2025

Utilization Management Program Description

KAISER FOUNDATION HEALTH PLAN
SOUTHERN CALIFORNIA REGION

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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).The scope of the program encompasses Medical and Behavioral Health Care services.

> ****KFHP of Southern California does not require Health Plan Utilization Management (UM) prior authorization for pharmacy; therefore, there are no pharmaceutical authorizations and denials. At Kaiser Permanente, physicians and healthcare professionals determine whether a pharmaceutical service or treatment, non-formulary drugs, brand name drugs, among others, is clinically appropriate.*

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.

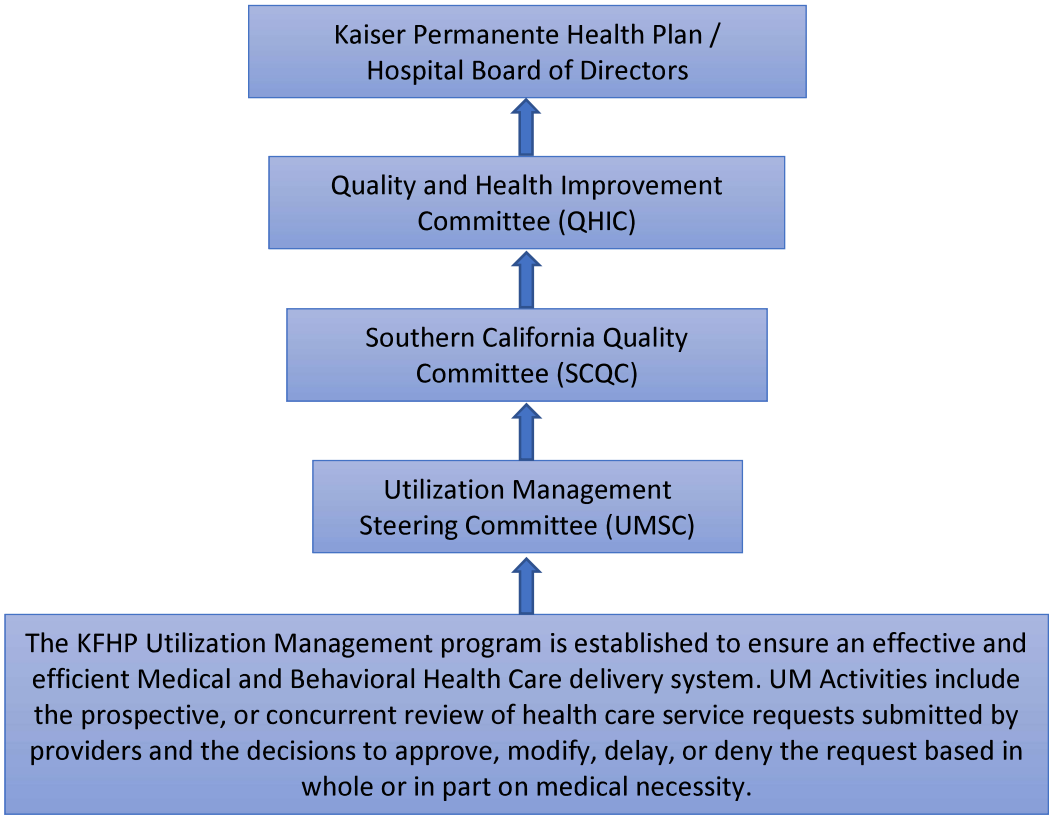
To assist and support its obligations, SCQC has appointed the Utilization Management Steering Committee (UMSC) to ensure the effective oversight of the KFHP UM Program across the continuum of care.

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
- 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
- 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 criteria developed by a nonprofit professional association as required by Rule 1300.74.72(c) of the California Code of Regulations, title 28, 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

[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)

treatment is clinically appropriate by using clinical judgment, and where Utilization Review (UR) is required, using: clinical criteria and guidelines developed by the following nonprofit professional associations:

- American Academy of Child and Adolescent Psychiatry
- American Academy of Family Physicians
- American Academy of Neurology
- American Academy of Pediatrics
- American Academy of Sleep Medicine
- American Association for Community Psychiatry
- American College of Physicians
- American Medical Association
- American Psychiatric Association
- American Psychological Association
- American Society of Addiction Medicine
- Canadian Network for Mood and Anxiety Treatment
- Counsel of Autism Providers
- World Professional Association for Transgender Health
- LOCUS (Level of Care Utilization System), as developed by the AACP (American Association of Community Psychiatrists)
- 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)
- ASAM (American Society of Addiction Medicine)
- 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, poten al loss of life, limb, or major bodily func on, 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 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 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.

[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.

- 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. After the referring specialist and/or other specialists participating in the case conference have gathered and received all the information needed to facilitate referral to the Transplant COE the referring physician and member are notified and 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]

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.

[3] 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.

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 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.

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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 include members with physical or developmental disabilities, multiple chronic conditions, severe injuries, members who will benefit from intensive post-discharge care who are identified using a validated predictive model which evaluates length of stay, acuity of admission, pre-existing co-morbidities, and multiple emergency department visits.
- To optimize member wellness through education and preventative care at all stages of life.
- To improve clinical outcomes by utilizing a care team, patient-centric approach to meet individual health goals and needs.
- To promote self-efficacy and appropriate resource management across the care continuum, through efficient care coordination, education, referrals to health care resources, and advocacy.
- To care without delay through timely appropriate follow-up and care transition.
- To reduce health care disparities and improve outcomes.

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

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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.

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 the phone or through video conferencing for 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 primary care physician 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 primary care physician 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 diagnosis of Pyelonephritis within 7 days of gross hematuria diagnosis, 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 primary care physician 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. Proactive Office Encounter impacts all care settings and is also available in virtual visits with recommended instructions/workflows on how patients can proceed to close their gaps in care. Appropriate gaps in care are addressed and documented. All specialties engage in POE activity by using a Proactive Care Checklist at the point of care designed to be acted upon by staff in any specialty/department. Lab orders for screening and monitoring specific conditions have already been signed by the patient's primary care physician through a Bulk Order program. This allows the specialty staff to inform members that labs are due, without having to take the extra responsibility of following up on abnormal labs, as those results will be directed back to the primary care physician. The Proactive Office Encounter has been nationally recognized by groups like the Institute for Healthcare Improvement (IHI), Alliance of Community Health Plans (ACHP), National Business Coalition on Health (NBCH), and others.

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

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

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

Regional Outreach and Patient Engagement team is an infrastructure for efficiently coordinated, centralized, actionable, and standardized online and outbound mass communications to members, aimed to improve clinical quality and outcomes. The team ensures that strategic initiatives are thoroughly documented within each patient's HealthConnect chart, optimizing resource utilization, and promoting consistent message delivery. Outreach modalities include letters, digital notifications through kp.org,

automated telephone outreach, and text messages, all designed to provide members with actionable steps for proactive health management and enhanced member engagement. The team is responsible for developing and maintaining outreach initiatives that support the core functions of Comple Care, including:

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

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

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

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

Complex Case Management (CCM)

The Medi-Cal Complex Case Management Program supports KP Medi-Cal members with complex medical and non-medical needs, including mental health or substance abuse. These members are connected with their Care Coordinator who partners with the member to conduct an assessment, create an individualized member-centric care plan, and to implement targeted interventions using telephonic, video, text, secure messaging, and when necessary, in-person support depending on member preference, ability and need.

