SCAL Medical centers with an Affiliated Hospital** ◊ AV: Sandra Stanley ◊ KC: Brenda Heideman ◊ RIV/CV: Elsa Rodriquez ◊ SD: Jocelyn Bittenbender, Thea Shiansky ◊ WH/WV: Eva Yap **Affiliated Hospital Quality Representatives as of 10/20/23** ◊ Adventist Health: Lisa Kreber (Interim) KreberLA@ah.org ◊ Antelope Valley Medical Center: Yolanda Chartan Yolanda.Chartan@avmc.org ◊ Antelope Valley Medical Center: Amy Villaroya Amy.Villaroya@avmc.org ◊ Community Memorial: Maureen Archambault marchambault@cmhshealth.org ◊ Community Memorial: Melissa Grafals, MD mgrafals@cmhshealth.org ◊ Community Memorial: Roya Nassipour, rnassirpour@cmhshealth.org ◊ Rancho Springs: Sandra Wachenheimer, sandra.wachenheimer@uhsinc.com ◊ Inland Valley: Cheryl Davey, Cheryl.Davey@uhsinc.com ◊ Temecula Valley: Tera Cobb, tera.cobb@uhsinc.com ◊ Palomar Medical Center/Downtown, valerie.martinez@palomarhealth.org ◊ Palomar Medical Center/Downtown, Tricia.Kassab@palomarhealth.org ◊ Eisenhower Health: Toni Pellum, tpellum@eisenhowerhealth.org ◊ Eisenhower Health: Kera Arias, KArias@eisenhowerhealth.org ◊ Tri-City Medical Center: Jamie Epps, JEpps@tcmc.com ◊ Tri-City Medical Center: Heidi Benson, hdbenson@tcmc.com ◊ Maui Memorial: Kelly Catiel, Kelly.m.catiel@kp.org
AD HOC MEMBERS	• Subject Matter Experts (SME's) as needed.
MEETING FREQUENCY	• Quarterly: January – April – July – October • Ad Hoc As Needed

KAISER PERMANENTE SOUTHERN CALIFORNIA
BEHAVIORAL HEALTH QUALITY OVERSIGHT COMMITTEE CHARTER

PURPOSE

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.

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 reporting results to SCQC.
- Ensuring regulatory compliance in our Behavioral Health Program

AREAS OF FOCUS

- 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)

REPORTING STRUCTURE

- The BHQOC is a subcommittee of the Southern California Quality Committee (SCQC) and reports to SCQC on a biannual basis.
- The SCPMG Regional Physician Director of Quality, Risk Management, Regulatory & Safety and KFHP Vice President, Quality, Safety & Regulatory Services are committee sponsors.

MEETING PROCESS

The committee will meet monthly with a minimum of 6 meetings per calendar year. Membership includes representatives from KFH, KFHP, and SCPMG. A quorum is a simple majority of the members. Actions and decisions are documented in minutes. If BHQOC is unable to meet in person or via video conferencing, members will review quality reports, minutes, and associated documents and vote on approval offline.

ANNUAL EVALUATION

The Behavioral Health Quality Oversight Committee Charter is reviewed, updated, and approved annually.

Approved March 14, 2024

KAISER PERMANENTE SOUTHERN CALIFORNIA
BEHAVIORAL HEALTH QUALITY OVERSIGHT COMMITTEE CHARTER

CONFIDENTIALITY

Participation in BHQOC may necessitate access to privileged or otherwise confidential information. The confidentiality of such information is vital to the free and candid communication necessary to fulfill the activities and function of the committee. All records are maintained in a manner that preserves their integrity in order to assure that patient and practitioner confidentiality is protected.

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

1. Respect and maintain the confidentiality of all discussions and information.
2. Make no voluntary disclosures of discussion and information except to persons authorized to receive it in the conduct of BHQOC activities.
3. Notify a BHQOC chair in the event any person or entity seeks to compel disclosure of privileged or confidential information.
4. Not create or retain any copies or reproduction of discussion or information except as required for participation.

MEMBERSHIP

The committee is chaired by SCPMG Regional Chief of Psychiatry, SCPMG Regional Operations Director, and KFHP Regional Director of Quality & Regulatory Services.

The following individuals constitute the BHQOC membership:

Tri - Chairs:
SCPMG Regional Chief of Psychiatry
SCPMG Regional Operations Director
KFHP Senior Director, Behavioral Health Quality & Regulatory Services

Member(s):
SCPMG Regional Clinical Director
SCPMG Regional Chief of Addiction Medicine
KFHP Health Plan Physician Advisor
SCPMG Manager, Consulting, Regional Service and Access, Regulatory
KFHP Regulatory Services Director
KFHP Vice President of Behavioral Health and Wellness
KFHP Senior Manager of Behavioral Health Quality

Ad Hoc:
KFHP Health Plan Regulatory Services Representative
SCPMG Regional Practice Leader, Autism & Developmental Disabilities
SCPMG Director of Case Coordination Center
SCPMG Regional Psychiatry Director
SCPMG Regional Addiction Medicine Director
SCPMG Assistant Regional Medical Director, Care Experience
SCPMG Regional Addiction Medicine Physician Champion for Quality
KFHP Quality & Safety Oversight Specialist(s) V
KFHP Quality & Safety Oversight Specialist IV
KFHP Quality & Safety Oversight Specialist II
KFHP Quality & Safety Oversight, Area Safety and Quality Officer
SCPMG Consultant IV, Regional Service and Access, Regulatory
Support Staff: Health Plan Quality Staff

Approved March 14, 2024

Southern California
Kaiser Permanente
Clinical Information Systems
Quality and Patient Safety
Committee Charter

Date Last Updated and Approved: **February 9, 2024**

Questions/Corrections?
Please Contact: Noemi Valenzuela (noemi.s.valenzuela@kp.org)

Charter

Vision	**The vision of the SCAL Clinical Information Systems Quality and Patient Safety Committee is to continually improve the care and safety of our patients, workflows for our clinical providers and ensure regulatory compliance via the use of clinical information systems.**
Goals	1. 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 2. Promote consistency, continuity, and accuracy of electronic medical information as it relates the quality and patient safety 3. Provide the forum to refine SCAL quality of care & patient safety needs from KP HealthConnect and create a communication path to the national level 4. Provide recommendations to any relevant groups and individuals related to the quality of care and patient safety aspects associated with Clinical Information Systems & use of technology 5. Act as a liaison between local and regional stakeholder leaders and committees with recommendations for operations.
Guidelines	• Follow legal, regulatory, and compliance standards and requirements • Integrate existing, functional groups and processes rather than replacing them • Adopt a systems perspective to recognize and address all necessary linkages between Clinical Information Systems and Medical Center Operations • Focus on quality of care and patient safety
Benefits	• Ensure accurate, timely, complete and consistent identification, mitigation, and communication of Clinical Information Systems, quality of care and patient safety issues • Promptly identify recommendations to help resolve pre-existing system issues • Coordinate of processes and communication between Clinical Information Systems and Medical Center Operations to ensure patient safety • Utilize existing partnerships to assist in the efficiency and escalation of issue resolution

	• Support the creation of high-quality information that enhances the quality of care and patient safety
Organization	Clinical Information Systems Quality and Patient Safety Committee is a sub-committee of the Southern California Quality Committee (SCQC).
Participants	• Physician Leaders of Quality, KP HealthConnect, Laboratory and Pharmacy • SCPMG and KFH Medical Center and Hospital Operations Leadership • Regional Patient Care Services • Regional Ambulatory Clinical Practice • Quality, Patient Safety and Risk Management leadership • KP HealthConnect application owners • Application and subject-area experts • Data Accuracy Unit

KAISER PERMANENTE, SOUTHERN CALIFORNIA (KPSC) CLINICAL STRATEGIC GOALS STEERING COMMITTEE (CSGSC) CHARTER

I. Purpose

The KPSC 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

II. Sponsorship

The CSGSC is sponsored by the Kaiser Foundation Health Plan (KFHP) Vice President, Quality, Regulatory & Clinical Operations Support and the Southern California Permanente Medical Group (SCPMG) Regional Medical Director of Quality & Clinical Analysis.

III. Accountability

The CSGSC is a subcommittee of the Southern California Quality Committee (SCQC). SCQC is sponsored by the KFHP Southern California President and the SCPMG Executive Medical Director.

IV. Membership

CSGSC membership consists of members from Kaiser Foundation Health Plan & Kaiser Foundation Hospitals (KFHP/H) and SCPMG regional services and operations.

The CSGSC is co-chaired by the KFHP/H Vice President, Quality, Safety & Regulatory Services and the SCPMG Regional Assistant Medical Director, Quality & Complete Care.

V. CSG Planning Group

The work of the CSGSC is supported by the CSG Planning Group. Members of the CSG Planning Group are KFHP and SCPMG performance reporting and performance improvement experts. The CSG Planning Group is primarily responsible for:

1. Selecting measures and methods of measurement
    - Recommend a set of specific measures for each of the broad strategic goal areas to track progress on meeting ambulatory CSGs
    - Recommend additions, deletions, or modifications of measures
    - Ambulatory CSGs are derived from publicly reported measures, such as Healthcare Effectiveness Data & Information Set (HEDIS). Other measures may be included if they are determined to be important for the health and safety of individuals and communities. These measures may be used to monitor for potential underutilization or overutilization of services.

2. Developing targets
    - Utilize objective and transparent approaches to determining targets, which may include:
        - Benchmarks from external organizations, such as National Committee for Quality Assurance (NCQA), Integrated Healthcare Association (IHA), Centers for Medicare & Medicaid Services (CMS), and others
        - Benchmarks from other areas of Kaiser Permanente, such as performance of other regions or program-wide performance
        - Purchaser agreements
        - Internal benchmarks, such as medical center performance or regional performance
        - Meeting disparity reduction targets for specific populations and/or measures
3. Assuring alignment of measures and measurement sets
    - Recommend strategies to assure alignment between CSG measurements and other internal or external measures or measurement sets to minimize confusion, discrepancies, and redundancies
4. Monitoring and reporting of performance and variation. Additionally, assist in determining if performance gaps or variation among medical centers is being exacerbated by the following:
    - Systems and structure issues, such as lack of clinical decision support, or lack of standardized workflows
    - External factors, such as geography, social determinants of health, seasonality, or public health emergencies
    - Differences in quality of care and utilization, such as underlying reasons for variations in the provision of care to members.
    - Technical issues, such as specification changes, quality measurement coding, or data interface issues

VI. Clinical Quality Key Measures

A subgroup of the CSG Planning Group annually develops prioritized measures and establishes performance targets for those measures. These measures are called the CSG Clinical Quality Key Measures. The work of the subgroup is presented to both CSG Planning Group and CSGSC.

The following guiding principles are employed to select Clinical Quality Key Measures:

- Protection and improvement of the health of individuals and communities
- Evidence based input from key stakeholders, including clinicians
- Regulatory and accrediting requirements
- Purchasers' expectations and requirements
- Future strategy and adaptation to market forces
- Greatest benefit for level of effort
- Potential vulnerabilities

Clinical Quality Key Measures are submitted to the following groups and individuals for approval: KFHP President, SCPMG Board of Directors, SCPMG Executive Medical Director, and SCQC.

