



**Kaiser Foundation Health Plan, Inc.
Northern California Region**

2024 Quality Program Description

**2024 Utilization Management (UM) / Resource Management
(RM) Program Description**

2023 Quality Program Evaluation

2024 Quality Program Workplan

Quality Oversight Committee Approval Date: April 16, 2024



Kaiser Foundation Health Plan, Inc

Northern California Region

2024 Quality Program Description

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2024 Northern California Region Quality Program Description

SIGNATURE PAGE



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Vice President, Safety, Quality & Regulatory Services
Co-Chair Quality Oversight Committee

04/18/2024

Date



Yi-Fen (Irene) Chen, MD
Associate Executive Director for Quality
Co-Chair Quality Oversight Committee

04/18/2024

Date

KAISER FOUNDATION HEALTH PLAN, INC.

CERTIFICATE

I, Kristin Bear, Assistant Secretary of Kaiser Foundation Health Plan, Inc. ("the Corporation"), do hereby certify that the Quality and Health Improvement Committee (the "Committee") of the Board of Directors of the Corporation took the following action at its June 18, 2024 meeting, upon motion duly made and seconded:

RESOLVED, that the 2024 Quality and Utilization Management Program Descriptions and Work Plans, and the 2023 Quality and Utilization Management Program Evaluations for the health plans operated by Kaiser Foundation Health Plan, Inc. are approved by the Quality and Health Improvement Committee on behalf of the Boards of Directors of Kaiser Foundation Health Plan, Inc., effective June 18, 2024.

IN WITNESS WHEREOF, the undersigned has hereunto signed her name this 21th day of June 2024.



Kristin Bear
Assistant Secretary

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1. MISSION

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.

2. KAISER FOUNDATION HEALTH PLAN NORTHERN CALIFORNIA REGION

Overview of Organization Structure

Kaiser Foundation Health Plan, Inc. (KFHP) is a not-for-profit public benefit California corporation that contracts with individuals and groups to provide, or arrange for, comprehensive health care benefits. KFHP is a health maintenance organization and a California-licensed Knox-Keene health care service plan serving over 4 million members in the Northern California Region. KFHP is regulated by the California Department of Managed Health Care (DMHC) and is subject to the requirements of the Knox-Keene Act and its regulations (California Health and Safety Code §1340, et seq.; Title 28, commencing with Section 1300.43, of the California Code of Regulations).

KFHP participates in an integrated healthcare delivery system in its Northern California Region with two other separate, yet closely aligned, entities Kaiser Foundation Hospitals (KFH) and The Permanente Medical Group, Inc. (TPMG).

KFHP has an exclusive contract with Kaiser Foundation Hospitals (KFH), a not-for-profit public benefit corporation that owns and operates hospitals that provide or arrange hospital services for KFHP members. KFHP has an exclusive contract with The Permanente Medical Group, Inc. (TPMG). TPMG is a multi-specialty physician professional corporation that provides, and arranges for the provision of, medical services to members in the Northern California Region. Both KFH and TPMG are contractually bound to cooperate fully with KFHP to enable it to comply with the California Knox-Keene Health Care Service Plan Act of 1975 and federal Medicare rules and regulations which require compliance with KFHP's quality assurance program requirements.

KFHP's network also includes contractual arrangements with institutional providers including community facilities and individual practitioners through its agreements with KFH and TPMG. However, the majority of services provided to members are provided by KFH and TPMG.

KFHP is responsible for quality improvement for its members. KFH and TPMG cooperate with KFHP to provide and coordinate appropriate and effective care and medical management to KFHP members. Together these three entities represent the Kaiser Permanente Medical Care Program in the Northern California Region.

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

KFHP has credentialing, quality improvement and utilization management processes and policies, in compliance with regulatory and accreditation requirements, to protect members when they are seeking

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services outside of their home region. Collective Representatives from National and Regional Quality, Credentialing and Utilization Management Departments perform delegation oversight in all regions as it pertains to the Visiting Member Program.

Northern California Service Area Structure

(Attachment P: Northern California Region Service Areas)

KFHP's Northern California Region serves fourteen service areas. Each service area contains one or more KFH hospitals. The service areas include all or part of the following counties: Alameda, Amador, Contra Costa, El Dorado, Fresno, Kings, Madera, Marin, Mariposa, Napa, Placer, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Sutter, Tulare, Yolo, and Yuba.

Each service area is led by a KFHP Area Manager (AM). The AMs report to a Senior Vice President of Regional Hospital and Health Plan Operations and to the KFHP Regional President, and are responsible for KFHP operations, including the quality of care provided to all members within the applicable service area. Each service area also has an Area Safety and Quality Officer and a Continuum Administrator (CA). These KFHP leaders are accountable for ensuring that the Quality Program addresses the quality of care, utilization management, and services provided/available to all members within their respective service area. Each leadership team reports quality, safety, utilization, and service activities and metrics to the QOC, which in turn reports this information to the KFHP Board of Director's QHIC.