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Program Services

- Access to all medical and mental health care provided by KP, including disease specific management programs
- Assessment of medical and social needs
- Evaluation of available benefits
- Screening for preventive care needs
- Assigning a Primary Care Provider and scheduling appointments
- Creating a patient-centered Care Plan and Goals with the patient
- Regular follow up on progress, barriers, and successes related to those Care Plan goals
- Assessment following transitions of care
- Coordination with Kaiser Permanente services, departments, and programs
- Closed-loop referrals to community-based organizations
- Referrals and authorization to Department of Health Care Services (DHCS) defined Community Supports
- Care coordination focused on longer-term chronic conditions
- Interventions for episodic, temporary member needs
- Connection to a Community Health Worker (CHW), as appropriate
- Coordination with disease-specific management programs

Target Population

Medi-Cal members with medium or rising risk who would benefit from ongoing support from a care manager. Members may include, but are not limited to, those with:

- Multiple chronic conditions or one serious condition
- Significant deficits in social determinants of health that impact their health
- Difficulty navigating the health care system
- Difficulty managing treatment prescribed by their provider or nonadherence to treatment plans
- Frequent missed appointments
- A pattern of utilizing emergency services in lieu of primary or urgent care

Informing Members

- Identify eligible members monthly through a risk stratification process. Eligible members are outreached, assessed for needs, and connected to a PCP. Targeted outreach is also conducted for special high-risk populations.

- CCM team partners with PCPs, specialty physicians and community-based organizations across the care continuum to support and enhance care delivery including increasing awareness of the program amongst eligible members.
- Members can be referred to the program through multiple pathways including via member self-referral, community referral, or provider referrals.
- Invite members to participate in the program and explain that CCM participation is voluntary and can be discontinued at any time.

Enhanced Care Management (ECM)

Enhanced Care Management is a whole-person, interdisciplinary approach to meet the needs of vulnerable, high-need Medi-Cal members who are part of specific Populations of Focus prescribed by the Department of Health Care Services. ECM provides in-person comprehensive care management to coordinate physical, mental, and dental care, as well as social services. Members who enroll in the program are assigned a Lead Care Manager who is embedded within the local community to coordinate services.

Program Services

- High-touch, primarily in-person services coordinated by a Lead Care Manager from a community-based organization
- Access to all medical and mental health care provided by KP
- Assessment of medical and social needs
- Communication of available benefits
- Screening for preventive care needs and health promotion support to adopt healthy behaviors
- Creating a patient-centered Care Plan and goals with the patient
- Regular follow up with members (including family engagement, as appropriate) to address progress, barriers, and successes related to Care Plan goals
- Care transition support post hospitalization or Emergency Department visit
- Coordination with Kaiser Permanente services, departments, and programs including Care Coordination
- Closed-loop referrals to a community-based organization
- Referrals for DHCS defined Community Supports

Target Population

Populations of Focus, as defined in DHCS guidelines and policy documents, including:

- Adults, unaccompanied youth and children, and families experiencing homelessness
- Adults, youth, and children who are at risk for avoidable hospital or emergency department care

- Adults, youth, and children with serious mental health and/or substance use disorder needs
- Adults living in the community and at risk for long-term care institutionalization
- Adult nursing facility residents transitioning to the community
- Children and youth enrolled in California Children's Services (CCS) or CCS Whole Child Model with additional needs beyond their CCS condition(s)
- Children and youth involved in child welfare (foster care)
- Adults and youth who are transitioning from incarceration
- Pregnant and postpartum individuals; birth equity population of focus

Informing Members

- Identify eligible members monthly through a risk stratification process to identify members who meet the DHCS criteria for a Population of Focus.
- Use multiple strategies for outreach and engagement including direct communication with the member and/or their parent, caregiver, or guardian such as in-person meetings, mail, email, texts and telephone calls.
- Provide the member with basic understanding of Enhanced Care Management including eligible populations of focus and to submit a referral.
- Inform members about ECM through KP.org website and member-facing flyers (general and tailored to specific populations of focus).
- Invite members to participate in the program and explain that ECM participation is voluntary and can be discontinued at any time.
- Members can be referred to the program through multiple pathways including via member self-referral, community referral, or provider referrals.
- Meet standards for culturally and linguistically appropriate communication.

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 primary care physician.) If the patient wishes to, they may opt out of the program when they talk with their Care Manager, who will then alert the primary care physician 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 primary care physician 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
- Advanced data sources

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/Latine 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 Latine/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 6-months and older in age
Goal: Increase flu vaccination penetration among members

- Commercial: 46%
- Medicare: 46%
- Exchange: 46%
- Medicaid: 46%

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 third 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 (Commercial, Medicare)
Targeted population: Adults 18-75 at risk for diabetes, adults 18-75 with controlled diabetes
Goal: Maintain or lower HbA1c < 8.0 (Commercial, Medicare)

- Commercial: 73.1%
- Medicare: 79.6%

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 primary care physician 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.

Measure: HbA1c control > 9.0 (Exchange, Medicaid)
Targeted population: Adults 18-75 at risk for diabetes, adults 18-75 with controlled diabetes
Goal: Maintain or lower (lower % is better) HbA1c > 9 (Exchange, Medicaid)

- Exchange: 18.7%
- Medicaid: 16.3%

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 primary care physician 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: Controlling High Blood Pressure
Targeted population: Members over 18 years old diagnosed with Hypertension.
Goal: Members blood pressure within control rate

- Commercial: 82.1%
- Medicare: 85.4%
- Exchange: 82.1%
- Medicaid: 82.1%

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 Services: Complete Care: Hypertension Management

The Complete Care Hypertension Management Program offers the following services for members:

- Education on high blood pressure condition basics, checking blood pressure at home, and lifestyle changes including dietary recommendations.
- Medication adherence
- Instructor led classes offered virtually and in person from the Center for Healthy Living on Taking Care of Your Heart.

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 for members with multiple chronic illnesses.

- Commercial: 0.44
- Medicare: 0.86
- Exchange: 0.48
- Medicaid: 0.82

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
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 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.

2025 Kaiser Permanente Southern California
Population Health Management Strategic Program Summary

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.

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.

2025 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)

2025 SCAL & HI KP CARE AT HOME (HOME HEALTH) QUALITY PROGRAM DESCRIPTION

TABLE OF CONTENTS

2025 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.