VII. Meeting Process

The CSGSC meetings will occur quarterly, with a minimum of two (2) meetings per year.

VIII. Annual Evaluation

CSGSC charter will be reviewed, updated, and approved annually.

IX. Confidentiality

Participation in the CSGSC may necessitate access to privileged or confidential information. Access to such information is necessary to fulfill the purpose of the CSGSC.

As a condition of membership, members of the CSGSC agree to:

- Be respectful and maintain confidentiality of all reports, data, discussions, and information
- Make no voluntary disclosures of reports, data, discussion, and information, except to persons authorized to receive it in the context of CSGSC activities
- Notify a chair in the event any person or entity seeks to compel disclosure of privileged or confidential information
- Do not create any copies or retain any reproduction of reports, data, discussion, or information except as required for participation

X. Membership

Membership includes representatives from KFHP and SCPMG.

The following individuals constitute the CSGSC membership:

- Chairs:
  - KFHP/H Vice President, Quality, Safety & Regulatory Services
  - SCPMG Regional Assistant Medical Director, Quality & Complete Care
- Members:
  - KFHP Physician Advisor
  - KFHP Regional Quality and Regulatory Services, Director
  - KFHP Regional Medicare Strategy, Managerial Consultant
  - SCPMG Regional Assistant Medical Director, Quality & Clinical Analysis
  - SCPMG Regional Assistant Medical Director, Quality & Value Demonstration
  - SCPMG Regional Administrative Leader, Medical Specialties
  - SCPMG Clinical Analysis, Executive Leader
  - SCPMG Clinical Analysis, Director
  - SCPMG Clinical Analysis, Data Reporting & Analytics Consultant V
  - SCPMG Complete Care Clinical Quality, Regional Director
  - SCPMG Complete Care Clinical Quality, Consultant IV
  - SCPMG Performance Assessment, Director
  - SCPMG Performance Assessment, Group Leader
- Meeting Support:
  - KFHP Quality & Regulatory Services, Staff Specialist
  - SCPMG Clinical Analysis, Clinical Consultant IV

At all meetings of this committee, a majority of the committee members shall constitute a quorum including at least one member from SCPMG and at least one member from KFHP for the transaction of business.

Hospital Quality & Performance Executive Committee (HQPEC)
Kaiser Permanente, Southern California
2024 Committee Charter

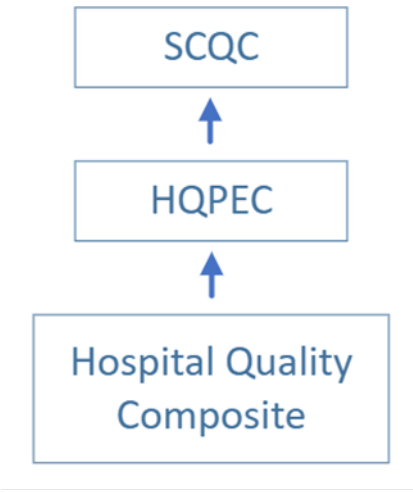
Mission

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

Purpose

- Oversee and govern Hospital Quality Composite (HQC) as the standard tool demonstrating KFH clinical quality performance.
- As a leadership committee, 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 to improving clinical quality and performance and work with sponsors to remove these barriers.
- 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.
- When appropriate, communicate with the Kaiser Permanente Affiliated Hospital Council about initiatives and practices of interest.

Reporting Structure of HQPEC (a subcommittee of SCQC)



Scope

Within Scope:

- Patient care clinical processes and outcomes in the Kaiser Foundation Hospital environment (including care delivered immediately prior to or after the hospital encounter).

Out of scope:

Issues not related to improving the quality of clinical care for patients in the hospital setting.

Expected Deliverables

- Monthly Core Initiative performance review (e.g., Cardiac monitoring, Sepsis).
- Bi-Annual SCQC Committee Report-out.
- Hospital Quality Composite Review & Governance including bi-annual updates.
- Annual landscape review for new initiative opportunities (using surveys or analytics as appropriate).
- Annual alignment with Strategic and Operating Plans.
- Identification of strategic priorities impacting the clinical quality of care and experience in the hospital.

Organization structure:

- We are an interdependent group of local and regional leaders representing SCPMG and KFH/HP. The group is sponsored by Southern California & Hawaii Executive leaders.

HQPEC Membership:

Role	Name	Entity	Title
Sponsor	Nancy Gin, MD	SCPMG	Regional Medical Director of Quality & Clinical Analysis
Co-Lead	Ben Broder, MD, PhD	SCPMG	Regional Assistant Medical Director, Quality & Clinical Analysis
Sponsor & Co-Lead	Tara Harder, MBA	KFH/HP	Vice President, Quality, Safety & Regulatory Services
Member	Andrew DiFronzo, MD	SCPMG	Assistant Regional Medical Director, Surgical Service Line
Member	Christopher Subject, MD	SCPMG	Assistant Regional Medical Director, Hospital Based Continuing Care and Support Services
Member	Dan Huynh, MD	SCPMG	Regional Chief, Hospital Medicine
Member	Giselle Willick, PharmD	SCPMG	Regional Chief Quality Officer
Member	Glenda MaHall, MSN	KFH/HP	Assistant Hospital Administrator for Quality (AAQ), Riverside Medical Center
Member	Brian J. Rappe	KFH/HP	Assistant Hospital Administrator for Quality (AAQ) Panorama City Medical Center
Member	Jerry Spicer, DNP, RN	KFH/HP	Regional Chief Nurse Executive and Vice President Patient Care Services
Member	Lisa Lopez	SCPMG	Chief Administrative Officer, Downey Medical Center
Member	Tania Tang	SCPMG	Executive Leader, Clinical Analysis
Member	Margie Harrier, MSN	KFH/HP	SVP, Area Manager, South Bay Medical Center
Member	Marianna Volodarskiy, RN, MSN	KFH/HP	Executive Director, SCAL Regional Patient Care Services
Member	Ruby K. Gill, RN	KFH/HP	KFH/HP, COO, Baldwin Park Medical Center
Member	Raye Burkhardt, RN	KFH/HP	Chief Nurse Executive, Fontana Medical Center
Member	Xam Tometich, DNP, RN	SCPMG	Assistant Medical Group Administrator, Fontana Medical Center
Member	Susie Becken	RPAC Member	Co-Chair Emerita and Member of the Regional Patient Advisory Council and the Los Angeles Patient Advisory Council
Member	Cary Brown	RPAC Member	Patient Advisor, Woodland Hills, and a Member of the Regional Patient Advisory Council
Member (ad-hoc)	Sylvia Everroad, MSN, RN	SCPMG	Chief Operating Officer, Region

Committee Support Staff:

Role	Name	Entity	Title
Support (Analytics)	Antony Bogdanovski	KFH/HP	Sr Director, Quality and Safety Improvement
Support (Consultant)	Christine Iacobellis	KFH/HP	Quality and Safety Oversight Specialist II, Regional Health Plan Quality

Connection to Related Groups

- Regional Leadership (SCPMG Regional Medical Director of Quality and Clinical Analysis and KFH/HP Vice President for Quality, Safety & Regulatory Services, Southern California, and Hawaii): Sponsor efforts, removes barriers.

The following groups are:

    - represented in the HQPEC,
    - execute and refine process improvements via coordinated PDSA cycles,
    - and may set aims and goals beyond those specified by the HQPEC:
- Medical Center Leadership teams
- Chiefs Groups
- Nursing

Regional Performance Improvement, Consultancies, Data and Analytic Departments (i.e., Clinical Analysis, KP Insight, and Data & Communications for Quality and Risk Management), and IT groups including KP HealthConnect are service providers.

Process

Our members agreed upon the following metrics to guide the success:

- Goals & goal alignment set annually.
- Metrics set annually.
- Improvement activities implemented based on identified opportunities
- Improvement achieved.

Meetings

HQPEC will meet monthly with a minimum of 9 meetings a year. Quorum is achieved with 50% or more members in attendance.

The Kaiser Permanente Southern California Medi-Cal Quality Improvement Health Equity Committee Charter

PURPOSE

The Kaiser Permanente Southern California (SCAL) Medi-Cal Quality Improvement Health Equity Committee (QIHEC) is a subcommittee of the Southern California Quality Committee (SCQC), which reports to the Quality & Healthcare Improvement Committee (QHIC), the committee of the Kaiser Foundation Health Plan / Kaiser Foundation Hospitals (KFHP/H) Board of Directors. The function is to ensure that the KFHP/H QHIC has an established infrastructure for oversight of quality, health equity, and regulatory performance within Medi-Cal & State Programs.

The SCAL Medi-Cal Quality Improvement Health Equity Committee is a multidisciplinary, cross-functional program committee that provides quality oversight for Medi-Cal & State Programs to ensure compliance with the Kaiser Permanente's Medi-Cal Managed Care contract with the Department of Health Care Services (DHCS) and to monitor, coordinate, and support the implementation and evaluation of equitable medical and experiential care provided to Medi-Cal members.

AUTHORITY AND SCOPE

The functions of the SCAL Medi-Cal QIHEC will include, but are not limited to:

- Identifying, reviewing, and evaluating relevant quality and other performance improvement measures and report results to the Southern California Quality Committee (SCQC).
- Monitoring quality, clinical, and health equity activities for implementation and improvement.
- Escalating potential quality concerns to the SCQC.
- Reviewing data and assuring compliance with quality and regulatory standards.
- Identifying care delivery regulatory gaps in Medi-Cal and determining necessary actions to improve care delivery process.
- Tracking progress and closure of corrective action plans from DHCS audits and internal audits.
- Reviewing, tracking, and monitoring the results of Community Advisory Committee (CAC) recommended quality initiatives and programs that impact Medi-Cal members.
- Ensuring oversight of Subcontractors and downstream Subcontractors for any delegated QIHEC activities.

AREAS OF FOCUS

- Regulatory Standards;
- Publicly reported quality measures including, but not limited to, HEDIS® and Managed Care Accountability Set (MCAS) outcomes;
- Complaints, Grievances, and Appeals;

- Over/Under Utilization of services;
- Oversight of Fully Delegated Subcontractors and Fully Delegated Downstream Subcontractors, if any;
- Provides a comprehensive assessment of all QI and health equity activities undertaken, including an evaluation of the effectiveness of QI and health equity interventions, and an assessment of all Subcontractors' performance for any delegated QI and/or health equity activities;
- Oversight and monitoring of Performance Improvement Projects (PIPs) and Consumer Satisfaction Survey results.

REPORTING STRUCTURE

- The SCAL Medi-Cal QIHEC is a subcommittee of the SCQC and reports findings, recommendations, and action to the SCQC after each meeting. The SCQC in turn report to QHIC after each meeting.
- The SCAL Medi-Cal QIHEC will also report to SCQC the Medi-Cal QIHEC activities of its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, if applicable.

MEETING PROCESS

- The SCAL Medi-Cal QIHEC will meet at least quarterly.
- SCAL Medi-Cal QIHEC activities will be made publicly available on the website at least quarterly.
- The SCAL Medi-Cal QIHEC charter, goals, and membership will be set and evaluated annually.
- All views will be represented.
- A quorum shall consist of one-half (50%) of the voting members of the committee.
- E-mail may be used to vote only on actions for issues previously discussed at a meeting in person or by telephone or video conference. An e-mail vote may be deferred at the request of any voting member if the voting member believes that further live discussion is warranted. Documentation of an e-mail vote will include the names of the members voting and the decision date and shall be appended to the following regular meeting minutes.
- SCAL Medi-Cal QIHEC actions and decisions are documented in contemporaneous minutes of the meeting proceedings. Minutes will be signed and dated. Minutes are considered confidential and protected under California Evidence Code 1157.
- The SCAL Medi-Cal QIHEC uses standard agenda formats and reporting and documents and distributes meeting records.

CONFIDENTIALITY

Participation in SCAL Medi-Cal QIHEC may necessitate access to privileged or otherwise confidential information. The confidentiality of such information is vital to the free and candid communication necessary to fulfill the activities and function of the SCAL Medi-Cal QIHEC.

Members agree as a condition of membership to:

- Respect and maintain the confidentiality of all discussions and information.
- Ensure Medi-Cal Member confidentiality is maintained in Quality Improvement (QI) discussions.
- Make no voluntary disclosures of discussion and information except to persons authorized to receive it in the conduct of SCAL Medi-Cal QIHEC activities.
- Notify the chair in the event any person or entity seeks to compel disclosure of privileged or confidential information, or of any conflict of interest among committee members.
- Do not create or retain any copies or reproduction of discussion or information except as required for participation.

MEMBERSHIP

The following individuals constitute the SCAL Medi-Cal QIHEC membership (or their designees):

Co-Chairs:

KFHP/H Vice President, Associate Chief Medical Officer, National Medicaid

Southern California Permanente Medical Group (SCPMG) Regional Assistant Medical Director (SCAL Medi-Cal Medical Director)

Voting Member(s):

- Executive Director, Medicaid Chief Health Equity Director, National Quality; Vice-Chair (role may not be delegated)
- KFHP/H Senior Vice President, Area Manager
- SCPMG Physician Designee
- State/County Partner
- SCPMG Regional Chief of Family Medicine
- Subcontractor/Downstream Subcontractor Representative
- SCPMG Pediatrics Physician
- Network Provider Representative
- Medi-Cal Member Representation (member and/or caregiver)
- KFHP/H Vice President, Medicaid Care Delivery and Operations
- County Dental Officer, or designee
- SCPMG Assistant Regional Medical Director, Behavioral Health
- KFHP/H Vice President, Quality, Safety, & Regulatory Oversight
- SCPMG Quality & Regulatory Leader
- KFHP/H Vice President, Care Coordination
- SCPMG Continuing Care Representative

- KFHP/H Executive Director, Medicaid Care Delivery & Operations
- SCPMG Physician Leader, Population Care
- SCPMG Regional Quality Representative

Non-Voting Members:

- KFHP/H Vice President, Behavioral Health and Wellness
- KFHP/H Vice President Consumer Experience
- SCPMG Regional Administrative Leader, Care Experience, Service, & Access
- SCPMG Director, Data Analytics & Reporting, Clinical Analysis
- KFHP/H Regional Director, Medicaid Care Delivery & Operations
- KFHP/H Sr. Manager, Medicaid Care Delivery & Operations
- KFHP/H Medi-Cal Quality Regional Director
- KFHP/H Medi-Cal Quality SA Program Managers
- KFHP/H Medi-Cal Quality Consultant
- KFHP/H Medi-Cal Quality Project Manager, QIHEC
- KFHP/H Medi-Cal Quality Data Analyst

Meeting Support:

KFHP/H Regional Quality

Approved by: SCAL QIHEC Voting Members

Approved on: 03/08/2024

KP Southern California Medi-Cal Quality Improvement and Health Equity Committee (QIHEC) (Appendix)

Qualifications of QIHEC Members Responsible for Quality Improvement and Health Equity Activities

Timothy Ho, M.D., MPH, CPHQ
Regional Assistant Medical Director, Quality & Complete Care, Southern California Permanente Medical Group
Master's Degree in Public Health (MPH), University of California, Berkeley
Doctor of Medicine, Loma Linda University
BS, College of Arts and Sciences, Loma Linda University
Executive Leadership Program, Harvard Business School
Advanced Management Program, University of Southern California, Marshall School of Business
Middle Management Program, Kaiser Permanente, Southern California
Medical Board of California; Physician & Surgeon 1993 – Present
Board Certified, American Board of Family Medicine 1995- Present
Certified Professional in Healthcare Quality (CPHQ)
Fellow; American Academy of Family Physicians
Years in Current Position: 8
Years with Kaiser Permanente: 27
Total years in Healthcare: 29
Years in KP Leadership: 21
Years in Healthcare Leadership: 23

Claire Horton, M.D., MPH
Vice President, Associate Chief Medical Officer, National Medicaid and State Programs, Kaiser National Health Plan and Hospitals Quality
Internal Medicine Residency, University of California, San Francisco
Medical Degree, Duke University Medical School
Master's Degree Public Health, University of North Carolina – Chapel Hill School of Public Health
Bachelor of Arts, Duke University
Board Certification, Internal Medicine
Medical Licensure, California
Years in Current Position: 1
Years with Kaiser Permanente: 1
Total Years in Healthcare: 22
Years in KP Leadership: 1
Years in Healthcare Leadership: 18

Esme B Cullen, M.D., MPH
Executive Director, Chief Health Equity Officer, National Medicaid and State Programs, Kaiser National Health Plan and Hospital Quality
Medical Degree, University of California San Francisco
Master's Degree in Public Health (MPH), University of California Berkeley

Bachelor of Arts, Brown University
Internal Medicine Internship/Residency: Kaiser Permanente East Bay
Medical Board of California Board Certified
American Board of Internal Medicine
Elected Board Member San Francisco-Marin Medical Society
UCSF Clinical and Translational Science Fellowship
Years in Current Position: <1
Years with Kaiser Permanente: 6
Total Years in Healthcare: 13
Site Medical Director Marin Community Clinics: 3

Susan Mitchell-Mattera, RN, MN, CHA, IA, CPHQ
Director, Quality & Safety Oversight, Clinical Quality Oversight-Medi-Cal, Southern California
Quality & Safety Clinical Oversight, Kaiser Foundation Health Plan/Kaiser Foundation Hospitals (KFHP/H)
Master of Nursing, University of Phoenix
Bachelor of Nursing Health Science, Chapman University
Associate Degree of Science in Nursing, Los Angeles Harbor Community College
Certified Professional in Healthcare Quality (CPHQ)
Certified Hospice Administrator (HCA) California Association for Health Services at Home (CAHSAH) National Certification
Kaiser Permanente Improvement Advisor (IA)
Kaiser Permanente Middle Management Program
Home Care Advanced Certification, CAHSAH
Quality Assurance Certificate from Learning Tree University, Thousand Oaks, California
Learning Tree University Quality and Utilization, Los Angeles, California
InterQual Utilization Review Los Angeles, California
Kaiser Permanente Medical Program Leadership in Utilization Management, Harbor City, California
Certificate in Long Term Health Care, Chapman University May 1994
Years with Kaiser Permanente (KP): 35
Years in Healthcare: 39
Years in KP Leadership: 30
Total years in Healthcare Leadership: 35

Sarah Legg, MSN, RN, PHN, CPQH, CCM
Quality & Safety Improvement Consultant VI, Clinical Quality Consulting, Southern California
Quality & Safety Clinical Oversight, Kaiser Foundation Health Plan/Kaiser Foundation Hospitals (KFHP/H)
Master of Science Nursing (MSN), University of Phoenix
Bachelor of Science in Nursing, University of Phoenix
Registered Nurse (RN)
Public Health Nurse (PHN) Certification
Certified Professional in Healthcare Quality (CPHQ)
Certified Case Manager (CCM)
Kaiser Permanente Improvement Advisor
Years in Current Position: <1
Years with Kaiser Permanente: 15
Total Years in Healthcare: 30+
Years in KP Leadership: 10+
Years in Healthcare Leadership: 15+

Tamara Bondar, MSN-Ed, RN, PHN
Quality & Safety Improvement Consultant V, Clinical Quality Consulting, Southern California
Quality & Safety Clinical Oversight, Kaiser Foundation Health Plan/Kaiser Foundation Hospitals (KFHP/H)
Master of Science in Nursing (MSN-Ed), Point Loma Nazarene University
Bachelor of Science in Nursing, Point Loma Nazarene University
Bachelor of Science in Health Care Management, Southern Illinois University
Kaiser Permanente Improvement Advisor
Years in Current Position: <1
Years with Kaiser Permanente: 7
Total Years in Healthcare:>30
Years in KP Leadership: 7
Years in Healthcare Leadership: >25

Eileen Anonas- Alegre, BSN, RN, PHN
Quality & Safety Improvement Consultant V, Clinical Quality Consulting, Southern California
Quality & Safety Clinical Oversight, Kaiser Foundation Health Plan/Kaiser Foundation Hospitals (KFHP/H)
Bachelor of Science in Nursing, Mount St. Mary's College
Registered Nurse
Years in Current Position: <1
Years with Kaiser Permanente: 6
Total Years in Healthcare: 30
Years in KP Leadership: 2
Years in Healthcare Leadership: 5

Rochele Nubla, BSN, ACM-RN
Quality & Safety Improvement Consultant V, Clinical Quality Consulting, Southern California
Quality & Safety Clinical Oversight, Kaiser Foundation Health Plan/Kaiser Foundation Hospitals (KFHP/H)
Bachelor of Science in Nursing, University of Santo Tomas
Associate Degree of Science in Nursing, Glendale Community College
Registered Nurse (RN)
InterQual Utilization Review Los Angeles, California
Kaiser Permanente Regional Preceptor Training Program, Pasadena, California
Accredited Case Manager (ACM-RN)
Years in Current Position: <1
Years with Kaiser Permanente (KP): 13
Total Years in Healthcare: 25
Years in Healthcare Leadership: 15

Joseliz L. Petalver, MBA, BSN, RN, CAPA, LNC
Quality & Safety Improvement Consultant IV, Clinical Quality Consulting, Southern California
Quality & Safety Clinical Oversight, Kaiser Foundation Health Plan/Kaiser Foundation Hospitals (KFHP/H)
Master of Business Administration (MBA), Western International University
Bachelor of Science in Nursing, St. Paul University
Certified Legal Nurse Consultant (LNC), California State University Long Beach
Certified Ambulatory Perianesthesia Nurse (CAPA)

Basic Life Support (BLS)/ Advanced Cardiovascular Life Support (ACLS)/ Pediatric Advanced Life Support (PALS)
Years in Current Position: <1
Years with Kaiser Permanente (KP): 4
Total Years in Healthcare: 15
Years in KP Leadership (if applicable): 2
Years in Healthcare Leadership (if applicable): 3

Vana Keshishian, MBA, CPPS, LSSGB, CSM
Consultant IV, Southern California Quality & Safety Clinical Oversight, Kaiser Foundation Health Plan/Kaiser Foundation Hospitals (KFHP/H)
Master of Business Administration (MBA) in Healthcare Management, Western Governors University
Bachelor of Science in Health Administration, California State University, Northridge
Bachelor of Science in Pharmacy, University of Aleppo
Certificate in Safety, Quality, Informatics, and Leadership - Harvard Medical School
Certificate in Project Management, University of California, Los Angeles
Certified Professional in Patient Safety (CPPS)
Certificate in Quality & Safety, The Institute for Healthcare Improvement (IHI)
Lean Six Sigma Green Belt (LSSGB)
ASHP/ISMP Medication Safety Certification
Certified Scrum Master (CSM)
Years in Current Position: <1
Years with Kaiser Permanente (KP): 9
Total Years in Healthcare: 17
Years in Healthcare Leadership: 2

Kevin Chun-Wei Ong
Data Analyst IV, Southern California Quality & Safety Clinical Oversight, Kaiser Foundation Health Plan/Kaiser Foundation Hospitals (KFHP/H)
Bachelor of Science in Computer Information Systems (CIS), California State Polytechnic University, Pomona
Years in Current Position: <1
Years with Kaiser Permanente (KP): 8

KAISER PERMANENTE®

KAISER PERMANENTE SOUTHERN CALIFORNIA
MEMBER CONCERNS COMMITTEE
2022 CHARTER

PURPOSE

The Member Concerns Committee (MCC), Kaiser Permanente Southern California, 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.