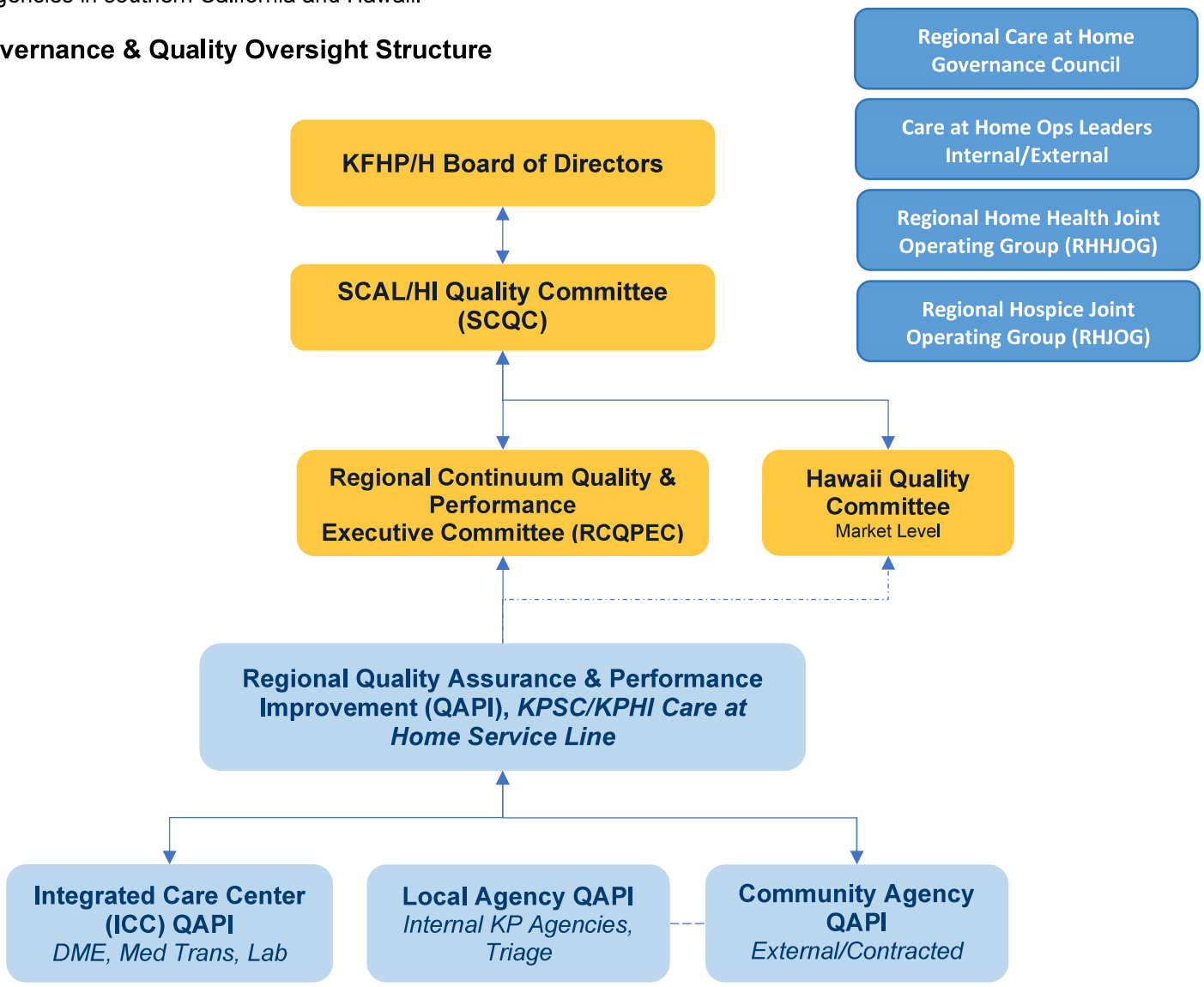
- Principle #2: Drive improvement of clinical operations and sustain quality of care delivery.
- Principle #3: Base decisions on data and input from all stakeholders, including the patient's voice.
- Principle #4: Focus on identification and removal of system and/or process gaps that hinder high-quality 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.

2025 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 9 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*

2025 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 implementing 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 fulfills 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
- Oversee the quality of care and financial performance
- Guide, review or consult on Home Health 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 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 collaborates with the quality team to set the list of indicators that measure the quality of care, services delivered, appropriateness of the service, and regulatory readiness, and reviews progress quarterly. 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 SCAL & Hawaii.

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 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. **Nursing/ Rehab Clinician Supervisors or Agency Managers -** These positions provide direct supervision to all front-line field staff (direct care and coordination) and/or office staff (e.g., intake and scheduling).

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 assists 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. **Quality Assurance Performance Improvement (QAPI) –** see QAPI section below

Medical Staff: The Southern California Permanente Medical Group (SCPMG) and the Hawaii Permanente Medical Group (HPMG) are 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

- participate 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 or specialty 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
- address clinician escalations
- 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.
- It is jointly managed by Director of Patient Care Services and the Divisional Service Line Administrator.
- 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 9 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

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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 the 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 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 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 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 generally 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.

2025 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 • Care of Patients • Communication Between Providers and Patients • Specific Care Issues	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	Monthly, Quarterly, Annual	Quarterly, Annual

	c) Monitoring of unusual occurrences • Shift Care outside vendor contract 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		

2025 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 an alternate level of care is requested by the patient/family.
- 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.

2025 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)

2025 SCAL & HI KP CARE AT HOME (HOSPICE) QUALITY PROGRAM DESCRIPTION

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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. 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

2025 SCAL & HI KP CARE AT HOME (HOSPICE) QUALITY PROGRAM DESCRIPTION

Guiding Principles/Goals:

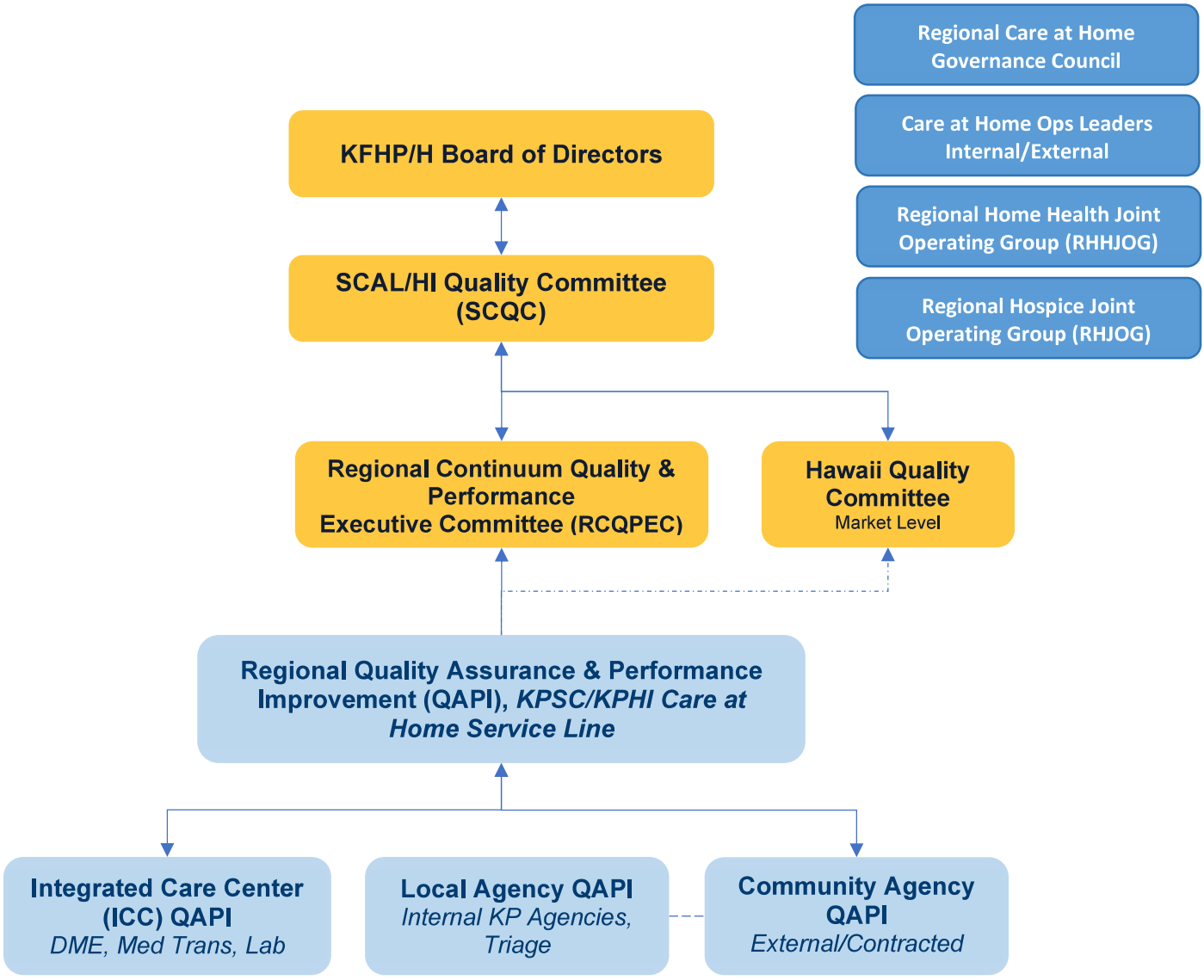
- Principle #1: Monitor reported billing accuracy via our Sarbanes-Oxley (SOX) review program.
- Principle #2: Drive improvement of clinical operations and sustain quality of care delivery.
- Principle #3: Provide patients, families, and caregivers superior and sustained clinical and non-clinical care, services, and satisfaction across all touch points throughout the Continuum of Care.
- Principle #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: Create a culture of trust where employees are empowered to speak up on errors, system breakdowns and/or opportunities for improvement.

2025 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



2025 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 KPCAH 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 KPCAH Agency's program consistent with the KPCAH'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. The duration of this document will be referring to the Hospice Service Line 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, 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 (Hospice)

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.

2025 SCAL & HI KP CARE AT HOME (HOSPICE) QUALITY PROGRAM DESCRIPTION

Kaiser Permanente Care at Home Service Line (Hospice):
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.

(Hospice) 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

(Hospice)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.

2025 SCAL & HI KP CARE AT HOME (HOSPICE) QUALITY PROGRAM DESCRIPTION

The following describes the Management Team (Hospice):

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 in accordance with the Center of Medicare and Medicaid Services, (CMS) regulations
- 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 (Hospice) 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 (Hospice)** 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 (Hospice) 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 (Hospice): 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.

2025 SCAL & HI KP CARE AT HOME (HOSPICE) QUALITY PROGRAM DESCRIPTION

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 (Hospice)** 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.

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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.

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 I 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 spiritual support counselor (i.e. chaplain).

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 Performance Improvement 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.

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Core Theme	Description
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.
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.

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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**) 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.

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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 Monthly	Quarterly Monthly Bi-annual

2025
Regional Virtual Medical Center
Quality and Patient Safety
Program Description
Annual Work Plan and Evaluation

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

2025
REGIONAL VIRTUAL MEDICAL CENTER
QUALITY AND PATIENT SAFETY
PROGRAM DESCRIPTION

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REGIONAL VIRTUAL MEDICAL CENTER
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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 ensure that consistent and systematic efforts are maintained to continually measure, assess, and improve processes and outcomes related to services provided.

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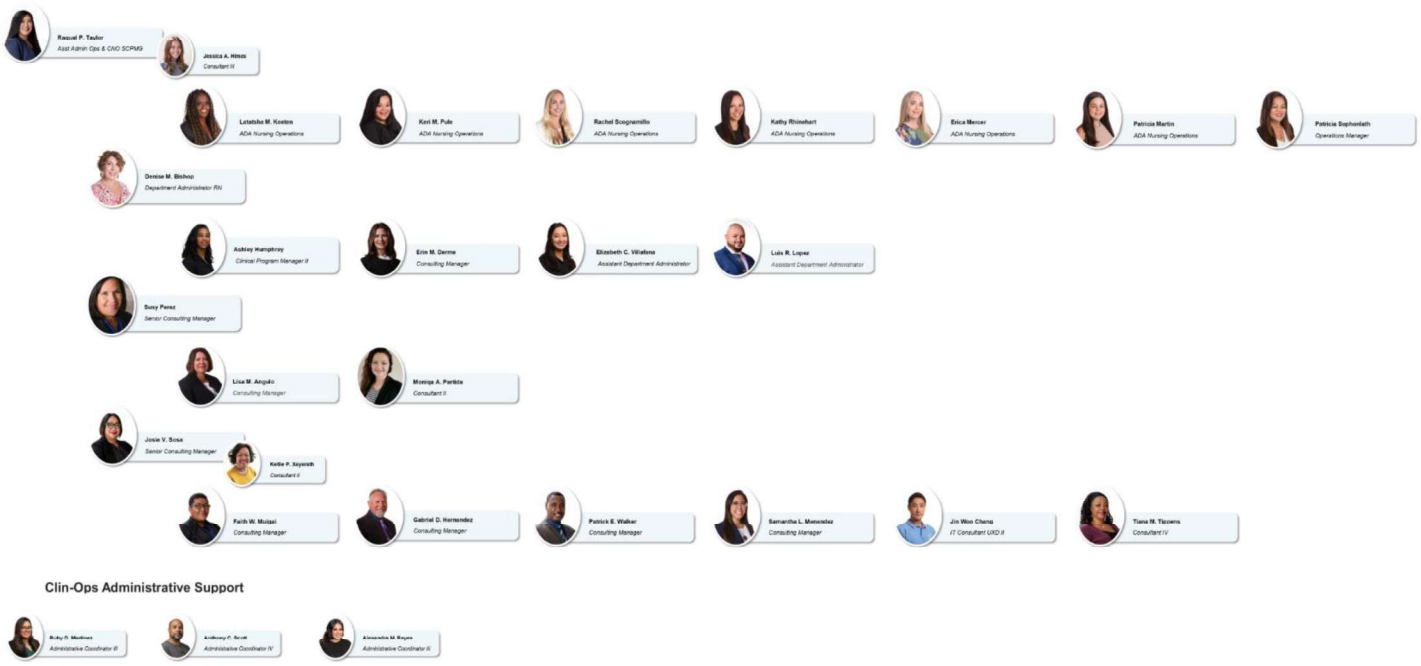
Pan Permanente Initiatives, Pediatrics and Education

2025
REGIONAL VIRTUAL MEDICAL CENTER
QUALITY AND PATIENT SAFETY
PROGRAM DESCRIPTION



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 Assistant Medical 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, 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, g 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.