AUTHORITY AND SCOPE

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.

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MEMBER CONCERNS COMMITTEE
2022 CHARTER

- 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.

REPORTING STRUCTURE

- The MCC is a subcommittee of the Southern California Quality Committee (SCQC). MCC reports to SCQC on a biannual basis.
- The MCC maintains ongoing reporting and communication with local KPSC medical center departments, committees, and/or leaders responsible for oversight of KPSC initiatives and priorities.
- KFH/P Vice President, Quality, Safety & Regulatory Services and SCPMG Regional Medical Director of Quality & Clinical Analysis, are committee sponsors.
- The Committee is chaired by a Health Plan Physician Advisor, and a Health Plan representative.

ROLES & RESPONSIBILITIES

- Reviews volume, type and outcome of member complaints, grievances, and appeals for all business lines and reports to SCQC.
- Examines performance and analyzes variation by medical center for prioritized metrics.
- Communicates directly with medical centers to execute SCQC decisions and monitor performance improvement.
- Identifies high and low performers and facilitates dissemination of successful practices.
- Facilitates standardization where appropriate.
- Track identified action plans.
- Documents and distributes meeting records and follows standard agenda formats and templates for reporting.

MEETING PROCESS

The MCC shall meet no less than six months each year.

Membership includes representatives from KFH, KFHP, and SCPMG. A quorum is a simple majority of the members in attendance. MCC actions and decisions are documented in contemporaneous minutes of the meeting proceedings.

ANNUAL EVALUATION

MCC activities are reported to SCQC biannually. The MCC Charter is reviewed, updated and approved annually.

Approved by MCC on April 27, 2022

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KAISER PERMANENTE SOUTHERN CALIFORNIA
MEMBER CONCERNS COMMITTEE
2022 CHARTER

CONFIDENTIALITY

Participation in MCC may necessitate access to privileged or otherwise confidential information. The confidentiality of such information is vital to the free and candid communications necessary to fulfill the activities and functions of the MCC.
Members of the MCC 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 MCC activities.
- Notify a MCC chair 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.

MEMBERSHIP

The following individuals constitute the MCC membership:

Vice President, Quality, Safety & Regulatory Services
Regional Medical Director of Quality & Clinical Analysis
Health Plan Physician Advisor KFHP
Health Plan Physician Advisor KFHP
Vice President, HPSA & Consumer Experience
Director, Regional Quality & Regulatory Services
Senior Vice President, Chief Operations Officer
Vice President, Member Relations
Executive Director, Member Relations, Grievance, Appeals, & Absence Documentation Services
Director, SCPMG Performance Assessment
Director, Regulatory Investigation & Response
Executive Director, SCAL Local Member Services
Assistant Medical Group Administrator, Psychiatry, Addiction Medicine, Social Medicine
Regional Assistant Medical Director, Care Experience & Access
Regional Outpatient Pharmacy Director
Chief Officer, Quality & Systems of Care
Executive Director, Member Relations Quality & Risk
Vice President, Care Coordination
Director, Regulatory Information Management Systems & Services
Director, Care Experience & Patient and Person Centered Care, Patient Care Services

Approved by MCC on April 27, 2022

KAISER PERMANENTE SOUTHERN CALIFORNIA
MEMBER CONCERNS COMMITTEE
2022 CHARTER

Assistant Medical Group Administrator, Regional Service & Access
Senior Director, Data & Reporting Member Relations National Integration, Regulatory & Data Services
Consultant, Regional Quality & Regulatory Services
Senior Business Consultant, HPSA & Consumer Experience
Patient Advisor

Approved by MCC on April 27, 2022

KAISER PERMANENTE®

SOUTHERN CALIFORNIA

REGIONAL ACCESS COMMITTEE

2024 CHARTER

REPORTING STRUCTURE

The Access Committee reports directly to the Southern California Quality Committee (SCQC) and will report appropriate activities and issues to SCQC on a quarterly basis or more frequently as needed. The Kaiser Foundation Health Plan (KFHP) Vice President, Quality, Safety & Regulatory Services, the Southern California Permanente Medical Group (SCPMG) Chief Administrative Officer, and the SCPMG Regional Medical Director, Operations, serve as committee sponsors.

ROLES & RESPONSIBILITIES

1. Understand and execute the access requirements by regulatory and accrediting organizations.
2. Review 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.
3. Review access trends and patterns and recommend areas of focus based on those data.
4. Request and oversee implementation of corrective action plans (CAP) to address gaps in access.
5. Escalate concerns and report resolution of CAPs to the SCQC.
6. Provide oversight for submission of service area and county-specific and Rate of Compliance (ROC) data for annual Timely Access Report submitted to DMHC. (Attachment: MY 2021 Timely Access Rate of Compliance Methodology)
7. Oversight of 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.

MEETING PROCESS

The committee will meet monthly. Membership includes representatives from Kaiser Foundation Health Plan/Hospital and Southern California Permanente Medical Group (SCPMG), with a quorum being a simple majority of the members. Actions and decisions of the Access Committee are documented in minutes of the meeting proceedings.

ANNUAL EVALUATION

The Access Committee will review and revise as necessary its charter and membership annually.

CONFIDENTIALITY

Participation may necessitate access to privileged or otherwise confidential information. The confidentiality of such information is vital to the free and candid communication necessary to fulfill the activities and functions of the committee. Members of the Access Committee explicitly agree, as a condition of membership to:

- Respect and maintain the confidentiality of all discussions and information
- Make no voluntary disclosure of discussions or information except to authorized persons
- Notify the Committee 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

MEMBERSHIP

Chairs:

- KFH/P Vice President, Quality, Safety & Regulatory Services
- SCPMG Assistant Regional Medical Director, Care Experience

Members:

- SCPMG Assistant Regional Medical Director, Access
- SCPMG Assistant Regional Medical Director, Service & Access
- SCPMG Regional Chief of Psychiatry

Approved May 20, 2024

- SCPMG Senior Manager, Regional Service & Access
- SCPMG Manager, Consulting, Regional Service & Access, Regulatory
- SCPMG Senior Consultant, Regional Service & Access
- KFH/P Director, Regional Quality & Regulatory Services
- SCPMG Regional Administrative Leader, Care Experience, Service & Access
- KFH/P Senior Counsel, Health Plan & Payor Operations, Legal Department
- KFH/P Senior Director, Provider Delivery Systems, Enterprise Regulatory Services
- KFH/P Senior Director, Behavioral Health Quality & Regulatory Services
- KFH/P Vice President, Consumer Experience and Hospital & Health Plan Service Administration (HPSA)
- KFH/P Practice Leader, Regional Quality & Regulatory Services
- KFH/P Consultant, Regional Quality & Regulatory Services

Non-Voting Members:

- SCPMG Executive Leader, Behavioral Health
- SCPMG Program Manager, Autism & Developmental Disabilities

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MY 2024 Timely Access Rate of Compliance Methodology

I. Collecting and External Reporting Annual Rate of Compliance to California's Department of Managed Health Care ("DMHC")

Beginning with Measurement Year 2018, at the direction of the Department of Managed Health Care (DMHC), for purposes of external reporting to the DMHC, KFHP changed the way it measures internal medical group provider access. The DMHC has directed all plans to use the Provider Appointment Availability Survey (PAAS) process to collect and report annual timely access data.

DMHC allows plans two surveying options: Extraction or Three-Step Process. Extraction allows extraction of appointment data from the plan's practice management software. The Three-Step Process is the more traditional surveying used in past years (i.e. via phone, email/online, or fax).

For Measurement Year 2024, Mazars, a third party contracted vendor, will administer the PAAS to the Plan's reportable providers, using the Extraction option for appointments with TPMG and SCPMG providers (Mazars worked remotely with Plan personnel) and the Three-Step Process option was used for surveying contracted providers, as it has been in previous years.

The PAAS must include all providers on or after January 15, 2024 who furnish health care service through enrollee appointments for the following Provider Survey Types:

- Primary Care Physician ("PCP"[1]) appointments and Non-Physician Medical Practitioner ("NPMP") urgent and non-urgent[2] appointments;
-
- Cardiovascular Disease urgent and non-urgent appointments (incl. Internal Medicine-Cardiovascular Disease, and Pediatric Cardiology);
- Dermatology urgent and non-urgent appointments (incl. Internal Medicine-Dermatology and Pediatric Dermatology);
- Endocrinology urgent and non-urgent appointments (incl. Internal Medicine-Endocrinology and Pediatric Endocrinology);
- Gastroenterology urgent and non-urgent appointments (incl. Internal Medicine-Gastroenterology and Pediatric Gastroenterology);
- Neurology urgent and non-urgent appointments (incl. Internal Medicine-Neurology, Epilepsy, and Pediatric Neurology);
- Oncology urgent and non-urgent appointments (incl. Internal Medicine-Oncology and Pediatric Hematology/Oncology);
- Ophthalmology urgent and non-urgent appointments (incl. Internal Medicine-Ophthalmology);
- Otolaryngology urgent and non-urgent appointments (incl. Internal Medicine-Otolaryngology and Pediatric Otolaryngology);
- Pulmonology urgent and non-urgent appointments (incl. Internal Medicine-Pulmonology and Pediatric Pulmonology);
- Urology urgent and non-urgent appointments (incl. Internal Medicine-Urology and Pediatric Urology);
- Psychiatrist[3] urgent and non-urgent appointments;

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[1] Primary Care Physicians may include Family Practice, General Practice, Pediatrics, OB/GYN, or Internal Medicine Physicians. For other specialty types, include only those providers that have agreed to serve as a PCP. PCPs include non-physician medical practitioners which are physician assistants and/or nurse practitioners performing services under the supervision of a PCP and/or nurse practitioners performing services in collaboration with a physician.

[2] Non-urgent appointments, by regulation, do not include preventative care and periodic follow up care, which may be scheduled in advance "consistent with professionally recognized standards of practice as determined by the treating licensed health care provider."

[3] The MY2020 does not require health plans to survey and report separate rates of compliance for Child and Adolescent Psychiatrists. Plans are still required to survey and report a rate of compliance for Psychiatrist.

- Non-Physician Mental Health Care Providers ("NPMH") urgent, non-urgent, and non-urgent follow-up appointments (Licensed Professional Clinical Counselor ("LPCC"), Psychologist (PhD-Level), Marriage and Family Therapist/Licensed Marriage and Family Therapist and Master of Social Work/Licensed Clinical Social Worker);
-
- Facilities or entities providing Physical Therapy (Ancillary) non-urgent appointments;
- Facilities or entities providing Mammogram (Ancillary) non-urgent appointments.

In addition to the description provided below under "Ongoing KP Quality Assurance Oversight" the Plan also reviews the PAAS data annually. The PAAS is a snapshot of single calendar days within the year it is conducted, and is retrospective from the point the Plan receives the PAAS results from Mazars, the Plan continues to rely on its own internal access data to make real time determinations where corrective action may need to be taken to improve accessibility. The Plan continues to work on how best to incorporate the annual PAAS data in its quality review program and expects this process will continue to evolve over time.

II. Ongoing Internal KP Quality Assurance Oversight

For appointed services rendered by providers of The Permanente Medical Group, Inc. ("TPMG") and Southern California Permanente Medical Group ("SCPMG"), the Plan's exclusively contracted medical groups in California, the Timely Access Rate of Compliance ("ROC") will be measured by the percentage of appointments that are actually scheduled within the time elapsed standards set forth in the Timely Access Regulation.

In each county where the Plan is licensed, each department within each Kaiser Permanente medical office measures the percentage of its appointments scheduled within the Timely Access standards. For example, if 28 out of 30 non- urgent appointments in the department of allergy in Los Angeles County were scheduled within 15 business days, this department would receive a score of 93.3%.

Urgent Specialty/Ancillary Appointments

The Plan does not have urgent data to review in all of the specialist and ancillary provider categories.

Clinically urgent referrals to most specialists are rare, as the actual practice of providing specialty consultations commonly occurs in real time. If there is truly an urgent need for a Mammography appointment, members can be seen on a walk-in basis. Other examples include, but are not limited to Cardiology, Gastroenterology, Endocrinology, MRI, and Physical Therapy—members with a truly urgent need and whose treatment physician believes their condition warrants urgent specialty treatment are seen in real-time through a consult with an appropriate specialist, or the member may be referred to the emergency department.

For example, if a primary care physician ("PCP") sees a member who they believe requires intervention or consultation from one of the specialties urgently, the PCP would either consult in real time with the specialist regarding the member's condition and administer the corresponding recommended treatment plan, or the specialist would see the member the same day at the request of the PCP and those appointments are not captured as "urgent" but rather as a new consultation under the non-urgent timeframes.

KAISER PERMANENTE®

Charter for the Bioethics Program of KP Southern California

Last Updated: 06/09/2022

Mission and Purpose

The mission of the Bioethics Program of KP Southern California is to:

- Promote ethical and medical care that reflects personal, social and spiritual values
- Support those involved in situations of ethical uncertainty or conflict to reach a moral understanding that promotes the good for the patient
- Promote an ethical environment of care within a vertically integrated system

The purpose of the Bioethics Program of KP Southern California is to:

- Provide leadership and oversight for healthcare ethics consultation and policy
- Assist with supporting and improving organizational ethics quality
- Support ethics education
- Integrate and align the Bioethics Program with other key organizational strategic priorities

Reporting Structure

The Bioethics Program reports to:

- The President of the Southern California Kaiser Foundation Hospitals and Health Plan (KFH/HP) or their designee
- The Executive Medical Director of the Southern California Permanente Medical Group (SCPMG) or their designee

Authority and Scope

The Bioethics Program encompasses the work performed by:

- SCAL Bioethics Program Co-Directors
- SCAL Regional Bioethics Committee
- SCAL Medical Service Area Bioethics Directors
- SCAL Medical Service Area SCPMG Physician Bioethics Committee Co-Chairs
- SCAL Medical Service Area Bioethics Committees

The Bioethics Program Scope Includes:

- Identifies opportunities and makes recommendations to leadership to strengthen bioethics quality
- Serves as an advisory resource for the Region and medical service areas
- Collaborates with Regional and Local Accreditation, Regulation and Licensing, KFH/HP and SCPMG Legal, and Compliance for regulatory standards related to policies and procedures under the custody of Regional Bioethics Committee
- Manages website presence for the Bioethics Program
- Provides health care ethics consultation
- Serves as a resource for organizational ethics questions or concerns
- Collaboration between Bioethics Committee Co-Chairs and Regional Bioethics Committee
- Provide Qualifications, Duties and Responsibilities to the Bioethics Program participants. For provided role descriptions, please see **Bioethics Program Charter Appendix A**

Charter for the Bioethics Program of KP Southern California

Regional Bioethics Committee

Regional Bioethics Committee Role

Regional Bioethics Committee (RBC) serves as a deliberative and voting body for policies under the custody of Bioethics. RBC 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 Bioethics Committee Membership

RBC will be co-chaired by the KFH/HP Co-Director of the Regional Bioethics Program and the SCPMG Co-Director of the Regional Bioethics Program.

Membership shall consist of:

- Medical Service Area Bioethics Directors
- Medical Service Area Bioethics Committee Co-Chair Physician

Medical Service Area Bioethics Committee Co-Chair members are accountable for meeting the goals articulated by the Regional Bioethics Program. Co-Chairs of each medical service area's Bioethics Committee will be appointed respectively by the medical service area Executive Director and the Area Medical Director. Medical service area Bioethics Committees will establish their structures, programs, resources and systems as detailed by the Regional Bioethics Program in order to address local health care needs, issues and priorities to the populations served.

Members shall represent their respective SCAL Kaiser Foundation Hospitals, Kaiser Foundation Health Plans and Southern California Permanente Medical Groups. Committee membership will include expert representation from, but not limited to, SCPMG and KFH/HP Legal Departments, Risk, Compliance, Regional Nursing, Accreditation, Regulation & Licensing (AR&L) and the community. Co-Chairs of medical service area Bioethics Committees may select designees to serve on their behalf.

Regional Bioethics Committee Governance

RBC will meet quarterly, with no fewer than three meetings per year. Committee meeting quorum requires a simple majority (greater than 50%) of the medical service areas being represented by at least one Bioethics Director or Bioethics Committee Co-Chair Physician. Regional Bioethics Committee actions and decisions are documented in meeting minutes.

All records are maintained in a manner that preserves their integrity in order to assure that patient and practitioner confidentiality are protected. Regional Bioethics Committee, medical service area Bioethics Committees and Bioethics Subcommittees will agree to confidentiality of all minutes, reports, recommendations, memoranda and documented actions. Committee members must:

- Respect and maintain the confidentiality of all discussions and information

- Make no voluntary disclosures of discussions or information except to persons authorized to receive it under the conduct of Bioethics Committee activities
- Notify RBC Co-Chairs in the event any person or entity seeks to compel disclosure of privileged or confidential information
- Refrain from creating or retaining any copies or reproductions of discussions or information except as required for Committee participation

Regional Bioethics Committee Voting Requirements

RBC voting rights will be granted to the two Regional Bioethics Program Co-Directors, up to two co-chair members of each medical service area bioethics committee (Bioethics Director and a Physician Co-Chair) and up to two Bioethics Committee community members. Bioethics Committee Co-Chairs should encourage participation by all members in arriving to a consensus. RBC members or guests without voting rights are deemed Consultants, who are expected to attend and contribute in meetings.

Decisions by Regional Bioethics Committee shall be made by a simple majority vote (greater than 50%) of the meeting quorum. Prior to a final vote, decisions will be open to discussion from Regional Bioethics Committee members. Preliminary votes may be held prior to a final vote in order to determine consensus. Following a preliminary vote, decisions will be reopened for discussion from Regional Bioethics Committee members prior to a final vote.

Ethical approaches approved in policies achieving a simple majority vote shall not be revised by a medical service area Bioethics Committee. When a policy has an indicated revision (routine review cycle, change in law, or change in practice standards), medical service area Bioethics Committee Co-Chairs shall bring the need for a review to Regional Bioethics Committee Co-Chairs. Medical service area Bioethics Committee Co-Chairs may make necessary changes to local workflow, logistics and nomenclature to further the approved policies in the local setting.

Charter for the Bioethics Program of KP Southern California

Bioethics Program Charter Appendix A

Bioethics Committee Members Qualifications, Duties and Responsibilities

1. Regional Bioethics Program Co-directors
    a. Duties and Responsibilities
        i. Provide local medical service area leadership with indicators of the medical service area's ability to promote an ethical environment of care
        ii. Assess the performance of Regional Bioethics Committee
        iii. Oversee the management of projects promoted by Regional Bioethics Committee
        iv. Represent the Bioethics Program within:
            1. The KP Interregional Medical Ethics Committee (as members)
            2. Kaiser Permanente (locally and nationally)
        v. Report and provide recommendations to the Southern California Quality Committee (SCQC)
        vi. Review candidates applying for positions as Medical Bioethics Directors with the local medical service areas
        vii. Direct the content of the KP SCAL bioethics websites (both internal and external).
        viii. Manage and maintain accountability for the Regional Bioethics budget.
    b. Qualifications
        i. KFH/HP Co-director of the Bioethics Program
            1. Will have a professional degree including, but not limited to social work, nursing, bioethics, theology, law, or philosophy
            2. Will have been educated in bioethics as evidenced by a certificate or degree in Bioethics or comparable experience
            3. Recommended, but not required, certified as a Healthcare Ethics Consultant (HEC-C) or is certified within four years from appointment.
            4. Experience as a medical service area Bioethics Director (at least two years)
            5. Demonstrated ability to offer programmatic leadership and direction, work collaboratively with multi-disciplinary groups, and represent the Bioethics Program locally and nationally.
        ii. SCPMG Physician Co-director of the Bioethics Program
            1. Will have a degree of MD or DO, maintains certification in their primary Specialty Board, and remains in good standing within SCPMG
            2. Will have been educated in bioethics as evidenced by a certificate or degree in Bioethics or comparable experience
            3. Recommended, but not required, certified as a Healthcare Ethics Consultant (HEC-C) or is certified within four years from appointment.
            4. Experience as a medical service area Bioethics Committee Physician Co-chair (at least two years)
            5. Demonstrated ability to offer programmatic leadership and direction, work collaboratively with multi-disciplinary groups, and represent the Bioethics Program locally and nationally.
2. Medical Service Area Bioethics Committee Co-chairs
    a. Duties and Responsibilities
        i. As co-chairs, plan the agenda and review the minutes for each Bioethics Committee meeting
        ii. The co-chair(s) (or designees) will regularly attend and represent the medical service area at Regional Bioethics Committee
        iii. Provide a medical service area report to Regional Bioethics Committee at least once every three years

iv. Organize and deliver educational programs at the medical service area's service area as needs are identified and as requested by medical service area leadership
v. Assist with medical service area education and implementation of Regional Policies for which Bioethics is a custodian
vi. Provide bioethics consultations and answer questions of an ethical nature for the medical service area
vii. Provide peer learning review for bioethics consultations done at the medical service area
viii. Provide an annual report to the medical service area's Medical Executive Committee
ix. Chair a regional Subcommittee(s) on Policy Suggestion (SOPS) as requested by Regional Committee or Program Co-directors.
x. Participate as a member of other regional SOPS as needs arise

b. Qualifications
   i. KFH/HP Medical Service Area Bioethics Director:
      1. Will have a professional degree including, but not limited to social work, nursing, bioethics, theology, law, or philosophy
      2. Will have been educated in bioethics as evidenced by a certificate or degree in Bioethics or comparable experience
      3. Recommended, but not required, to be certified as a Healthcare Ethics Consultant (HEC-C)
      4. Demonstrated ability to offer programmatic leadership, direction and to work collaboratively with multi-disciplinary groups
   ii. Medical Service Area Bioethics Committee SCPMG Physician Co-chair
      1. Will have a degree of MD or DO, maintains certification in their Specialty Board, and remains in good standing within the Southern California Permanente Medical Group
      2. Will have been educated, or within three years is educated in bioethics as evidenced by:
         a. Attending organized ethics educational activities (internal or external)
         b. Comparable experience based on expected duties and responsibilities.
      3. Recommended, but not required, to be Certified as a Healthcare Ethics Consultant (HEC-C)
      4. Demonstrated ability to offer programmatic leadership and direction
      5. Demonstrated ability to work collaboratively with multi-disciplinary groups

Regional Continuum Quality & Performance Executive Committee Charter

Name	Regional Continuum Quality & Performance Executive Committee	**Co-Chairs**	Della Williams, Dan Huynh, M.D.
Executive Sponsors	Tara Harder & Nancy Gin, M.D.	**Supporting Consultant**	Jaime Akiyama-Ciganek

Purpose

- 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.