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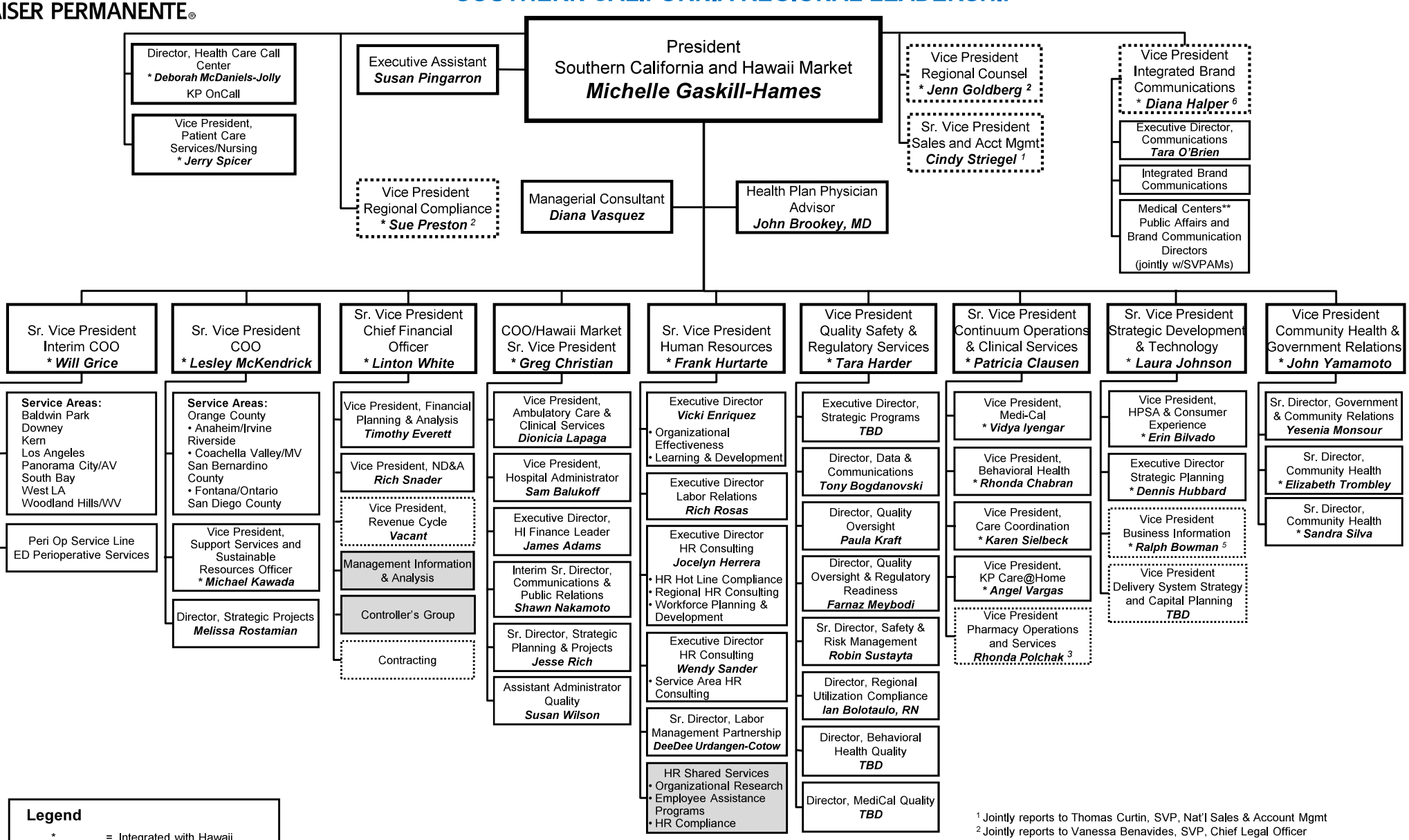
Kaiser Foundation Health Plan, Inc. / Kaiser Foundation Hospitals
SOUTHERN CALIFORNIA REGIONAL LEADERSHIP

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.

QUALITY AND HEALTH IMPROVEMENT COMMITTEE (QHIC) CHARTER

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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.

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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 quality assurance, 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 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;

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 patient 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 Joint Commission, the Centers for Medicare & Medicaid Services, and state agencies;

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; and

c. Reviewing matters relating to the competencies and effectiveness of direct patient care personnel of the hospitals and other facilities operated by the corporation who are not subject to the clinical privilege or professional staff or medical staff or clinical staff process.

d. Approving applications for appointments/reappointments to the professional staff, or clinical staff or medical staff, clinical privileges, and other actions related to professional staff or medical staff or clinical staff membership and clinical privileges that require governing body approval.

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

f. Approving policies and procedures, when governing body approval is required, of hospitals and other facilities operated by the corporation.

g. Appointing the psychiatric health facility clinical director and ambulatory surgery center medical director.

h. Recommending the appointment of the hospital administrator and the administrators of other facilities operated by the corporation.

4. Governance of the Psychiatric Health Facility

a. Identifying the purpose of the facility and the means of fulfilling such purpose.

b. Ensuring the fitness, adequacy and quality of the clinical and medical care rendered.

c. Appointing and reappointing the clinical staff who provide treatment, care and consultation to patients in the facility.

d. Approving policies and procedures for appropriate practices to be observed in the facility, including prohibiting the practice of division of fees.

e. Identifying the requirement for health and treatment records.

f. Requiring the interdisciplinary staffs to establish controls that are designed to ensure the achievement and maintenance of high standards of professional ethical practices.

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

KAISER PERMANENTE
2025 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.
- Analysis and evaluation of the results of QI activities, including identification, prioritization, and selection of necessary action(s) and review and evaluation of actions to determine effectiveness.
- Committing the organization to action and monitoring progress

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.
- Annu

Meeting Process: SCQC will meet monthly, for no less than ten months of the year. Membership includes representatives from KFH, KFHP, and SCPMG. The term of service for the SCQC co-chairs is one year. 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 docume

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

VOTING MEMBERS
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
Regional Vice President of Compliance
Chairperson, Regional Systems and Peer Review Oversight Committee (RSPROC)
Assistant Regional Medical Director, Surgical Quality Service Line
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.