Key Areas of Focus

- Updates to be provided 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 & Programs
- Performance and Improvement of services
- Oversight and monitoring of compliance with performance standards.

Outputs/Target Outcomes

- Review quality site visits, complaints/grievances, regulatory activities, survey activity/results, service area goals/performance, new compliance initiatives, contract oversight, quality measures, quality oversight of KFH contracted facilities.
- Standardized practices and increase efficiency in each service area.
- Identify and improve quality measures.
- Satisfaction survey program redesign to meet operating trends, efficiency, and quality improvement.
- Maintain the sustainability of initiatives, ensure consistent quality, and reduce unwanted variation.

Meeting Frequency

This committee would meet every other month for 2 hours and report out to SCQC twice a year.

Members

Continuum Leaders and Management
- Patricia Clausen, *SVP, Continuum and Clinical Services*
- Karen Sielbeck, *VP, Care Coordination and Continuum*
- Jose John, *ED, Care Coordination and Continuum*
- John Lapuz, *Director, Care Coordination and Continuum*
- Cora Bailey, *Director, Care Coordination and Continuum*
- Julie-ann Galang-Iansigan, *Director, Care Coordination and Continuum*
- Patty Ma, *Medi-Cal Manager*, *Care Coordination and Continuum*

KPCAH Leaders, Physicians and Management
- Angel Vargas, *VP, Care At Home*
- Christopher Subject, MD, *Assist. Reg. Medical Director, Service Line Leader, Hospital Based/Continuing Care/Support Services*
- Romina Rosen, MD, *CAH HH/HO/AMCAH Physician Champion*
- Khang Nguyen, MD, *Assistant Executive Medical Director for Care Transformation*
- Susan Wang, MD, *Regional Chief, Dept. of Geriatrics & Palliative Medicine*
- Jackie Block, *Sr. Director, Home Health Operations*
- Gina Andres, *Sr. Director, Hospice and Palliative Care Operations*
- Odylin Bundalian, *Sr. Director, Clinical Excellence and Chief Clinical Officer*

KPCAH ICC, DME and Transportation Leaders, Physicians and Management
- Tamica Lewis, *Sr. Director, Care At Home Operations*
- Jaclyn Gallardo, *Manager, DME*
- Ronald Loo, *Physician Leader, Durable Medical Equipment*
- Calvin Dong, *Director, Medical Transportation*

Medi-Cal Leaders & Management
- Vidya Iyengar, *VP, Medicaid Operations/Care Delivery*
- Celia Williams, *ED, Medicaid Operations/Care Delivery*
- Martha Shenkenberg, *Director,* Medicaid Operations/Care Delivery
- Kelly Kono, *Managerial Sr. Consultant, Medi-Cal Strategy & State Programs*
- Susan Mattera, *Director, Medi-Cal Quality and Safety*

KPCAH Hawaii Leadership and Management
- Susan Wilson, *ED, HI HP & Hospital Quality Oversight*
- Matthew Karpan, *Director, Quality Metrics, HI*

Patient Advisors: Susie Becken & Imelda Foley

Subcommittees reporting into Regional Continuum Quality Committee:
- Compliance: Charlotte Edwards, *Practice Leader, Compliance*
- Regional Quality SCAL & HI QAPI: Della D. Williams, *Sr. Director, Regional Quality & Safety Continuum Quality*
- Contract Oversight: Paula Kraft, *Sr. Director, Regional Quality & Safety*

Kaiser Foundation Hospitals and Kaiser Foundation Health Plan, Inc. (KFH/HP)

SCAL Region
Regional Credentialing Committee Charter

Purpose	The Regional Credentials Committee (RCC) is a subcommittee of the Southern California Quality Committee (SCQC). Its function is to improve patient care and safety through optimization of the credentialing and privileging processes while meeting all regulatory requirements. The RCC collaborates with the Regional Systems Peer Review Oversight Committee (RSPROC) and with members of each local Kaiser Foundation Hospital Credentials Committee on as needed basis. The committee serves both as a decision-making body, an oversight body and in an advisory role to the SCQC.
Responsibilities	**Decision making responsibilities for credentialing and privileging regionally, as follows:** a. 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 b. Approval of privileging and proctoring processes c. Review and Approval of delegated credentialing processes d. Oversight and management of the credentialing and privileging data base e. Oversight of local implementation of the credentialing and privileging policies and procedures. f. Ongoing review and monitoring of sanction activities and licensing board actions. g. 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. h. Oversight of Bylaws revision processes in conjunction with Accreditation, Regulation and Licensing i. Analysis of reports from monthly oversight reviews. j. Review of reports from RSPROC and oversight of credentialing actions taken to ensure consistent standards across the Southern California program. **Advisory responsibility for credentialing and privileging regionally, as follows:** a. Review and revision of Credentialing and Privileging policies and procedures. b. Development of educational programs to promote consistent implementation of consistent credentialing practices. c. Promote consistency of credentialing practices and uniformity of privileging criteria across departments, hospitals and medical centers in the southern California program. d. Escalate significant issues, trends, and variations to SCQC. e. Promote sharing of learning across the southern California program

Revised: 08/01/18
Revised: 03/04/20
Revised: 12/02/20
Revised: 07/06/22
Revised: 08/07/24

	f. Support compliance with Kaiser Permanente Policies and Procedures g. Support compliance with standards and regulations referable to credentialing and privileging, including the Department of Managed Health Care, The Joint Commission, NCQA, The Center for Medicare and Medicaid Services, Department of Health Care Services , and the California Department of Public Health.
Reporting Structure	The Regional Credentials Committee is a subcommittee of the Southern California Quality Committee and reports to SCQC at least quarterly. The committee maintains ongoing communication with the local medical center Credentials Committees and Medical Staff Departments, providing feedback on an ongoing basis.
Meeting Process	**Frequency -** The RCC will meet monthly, no fewer than ten times per year. **Quorum -** A quorum is a simple majority of voting members when at least 50% of the members present are physicians. **Minutes -** RCC minutes will be maintained for each in person meeting and each virtual/electronic meeting.
Annual Evaluation	The RCC will review its charter as needed and/or at least once annually .
Confidentiality	Prior to each meeting, the RCC members, consultants, staff and participants shall attest they will maintain the confidentiality of all discussions, credentials files and other materials/data/documentation presented in connection with the Regional Credentials Committee (RCC)
Voting	Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members. Any action taken must be approved by at least a majority of the required quorum for such meeting. Committee action may be taken by telephone conference, videoconference, or electronic mail, which shall be deemed to constitute a meeting for the matters discussed in that conference.
Membership	The Regional Credentials Committee members shall represent a cross section of surgical and medical specialties from all service areas. Membership shall consist of physicians (3 at minimum) and non-physicians representing Kaiser Foundation Hospitals, Kaiser Foundation Health Plan, Inc., and Southern California Permanente Medical Group. The committee members will have expertise in, but not limited to, credentialing, privileging, quality, risk management, accreditation, and licensing. The Committee will be chaired by an SCPMG physician who is a member of SCQC and reports to that committee. Voting Members: 1. Co-Chair, RCC – Physician Member 2. Co-Chair, RCC – KFH/HP Senior Vice President/Area Manager 3. Medical Center Physician members who either Chair the Medical Center Credentials Committee or serve as a member of the local Committee. 4. Co-Chair, Regional Systems Peer Review Oversight Committee 5. Physician – Behavioral Health Representative 6. Senior Director of Regional Credentialing 7. Regional Director of Accreditation, Regulatory & Licensing – KFHP/H

	8. Regional Director - Quality Oversight 9. KFH (Medical Center) Chief Operating Officer Non-Voting Members: 10. Assistant Director of Regional Credentialing 11. Regional Director of Quality – Behavioral Health 12. KFH Medical Staff Office Manager 13. Vice President, Quality, Safety & Regulatory Oversight (ad hoc) 14. Director of Ambulatory Clinical Practice, SCPMG (ad hoc) 15. Assistant Executive Medical Director, SCPMG - Permanente Human Resources and Chief Compliance Officer, SCPMG (ad hoc) 16. Representative from SCPMG Legal Department (ad hoc) 17. Representative from KFHP/H Legal Department (ad hoc) 18. Representative SCPMG Contracting (ad hoc) 19. Regional Credentialing Staff (ad hoc) 20. Affiliate/Contract Network Dentist – consultative (ad hoc)

KAISER PERMANENTE®

SOUTHERN CALIFORNIA
REGIONAL MEDICATION SAFETY OVERSIGHT COMMITTEE
CHARTER
Reviewed & Approved : January 24, 2024

CHARTER:

The SCAL Regional Medication Safety Oversight Committee (MSOC) supports the Kaiser Permanente Mission of promoting the health of our members in a safe environment. The Committee is an integrated, multidisciplinary oversight committee that works collaboratively in all care settings to promote medication safety.

MISSION STATEMENT:

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 management and improved health outcomes across the continuum of care.

OVERSIGHT AND COLLABORATION:

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 ambulatory care practice leaders, medication management teams, KP HealthConnect® leads, Pharmacy Nursing Committee, Pharmacy Informatics and Pharmacy Operations and Quality Leaders.

MEMBERSHIP:

The Regional Medication Safety Oversight Committee membership is comprised of physicians, SCPMG and HealthPlan senior leaders and regional and local key stakeholders from the following: Nursing Administration; Pharmacy, Risk Management and Patient Safety, Patient Care Services, HealthConnect®. Committee members communicate and support MSOC oversight to peers.

ACCOUNTABILITY:

The Regional Medication Safety Oversight Committee reports to the Southern California Quality Committee (SCQC).

MEETING STRUCTURE:

The Regional Medication Safety Oversight Committee meets monthly. A quorum consists of at least 1/3 of membership of mixed representation from the Committee roster. Committee expectation is at least one representative from each Medical Center be present on behalf of

their local committee. Committee members are asked to identify an alternate who is kept informed of MSOC issues and activities. Co-chair leadership is shared between the Medical Director, Regional Director Risk and Patient Safety, Pharmacy Director of Quality & Medication Safety. MSOC actions and decisions will be documented in contemporaneous minutes of the meeting proceedings. An ongoing action log reflects issues that require follow-up.

CONFIDENTIALITY:

The Committee activities necessitate the access to privileged or otherwise confidential information. The confidentiality of such information is vital to the free and candid communications necessary to fulfill the oversight functions of the Committee. Committee members agree to adhere to all KPSC confidentiality policies and procedures.
As a condition of membership, members of MSOC explicitly agree to:

1. Respect and maintain the confidentiality of all discussions and information.
2. Make no voluntary disclosures of discussions and information except to persons authorized to receive it in the conduct of RMSC activities.
3. Notify the MSOC Chair if any person or entity seeks to compel disclosure of privileged or confidential information.
4. Not create or retain any copies or reproductions of discussions or information except as required for participation.

KAISER PERMANENTE®

Person & Family Centered Care

Southern California Regional Patient Advisory Council

Regional Patient Advisory Council
Kaiser Permanente Southern California
Charter

Vision

Creating a strong partnership between members, patients, families, caregivers, and Kaiser Permanente to improve the care experience for all.

Mission

To improve quality of service and safety, enhance systems of care, represent the diversity of our members, and educate health care professionals and staff on the patients' perception of their health care experience at Kaiser Permanente Southern California (KPSC) facilities.

Purpose

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

- Identify and advise KP Southern California on regional issues related to quality, safety, care experience and all key areas of healthcare.
- Partner with KP regional and national leaders, committees, and other improvement teams to bring patient perspectives for more patient centered outcomes.
- Encourage 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.*

I. Executive Sponsors

- President, Kaiser Foundation Health Plan and Hospitals, Southern California
- Executive Medical Director and Chairman, Southern California Permanente Medical Group

Approved: 4/13/24

KAISER PERMANENTE®

Person & Family Centered Care

Southern California Regional Patient Advisory Council

Regional Patient Advisory Council
Kaiser Permanente Southern California
Charter

II. Reporting Relationships

- Formal annual report to RPAC KP Executive Sponsors. This will include a summary of the prior year's Council activities and recommendations for improvement of the KPSC program from a member perspective.
- Formal annual report to the Kaiser Permanente Southern California Quality Committee (SCQC), of which RPAC is a subcommittee.

III. Confidentiality

- All RPAC members are required to sign the *Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals KPSC Volunteer Patient Advisor Confidentiality Agreement.*
- RPAC members will refrain from speaking as a representative of KP or RPAC with outside organizations without appropriate approval from KP RPAC Co-Chairs or other KP leaders.

IV. Annual Charter Review

This Charter is a living document that will be annually (or more frequently, if needed) reviewed, modified, or otherwise amended as required to guide the Council, per the established decision-making process of the Council as stated in its *Policy & Procedures*.

Approved: 4/13/24

Title:	Policy No.:	
Regional Radiation Safety Committee Charter	H2	
Section:	Revised:	Reviewed and Approved:
Appendix	07/18/2023	04/24/2024

Purpose:
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.

Authority and Scope:
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)

Reporting Structure:
The RRSC is a sub-committee of the Southern California Quality Committee (SCQC). Reports of committee activity are provided to SCQC by the RRSO.

Roles and Responsibilities:

1. Review and approve all new and renewal applications for non-human use of radioactivity.
2. Monitor all uses and users of ionizing radiation by:
    a. Identifying uses that require modification/correction/additional oversight;
    b. Directing corrective actions as needed;
    c. Ensuring that corrective measures associated with radiation-related incidents are implemented; and
    d. Monitoring results for compliance.
3. Establish regional policies necessary to ensure compliance with applicable laws, regulations, conditions of radioactive materials licenses and accepted principles of good radiation safety practice.
4. Review the occupational radiational exposure monitoring program on a regular basis.
5. Assign/oversee the duties/responsibilities of the RRSO.

Meetings
The committee meets once each calendar quarter, as required by conditions of our Radioactive Materials Licenses, issued by the Radiologic Health Branch, California Department of Public Health. Ad hoc meetings may be called by the Chair or Regional RSO, as needed to address radiation safety/regulatory issues that must be resolved before the next quarterly meeting. At least half of the voting members including the RRSO must attend to constitute a quorum.

Title:	Policy No.:
Regional Radiation Safety Committee Charter	H2
Section:	Revised:
Appendix	07/18/2023

Membership:

Membership includes stakeholders who have a regional perspective and are responsible for the radiation safety program throughout the Southern California Permanente Medical Group region of coverage:

Chair: Medical Director of Quality and Clinical Analysis (or designee)

Permanent membership:

- A physician representing regional Radiology and Nuclear Medicine;
- A physician representing regional Radiation Oncology;
- Regional Director, Accreditation, Regulation and Licensing (AR&L);
- Regional Radiation Safety Officer;
- Regional Radiology Directors

Ad-hoc membership:

- Regional Director, Risk Management
- Regional Accreditation, Regulation, and Licensing representatives
- Others as determined appropriate by the committee

KAISER PERMANENTE SOUTHERN CALIFORNIA
Regional Systems and Peer Review Oversight Committee (RSPROC)
Charter
RSPROC Approval Date: May 24, 2024
SCQC Approval Date: TBD

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 as defined below and collaborates with all SCQC quality subcommittees.

Mission:

1. Oversight of clinician-based errors and system issues with potential for harm
2. Prevent repetition of errors that have already been identified, utilizing education and other performance improvement processes.
3. Identify and promote medical center uniformity and efficiencies of processes for peer review and system/department review.
4. Advocate for improvement in systems to promote patient safety.

Scope:

1. Communicate issues and provide feedback regarding facility performance to medical centers and leadership.
2. Report routine status and recommendations to SCQC.
3. Escalate significant issues, trends, and variation to SCQC, including regular and ad hoc reporting.
4. Collaborate with the Medical Centers, and the Regional Credentialing Committee (RCC) regarding, P2 Scores, Focused Practitioner Reviews (FPR), and Practice Improvement Plans (PIPs) for practitioners with activity at multiple medical centers.
5. Collaborate with the Medical Centers and other SCQC subcommittees, as needed, including communications, identification of variations and trends, dissemination of information, and requests for necessary actions.
6. Identify, prioritize, and facilitate resolution of quality-of-care trends identified through the Peer and System/Department Review processes.
7. Promote best practices within a just culture environment.
8. Collaborate with Risk Management and Patient Safety where systems are below acceptable standards of care or is likely to be detrimental to patient safety.
9. Provide oversight regarding practitioners where performance is below acceptable standards of care and/or conduct or that is likely to be detrimental to patient safety, when the provision of quality patient care is identified through the 'Member Concern Focused Practitioner Review' reporting process, or regarding significant departure from accepted practice (Focused Professional Practice Evaluation).
10. Collaborate with other Regional Teams to communicate variations and trends and to promote that action be taken.

KAISER PERMANENTE SOUTHERN CALIFORNIA
Regional Systems and Peer Review Oversight Committee (RSPROC)
Charter
RSPROC Approval Date: May 24, 2024
SCQC Approval Date: TBD

Decision Making Authority:

1. Oversee selected quality improvement processes including Peer Review, and Focused Practitioner Review.
2. Oversee systems issues identified through Department and Peer Review and other identified select systems issues with potential for harm.
3. Monitor peer review and system/department review activities, to include aggregate reports of peer review and system/department review trends.
4. Based on performance of above, request and track Corrective Action Plans (CAPs)
5. Monitor and evaluate effectiveness of CAPs, escalate and report to SCQC.
6. Review medical center committee minutes (FPR or Credentials & Privileges) to provide oversight of FPR process.
7. Coordinate with other oversight committees, e.g., Health Plan Regulatory Services (HPRS), Risk/Patient Safety, to establish clear lines of responsibility and accountability.

Advisory Focus:

1. Identify and promote uniformity and efficiencies of processes for peer and system/department review.
2. Promote sharing of learnings identified through peer review.
3. Promote sharing of learnings concerning system improvements resulting from the peer, department, and system review processes through the Southern California Region
4. Review and revise peer review, focused practitioner review and system/department review policies and procedures.
5. Develop annual goals for peer review, system/department review, and the corresponding processes.
6. Escalate practices not consistent with KP Policies & Procedures and regulatory standards related to physician performance review and system/department review, with escalation to include such regulatory bodies as the Department of Managed Health Care (DMHC), The Joint Commission, and the National Council of Quality Assurance (NCQA).
7. Promote alignment of peer and system review findings to improve the care provided to Kaiser Foundation Health Plan (KFHP) Members.

Reporting Structure:

The Regional Systems and Peer Review Oversight Committee (RSPROC) is a subcommittee of the Southern California Quality Committee and reports to SCQC at least semi-annually. The committee maintains a collaborative relationship and ongoing communication with the local medical center quality departments/leaders responsible for peer and system/department review processes.

Meeting Process

The RSPROC will meet monthly, no fewer than ten times a year, except under extenuating circumstances. A quorum is a simple majority of the members. When a quorum is present a majority of the votes cast is sufficient for the adoption of the motion at hand. RSPROC minutes will be maintained.

KAISER PERMANENTE SOUTHERN CALIFORNIA
Regional Systems and Peer Review Oversight Committee (RSPROC)
Charter
RSPROC Approval Date: May 24, 2024
SCQC Approval Date: TBD

Annual Evaluation:
The RSPROC will review its Committee Charter annually and revise as needed.

Confidentiality:
The RSPROC members, consultants, staff, and participants shall maintain confidentiality of information.

Membership:
Membership shall consist of physicians and non-physicians representing Kaiser Foundation Hospitals (KFH), Kaiser Foundation Health Plan, Inc (KPHP)., and Southern California Permanente Medical Group (SCPMG). The committee members will have expertise in, but not limited to, quality, risk management, credentials, privileges, accreditation, and licensing.

Co-Chairs:

1. Quality Physician Leader
2. Regional Director, KPSC Quality Oversight

Voting Members:

1. SCAL Medical Director Quality/Risk/Regulatory/Safety
2. Vice President, Quality Safety & Regulatory Oversight
3. Regional Group Leader: MIDAS + Statit
4. Quality Physician Leaders (minimum of three in total)
5. Quality Director (minimum of 2, to include the current chair of the Quality Directors Workgroup)
6. Quality Coordinator
7. Health Plan Physician Advisor
8. Lead Practice Consultant, Regional Quality Oversight
9. CA Health Plan Compliance Representative
10. Medical Professional Staff Services Representative
11. Regional Safety and Risk representative, KFHP
12. Medical Center Assistant Administrator for Quality & Risk Management
13. Physician Advisor for Quality and Safety Management

Ad Hoc Members:

1. Chair, Ambulatory Care Practice Committee
2. Facilities Management representative
3. Infection Control representative
4. Accreditation, Regulatory Services, and Licensing representative
5. Nursing Quality Leader
6. Performance Improvement Mentor
7. Medical Center Department Administrators
8. Physician Advisor for Quality and Safety Management

Ex Officio Members:

1. SCAL Quality Physician Leaders
2. SCAL Quality Directors

Southern California Regional Transplant Services

Regional Transplant Committee – Charter

SPONSORS: DR GREG KELLMAN; DARIN TANKERSLEY **REGIONAL TRANSPLANT SERVICES: DR. AMANDEEP SAHOTA; AMBER GARDNER**

SERVICE LINE LEADERS: DR. KEVIN STILES; LISA BUFFONG

COMMITTEE NAME: REGIONAL TRANSPLANT COMMITTEE

1 PURPOSE

The Kaiser Permanente Southern California 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 our 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.