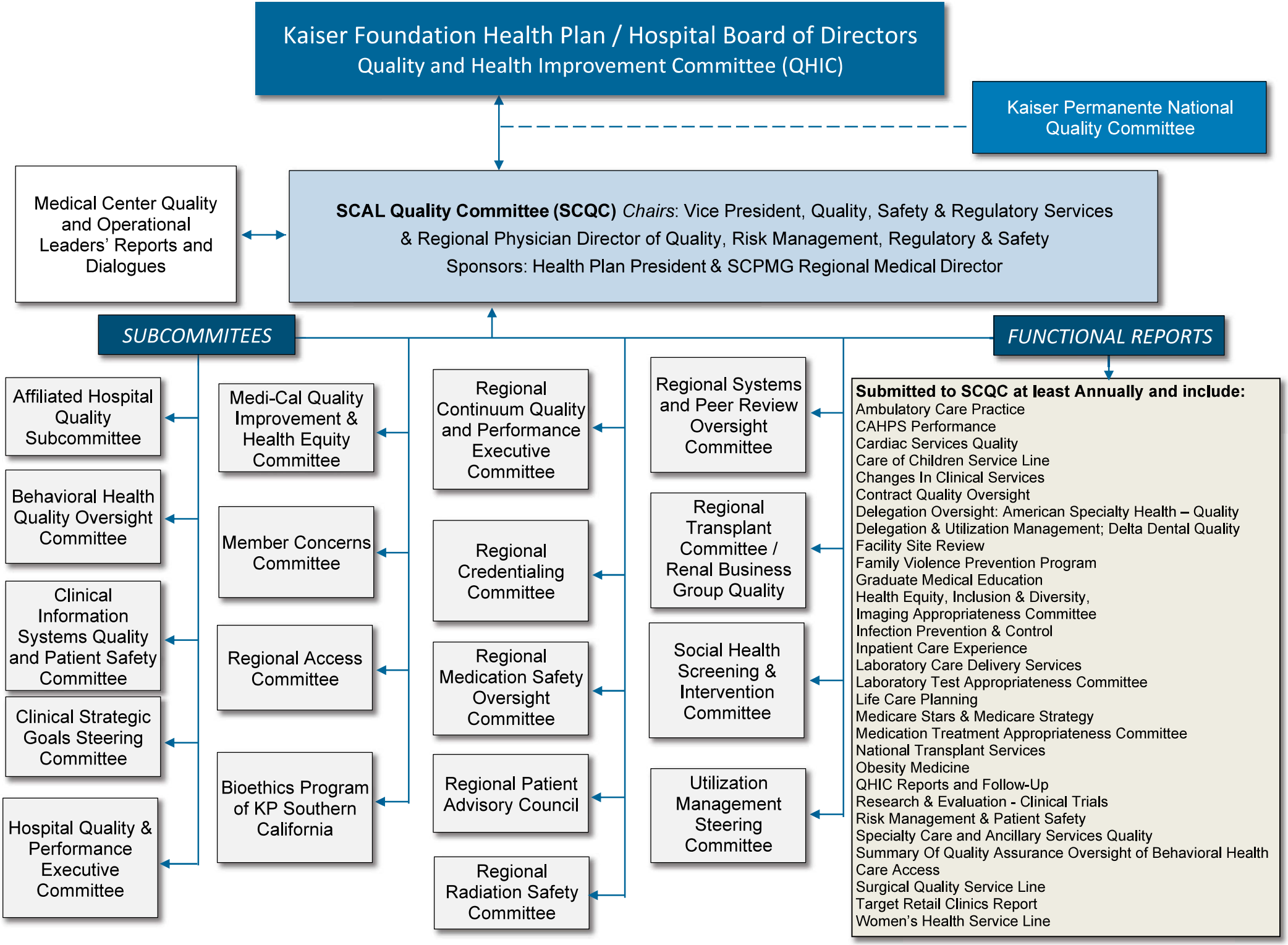
The Health Plan provides oversight of the local medical center quality/operational functions. The KFHP leaders receive regular reports on local performance of all quality and regulatory issues.

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 3/28/2025

Reporting Structure Updated: 3/21/25

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	Porsha Carter-Lewis	
SCAL Regional Bioethics Program Director	Alain Durocher	
Regional Vice President of Compliance	Jaimie Brandi	
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	Eric L. Williams	
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, January 15, 2025
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

Reviewed by the Affiliated Hospital Quality Subcommittee, January 15, 2025
Pending Approval by SCQC

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/MV: Dorcas Mutheki ◊ 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 ◊ Eisenhower Health: Toni Pellum, tpellum@eisenhowerhealth.org ◊ Eisenhower Health: Kera Arias, KArias@eisenhowerhealth.org ◊ Maui Memorial: Kelly Catiel, Kelly.m.catiel@kp.org
AD HOC MEMBERS	• Subject Matter Experts (SME's) as needed.
MEETING FREQUENCY	• Quarterly: February – April – July – October • Ad Hoc As Needed

Reviewed by the Affiliated Hospital Quality Subcommittee, January 15, 2025
Pending Approval by SCQC

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 February 26, 2025

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

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 Senior Director, Provider Delivery Systems, Enterprise Regulatory Services
KFHP Vice President of Behavioral Health and Wellness
KFHP/H National Vice President Behavioral Health Associate Chief Medical Officer
KFHP Senior Manager of Behavioral Health Quality

Ad Hoc:
KFHP Health Plan Regulatory Services Representative
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 February 26, 2025

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

Date Last Updated and Approved: **February 14, 2025**

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 mo
    - 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 Medica
  - 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, Sr. Manager
  - 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
2025 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 improve 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	Darin Tankersley	SCPMG	Chief Operating Officer
Member	Mehran Sina, MD	SCPMG	Regional Chief, Hospital Medicine, West Los Angeles Medical Center
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

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. A 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 reports 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 Executive, Regional Assistant Medical Director of Quality, Risk Management, Regulatory & Safety
- State/County Partner, County Dental Officer, or designee
- SCPMG Regional Chief of Family Medicine
- Subcontractor/Downstream Subcontractor Representative
- SCPMG Pediatrics Physician, Assistant Regional Medical Director, Care of Children Service Line Leader
- Network Provider Representative
- Medi-Cal Member Representation (member and/or caregiver)
- KFHP/H Vice President, Medicaid Care Delivery and Operations
- KFHP/H Health Plan Physician Advisor
- SCPMG Assistant Regional Medical Director, Behavioral Health
- KFHP/H Vice President, Quality, Safety, & Regulatory Oversight
- KFHP/H Regional Senior Director, Quality, & Safety Oversight - Continuum Program Management