2 REGIONAL TRANSPLANT COMMITTEE MEETING STRUCTURE & PARTICIPANTS

The Regional Transplant Committee (RTC) is structured as a report-out to share information and provide feedback on transplant services. RTC provides a forum to review transplant opportunities across the region, address escalated transplant-related issues, and support the spread of transplant initiative information.

RTC will meet bi-annually to discuss the following topics in addition to any ad-hoc items:

Transplant Quality

SCPMG Quality Metrics	Transplant Incidents Overview	KP SCAL Transplant Quality Initiatives
Program of Excellence Quality Metrics		

Transplant Operations

Transplant Subcommittee Report Outs	Operational Initiatives (Local Operations)	Program of Excellence Operations
Contracting Updates/Renewals	Outside Medical Update	Regional Initiatives
Additional KP SCAL Programs Impacting Transplant		

RTC will be comprised of the following members:

Executive Sponsors/Leadership

Regional Medical Director of Operations, SCPMG	Chief Operating Officer, SCPMG
Assistant Medical Director of Transplant Services	KFHP SVP Southern California Region
Regional Assistant Medical Director of Medical Specialties	Regional Administrative Leader, Medical Specialties
VP, Quality Safety & Regulatory Oversight	Transplant Services Practice Specialist

Transplant Operations

LAMC Transplant AAMD	SD Transplant AAMD	LAMC Transplant AMGA
CAO LAMC	SVP SD	Bone Marrow Transplant Physician Lead
Kidney Transplant Physician Lead	Heart Transplant Physician Lead	Liver Transplant Physician Lead
Lung Transplant Physician Lead	Transplant Pharmacist	Renal Pharmacist
Renal Business Group Director	Renal Transplant Coordinators	Transplant Physicians (As Needed)

Transplant Quality

AMD: Quality & Risk Management	KFHP Director: Quality and Regulatory Services	KFHP Regional Director Care Experience & Patient and Person-Centered Care
KFHP Director of Quality Management at LAMC	KFHP Regional Chief Nurse Executive & VP of Clinical Effectiveness	SCPMG Director for Quality at LAMC
Director of Medical Bioethics	Quality Clinical Consultant	

National Transplant Services

Executive Director	Senior Director, Operations	SCAL & HI Operations Manger
Medical Director of Quality	Senior Manager, Quality & Research	

Finance

KFHP SVP/CFO	VP Network Development & Administration SCAL	KFHP Area Chief Financial Officer
SCPMG Area Financial Officer		

Outside Medical Services

AMD: Non-KP Medical Services	VP: Outside Medical Services	KFHP Regional Director: Outside Medical Services

Supporting Services – As Needed

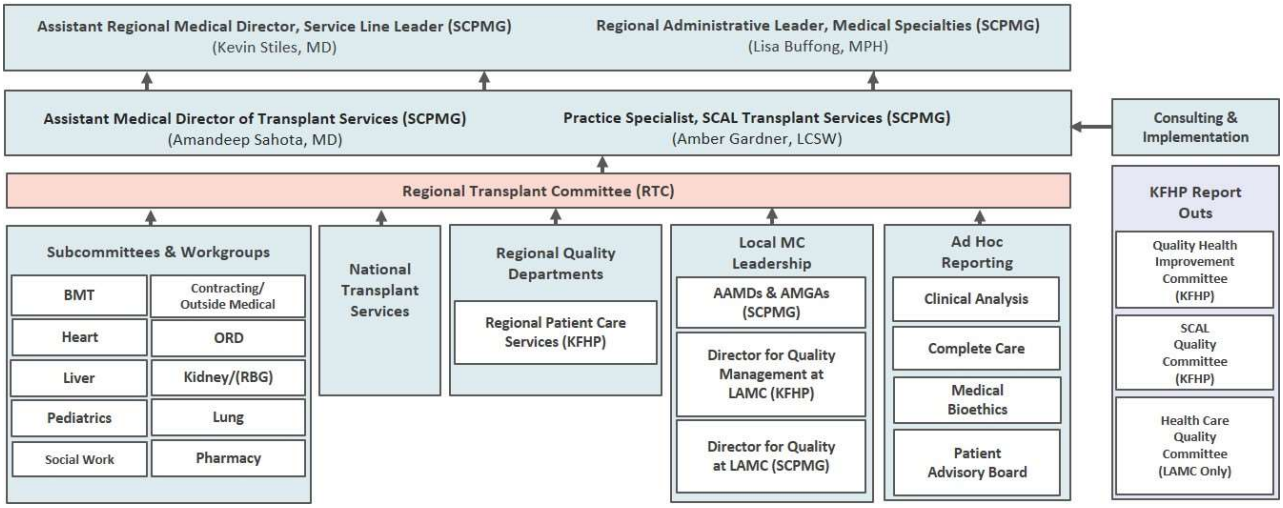
SCPMG Affiliated Provider Services	Network Development & Administration	KFHP Lab Quality Systems Leader
Director of Clinical Analysis	Complete Care	Business Consulting and Implementation
Virtual Medical Center	Benefits	Regional Transplant Patient Advisory Council
Addiction Medicine Champions	Psychiatry Champions	

3 Regional Transplant Services Report Out Structure

The Regional Transplant Committee serves as a conduit to update SCPMG and KFHP executive leaders on regional/local transplant initiatives. RTC is responsible for overseeing all required Southern California Quality Committee (SCQC) report-outs and updating SCPMG's Regional Medical Director of Operations on all operations-focused initiatives.

Transplant Subcommittees, Renal Business Group, National Transplant Services, Regional Transplant Patient Advisory Council, and Local Medical Center representatives are responsible for reporting out to the Regional Transplant Committee on their respective metrics and initiatives.

KP SCAL Regional Accountability Structure for Transplant Services:



KAISER PERMANENTE HEALTH PLAN – SCAL REGION

Utilization Management Steering Committee (UMSC)

A Sub Committee of Southern California Quality Committee

2024 Charter

Authority	The President of Kaiser Foundation Health Plan (KFHP), Southern California Region, and the Executive Medical Director, Southern California Permanente Medical Group (SCPMG), are responsible for the implementation of the Kaiser Foundation Health Plan Utilization Management (UM) and Resource Management (RM) Program. The UM/RM Program scope extends across the continuum of care to ensure the provision of efficient and appropriate patient care services based on medical necessity and using healthcare resources efficiently and appropriately. Oversight responsibility for the KFHP UM/RM Program is assigned to the Southern California Quality Committee (SCQC). As a Sub-Committee of SCQC, the Utilization Management Steering Committee (UMSC), monitors and supports the KFHP UM Program. Vice President, Quality, Safety & Regulatory Services, KFHP and the Medical Director, Quality and Clinical Analysis, SCPMG, are members of SCQC and executive sponsors for the Utilization Management Steering Committee (UMSC)
Purpose	The UMSC 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.
Responsibilities and Scope of Activities	**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;[1] 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;

[1] Section 1367.01(a), defines utilization review or utilization management functions as those processes "that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers. . ."

	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. **UMSC 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, including:** Integration of UM into the KFHP Quality Improvement Program to ensure the effectiveness of the Utilization Management Program and to monitor compliance with established UM processes to include: • Evaluation of complaints and assessment for trends • Review of provider referral and specialist care patterns of practice • Continuously monitor utilization of services to ensure they meet professionally recognized standards of practice. This will entail review and analyses of over and underutilization measures and any actions planned or implemented to improve performance. [2] • Implementation of performance improvement plans as needed • Mechanisms to communicate actions and results to key stakeholders • Monitor of measures of success related to performance improvement plans • Review and evaluation of other Health Plan committee proceedings Develop, implement, and periodically review and revise UM policies and procedures in compliance with applicable federal and state requirements and accreditation standards. Develop, implement, and annually review and update clinical criteria for UM decisions based on sound clinical evidence. Periodic monitoring and oversight of the Utilization Management/Drug Utilization Review (DUR) program for Medicare Advantage (MA) and Prescription Drug Plans (PDP) in the SCAL region **UMSC supports the effective implementation of the UM Program to include:** • Removal of impediments to ensure an effective Utilization Management Program • Foster optimal communication between all stakeholders regarding utilization management • Charter performance improvement teams for specific high-priority utilization management issues/initiatives • Make recommendations regarding resource allocation to ensure success of the Utilization Management program • Develop and propose recommendations to the President of Kaiser Foundation Health

[2] Over-Under Utilization is Primarily a Quality function.

		Plan, Southern California Region, and the Southern California Quality Committee (SCQC) in support of and in compliance with all matters related to utilization management. • Coordinate, review and approve information communicated to or from the Southern California Quality Committee (SCQC) related to utilization management.
Membership		The membership of the Group shall be approved annually by the Southern California Quality Committee**.** The Voting Membership will include:
		Committee Chairperson(s) > Health Plan Physician Advisors, KFHP
		Vice-President, Quality, Safety & Regulatory Services, SCAL Region, KFHP
		Executive Director, Care Coordination and Resource Stewardship
		Executive Director, Grievance Operations, California and Hawaii Member Relations, KFHP
		Senior Counsel, Health Plan & Payor Operations Practice Group, Legal Department, KFH/HP
		Regional Director, Health Plan Utilization Management, Regional Utilization Compliance SCAL KFHP
		Asst Medical Group Administrator, Case Coordination Center, SCAL Region, SCPMG
		Director, Enterprise Regulatory Services
		Regional Physician Director, Behavioral Health Care Clinical Oversight and Coordination SCAL Region, SCPMG
		Developmental and Behavioral Pediatrics, SCAL Region, SCPMG
		Physician Director of Durable Medical Equipment, Care Transformation, and Innovation
		Regional Assistant Medical Director, Quality & Complete Care
		Chief, Geriatrics & Palliative Medicine; Executive Leader, Dignified Journeys & Palliative Care
		Regional Chief Psychiatry & Addiction Medicine
Confidentiality		All UMSC minutes, reports, recommendations, memoranda, and documented actions are confidential. They are maintained in accordance with KFHP Southern California policies and procedures and are privileged and protected. All records are maintained in a manner that preserves their integrity in order to assure that patient and practitioner confidentiality is protected.
	Frequency	The Committee shall meet as often as necessary but at least six times per year.
	Agenda	A standing agenda shall be prepared annually to ensure that the committee oversees the utilization management activities required by regulating agencies.
	Minutes	The committee shall keep a permanent record of its proceedings and attendees. All committee minutes shall be provided to the Southern California Quality Committee
	Assessment of Committee Performance	The performance of the committee relative to its charter shall be evaluated annually and shall be reported to the Southern California Quality Committee.
	Reporting Structure	The committee shall provide periodic reports on its activities to the Southern California Quality Committee.