- KFHP/H Regional Director Quality & Safety Clinical Quality Oversight – Medi-Cal
- SCPMG Quality & Regulatory Leader
- KFHP/H Vice President, Care Coordination
- 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 Medi-Cal Quality & Safety Consultants Clinical Oversight – Medi-Cal
- KFHP/H Medi-Cal Quality Consultant
- KFHP/H Medi-Cal Quality Project Manager, QIHEC
- KFHP/H Medi-Cal Quality Data Analyst
- KFHP/H National Medicaid & State Programs Quality and Safety Consultant
- KFHP/H National Medicaid and State Programs Population Health Management Strategy Lead
- KFHP/H National Medicaid and State Programs Health Equity Strategy Lead
- KFHP/H Regional Director, Medi-Cal Provider Regulatory Oversight & Validation
- KFHP/H Community Advisory Committee (CAC) Coordinator

Meeting Support:

KFHP/H Regional Quality

Last Revised: 02/12/2025

Approved by: SCAL QIHEC Voting Members

Approved on: 02/19/25

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: 9
Years with Kaiser Permanente: 28
Total years in Healthcare: 30
Years in KP Leadership: 22
Years in Healthcare Leadership: 24

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: 2
Years with Kaiser Permanente: 2
Total Years in Healthcare: 23
Years in KP Leadership: 2
Years in Healthcare Leadership: 19

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: Ka

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: 2
Years with Kaiser Permanente: 7
Total Years in Healthcare: 14
Site Medical Director Marin Community Clinics: 4

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 in Current Position: 2
Years with Kaiser Permanente (KP): 36
Years in Healthcare: 40
Years in KP Leadership: 31
Total years in Healthcare Leadership: 36

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: 2
Years with Kaiser Permanente: 16
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: 2
Years with Kaiser Permanente: 8
Total Years in Healthcare: 30+
Years in KP Leadership: 8
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: 2
Years with Kaiser Permanente: 7
Total Years in Healthcare: 31
Years in KP Leadership: 3
Years in Healthcare Leadership: 6

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: 2
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: 2
Years with Kaiser Permanente (KP): 9
Total Years in Healthcare: 17
Years in Healthcare Leadership: 2

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KAISER PERMANENTE SOUTHERN CALIFORNIA
MEMBER CONCERNS COMMITTEE
2024 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
2024 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 the KFHP Senior Director, Regional Quality & Regulatory Services, KFHP Vice President, Consumer Experience & HPSA, and Assistant Regional Medical Director, Care Experience.

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 September 30, 2024

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KAISER PERMANENTE SOUTHERN CALIFORNIA
MEMBER CONCERNS COMMITTEE
2024 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
Vice President, Consumer Experience & HPSA
Senior Director, Regional Quality & Regulatory Services
Assistant Regional Medical Director, Care Experience
Health Plan Physician Advisor KFHP
Senior Vice President, Chief Operations Officer
Vice President, Member Relations
Executive Director, Member Relations, Grievance, Appeals, & Absence Documentation Services
Senior Director, SCPMG Performance Assessment
Executive Director, Regulatory Investigations & Enforcement
Regional Outpatient Pharmacy Director
Chief Officer, Quality & Systems of Care
Director, Care Experience & Patient and Person Centered Care, Patient Care Services
Regional Administrative Leader, Regional Service & Access
Consultant, Regional Quality & Regulatory Services
Senior Business Consultant, Consumer Experience & HPSA
Patient Advisor
Patient Advisor

Approved by MCC on September 30, 2024

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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 Physicians[1] 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 ca 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.

2025 Charter for the Bioethics Program of KP Southern California

Last Updated: 12/05/2024

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**

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.

2025 Charter for the Bioethics Program of KP Southern California

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.

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2025 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 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

Date: 2/21/25

Name	Regional Continuum Quality & Performance Executive Committee	**Co-Chairs**	Della Williams, Dan Huynh, M.D.
Executive Sponsors	Tara Harder & Letitia Bridges, 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*
- Joel Kim, *ED, Care Coordination and Continuum*
- Leana Tarvin, *ED, Medicare Strategy*
- Jennifer Cortez, *Director, SNF Strategy*
- John Lapuz, *Director, Care Coordination and Continuum*
- Tamica Lewis, *Sr. Director, Strategy and Operations, Continuum Operations and Clinical Services*
- Patty Ma, *Medi-Cal Manager, Care Coordination and Continuum*
- Karen Koshi, *Manager, SNF Strategy*
- Deepa Savani, MD, *LTC, Hospice, Palliative Care, Orange County*

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*
- Brenda Sillas, *Care Experience Leader, Care at Home*

KPCAH ICC, DME and Transportation Leaders, Physicians and Management
- Jaclyn Gallardo, Director, *DME*
- Ronald Loo, *Physician Leader, Durable Medical Equipment*
- Joanne Kauffman, *Sr. Manager, Program Management*

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

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

SCPMG
- Kim Kaiser, *Quality Administrator, Quality & Systems of Care*

AAQ Representative: Camille Bauer, *Quality & Safety Oversight, Area Safety & Quality Officer*

Patient Advisors: Susie Becken & Imelda Foley

Subcommittees reporting into Regional Continuum Quality Committee:
- Compliance: Kelli Segers, *Compliance Consultant V, Regional 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
Revised: 02/05/25

	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

Revised: 08/01/18
Revised: 03/04/20
Revised: 12/02/20
Revised: 07/06/22
Revised: 08/07/24
Revised: 02/05/25

	7. Regional Director of Accreditation, Regulatory & Licensing – KFHP/H 8. KFH (Medical Center) Chief Operating Officer 9. Vice President, Quality, Safety & Regulatory Oversight Non-Voting Members: 10. Director, Regional Credentialing – Regulatory Oversight 11. Senior Director of Quality & Safety Improvement 12. Regional Director of Quality – Behavioral Health 13. KFH Medical Staff Office Manager 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: February 26, 2025

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 mitigation, and improved health outcomes across the continuum of care. Through our efforts, we facilitate and promote the high reliability organizing (HRO) principles of deference to expertise, reluctance to simplify, preoccupation with failure, sensitivity to operations, and commitment to resilience.

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 Directors of Ambulatory Clinical Practices, 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 a minimum of six times a year. 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 Patient Safety Officer, 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 perspective 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: 2/15/25

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 Administrative Leaders 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: 2/15/25

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: January 24, 2025
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: January 24, 2025
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: January 24, 2025
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. SCPMG Quality Physician Leader
2. KFHP Regional Assistant Director, KPSC Quality Oversight

Voting Members:

1. SCPMG SCAL Medical Director Quality/Risk/Regulatory/Safety
2. KFHP Vice President, Quality Safety & Regulatory Oversight
3. KFHP Regional Group Leader: MIDAS + Statit
4. SCPMG Quality Physician Leaders (minimum of three in total)
5. KFHP Quality Director (minimum of 2, to include the current chair of the Quality Directors Workgroup)
6. KFHP Quality Coordinator
7. SCPMG Health Plan Physician Advisor
8. KFHP Regional Assistant Director, Regional Quality Oversight
9. KFHP Compliance
10. SCPMG Medical Professional Staff Services Representative
11. KFHP Regional Safety and Risk representative
12. KFHP Medical Center Assistant Administrator for Quality & Risk Management

Ad Hoc Members:

1. SCPMG Chair, Ambulatory Care Practice Committee
2. KFHP Facilities Management representative
3. KFHP Infection Control representative
4. KFHP Accreditation, Regulatory Services, and Licensing representative
5. KFHP Nursing Quality Leader
6. KFHP Performance Improvement Mentor
7. KFHP Medical Center Department Administrators
8. SCPMG Physician Advisor for Quality and Safety Management

Ex Officio Members:

1. SCMPG SCAL Quality Physician Leaders
2. KFHP 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

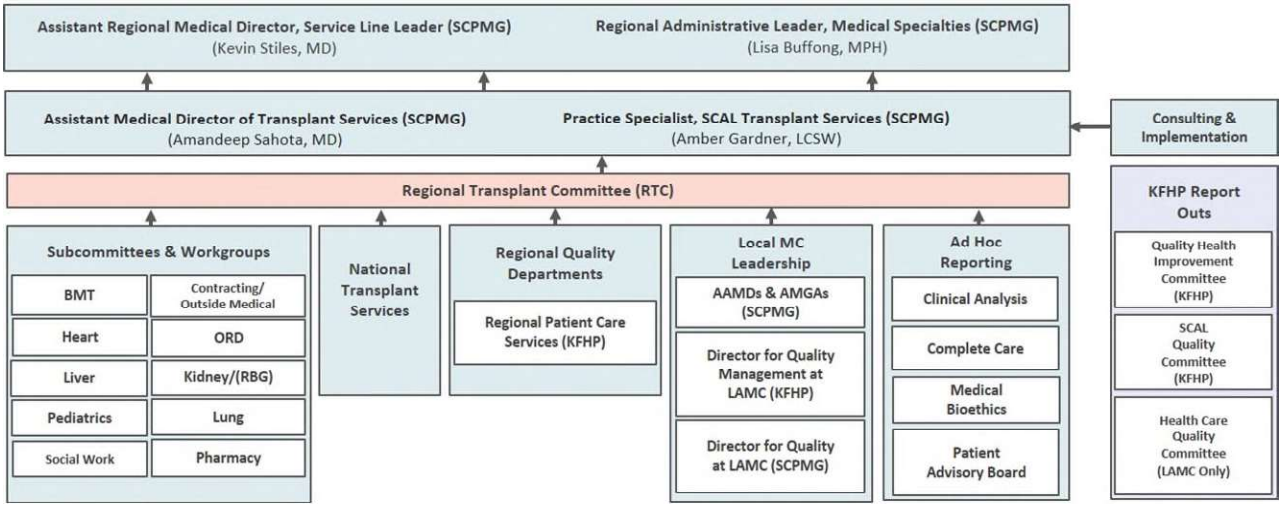
SCPMG Affiliated Provider Services	Network Development & Administration	KFHP Lab Quality Systems Leader
Director of Clinical Analysis	Complete Care	Business Consulting and Implementation
Virtual Medical Center	Benefits	Regional Transplant Patient Advisory Council
Addiction Medicine Champions	Psychiatry 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®

Southern California
Social Health Screening & Intervention Committee Charter

PURPOSE

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

AUTHORITY AND SCOPE

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

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

AREAS OF FOCUS

- Regulatory standards
- Publicly reported quality measures

Reviewed & Approved February 28, 2025

KAISER PERMANENTE®

Southern California
Social Health Screening & Intervention Committee Charter

REPORTING STRUCTURE

The Social Health Screening & Intervention Committee will report directly to SCQC and will report activities and issues to SCQC on a semiannual basis or more frequently, as needed. The SCPMG Regional Medical Director, Quality and Clinical Analysis and Southern California KFHP/H Vice President, Care Coordination and Continuum, will serve as committee sponsors.

MEETING PROCESS

The committee will be scheduled monthly with a completion of at least 6 meetings per calendar year. Membership includes representatives from SCPMG and KFHP/H, (Southern California and National), with a quorum being a simple majority of the members. Actions and decisions of the Social Health Screening & Intervention Committee will be documented in the minutes of the meeting proceedings.

ANNUAL EVALUATION

The Social Health Screening & Intervention Committee Charter will be reviewed, updated, and approved annually.

CONFIDENTIALITY

Participation may necessitate access to privileged, proprietary, 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. As a condition of membership, members of the Social Health Screening & Intervention Committee explicitly agree 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

Co-Chairs:

- SCPMG Regional Assistant Medical Director, Quality & Complete Care
- KFHP/H Vice President, Care Coordination and Continuum

Reviewed & Approved February 28, 2025

KAISER PERMANENTE®

Southern California
Social Health Screening & Intervention Committee Charter

VOTING MEMBERS

- SCPMG Regional Quality Administrator
- SCPMG Director of Ambulatory Clinical Practice
- SCPMG Regional Mar
- SCPMG Consultant V, Regional Behavioral Heal
- SCPMG Senior Manager, Education & Training, Clinical Documentation Services (CDS)
- SCPMG Consultant IV, Education and Training, Clinical Documentation Services (CDS)
- SCPMG Senior Director, SSD Inpatien
- SCPMG Senior Manager, SSD Ambulatory Business Operations
- SCPMG Consultant V, Data Consulting and Report Production, Clinical Analysis
- SCPMG Regional Physicia
- SCPMG Regional Physician Chair, Child Abuse Prevention Program
- SCPMG Regional Physician Leader, Elder/Dependent Adults Abuse Prevention Program
- SCPMG Clinical Consultant IV, Strategic Consulting Services (Family Violence Prevention)
- SCPMG Director, Quality Consulting
- SCPMG, Senior Scientific Program Manager, Research and Evaluation
- KFHP/H Regional Director, Care Coor
- KFHP/H, Senior Director, Quality and Safety Oversight, Regional Continuing Care Quality
- KFHP/H, Social Health Lead, Community Support Hub, National Social Health Practice
- KFHP/H, Nationa
- KFHP/H, Director, Social Health, National Social Health Practice
- KFHP/H, Compliance Consultant IV, Compliance Health Plan
- KFHP/H, IT Program Manager, National Functions Systems and Technology Corporate Services IT, Enterprise Business Services
- KFHP/H, Community Health Consultant IV

SUPPORT STAFF

- SCPMG Senior Consultant, Quality Consulting

Reviewed & Approved February 28, 2025

KAISER PERMANENTE HEALTH PLAN – SCAL REGION

Utilization Management Steering Committee (UMSC)

A Sub Committee of Southern California Quality Committee

2025 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; Appropriately licensed and credentialed physicians/healthcare professionals make UM

[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. . ."

	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 Plan, Southern California Region, and the Southern California Quality Committee

[2] Over-Under Utilization is Primarily a Quality function.

		(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
		Sr Dir, Incident Management, Grievances and Appeals Performance Improvement Admin
		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
		UM Health Equity Expert Lead
		Regional Chief Psychiatry & Addiction Medicine
		Director of Durable Medical Equipment for Southern California & Hawaii
		Vice President, Associate Chief Medical Officer, National Medicaid and State Programs
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 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.