These Health Plan leaders work collaboratively with TPMG Physicians-in-Chief (PICs) to oversee the quality of care, utilization management, and services provided/available to members in their respective Service Area. Each Service Area leadership team is responsible for:

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

Membership and Membership Diversity

(Attachment V: Culturally and Linguistically Appropriate Services Program Description)

KFHP's Northern California Region serves members under several commercial and government product lines. In 2015, KFHP's Northern California Region also began participating in Covered California, California's "Exchange Marketplace." Members enrolled in a product offered through the marketplace are "commercial" members. As of October and YTD 2023, KFHP's Northern California Region covers 4,562,357 lives under the following product lines:

- 3,454,948 lives in our Commercial products (this number includes the members who have enrolled in our Covered California products)
- 688,212 lives in our Medicare products
- 419,197 lives in our Medicaid & Charitable Coverage (this number includes Medi-Cal/Children's Health Insurance Program (CHIP), Center for Healthy Communities (CHC) and other Charitable Coverage)

KFHP's Northern California Region also serves a diverse cultural and linguistic membership. Of our members:

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- 41.7% are White (non-Hispanic)
- 24.7% are Hispanic or Latino (regardless of any other racial/ethnic identity)
- 24.8% are Asian or Pacific Islander (non-Hispanic)
- 6.9% are Black or African American (non-Hispanic)
- 1.9% are Multiracial (two or more racial/ethnic identities, non-Hispanic)

KFHP ensures the provision of culturally and linguistically appropriate services to our members. KPNC language and equity, inclusion and diversity will help to transform care delivery across the spectrum of care with the goal of eliminating disparities in care and transforming the KP experience by:

- Setting quality standards, building, and 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, and by spreading best practices. Embed Equity Centered Design principles and methods into our Human Centered Design approach to clinical innovation and design. Collaborating with human resources to enhance the ability of our workforce to consistently deliver high quality patient care and service experience to our members.
- Providing expert consultation on cultural and linguistic services to KP marketing, sales, and member services functions to improve members' and potential members' KP experience.

KPNC's language access leadership facilitates organizational compliance in the areas of cultural and linguistic services and supports the infrastructure responsible for driving regional strategic diversity and equity initiatives. Initiatives include:

- Interpreter and translation services, and bilingual employee programs.
- Advancement of stratified performance analyses required to set performance goals.

Nondiscrimination

KFHP does not discriminate in the delivery of healthcare services based on race, ethnicity, color, national origin, ethnic group identification, ancestry, citizenship, spoken/primary language (including those with limited English proficiency), immigration status, religion, sex (including pregnancy) gender identity, sexual orientation, marital or domestic partner status, veteran's status, age, genetic information, medical history, medical conditions, physical or mental disability, claims experience, source of payment of care, or evidence of insurability (including conditions arising out of acts of domestic violence), or identification with any other persons or groups defined in Penal Code section 422.56 to ensure 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.

The Quality Assurance Program & the Quality Program Documents

KFHP's regional Northern California Quality Assurance Program (QAP) has been established in accordance with applicable legal and accreditation requirements to ensure the continuous review of the quality of care, performance of medical personnel, and quality of services provided to our membership. The QAP is described in the Regional Quality Program Description and in the other quality program documents identified below. Together the four documents memorialize the scope, structure, authority, and operations of the QAP, whose primary purpose is to effectively identify and resolve quality problems within the health care delivery system.

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The Quality Program Description:

- Informs both internal and external audiences how KFHP's Northern California Region is organized to support a commitment to assessing and improving quality on a continuous, systematic, and outcome-oriented basis
- Describes the key components of the quality program and how they operate to improve quality of care and to optimize performance
- Describes the functions of the health care delivery system to foster an environment in which practitioners and providers improve care, safety, and service
- Describes roles, structures, and accountabilities within the program
- Explains how quality is aligned, linked, and integrated throughout the organization

The Quality Program Description is one of four regional quality program documents. Once approved by the QOC, all four regional program documents are made available to all regional stakeholders and service areas. The regional program documents include:

- The Regional Quality Program Description
- The Regional Utilization Management /Resource Management Program Description
- The Regional Quality and Utilization Management / Resource Management Workplan
- The Regional Quality and Utilization Management / Resource Management Evaluation

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

Evaluation includes:

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

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

The Quality Program includes three levels of authority, accountability, and responsibility related to quality of care and services provided to members. These include the KFHP Governing Body (the Board of Directors of Kaiser Foundation Health Plan, Inc.), the QOC, and the local Service Area's quality structure.

Governing Body

The Kaiser Foundation Health Plan, Inc., (KFHP) Board of Directors

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

The Kaiser Foundation Health Plan, Inc. (KFHP) Board of Directors (Board) is comprised of 13 external Directors the chief executive officer ("CEO") of KFHP and serves as Chairman

KFHP Board members have a broad spectrum of skill sets and come from diverse professional backgrounds, including leadership roles in business, finance, academia, health care, and community nonprofit organizations; and the composition of the Boards of Directors reflects our commitment to

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diversity. The KFHP Board of Directors, which meets quarterly, has ultimate accountability and responsibility for the quality of care and service provided to members.

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Quality and Health Improvement Committee (QHIC)

(Attachment B: QHIC Charter)

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

QHIC meets at least quarterly and reports its decisions, actions, and recommendations to the full KFHP Board of Directors. Annually, QHIC reviews and approves the Region's quality program description, workplan, and evaluation.

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

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

- Quality systems, including quality goals, objectives, and performance measures
- Identification and remediation of deficiencies in quality
- Results of internal standards and external surveys/audits and reports related to quality improvement, utilization management, and risk management
- Standards for global member experience including review of health and service improvement metrics, including Consumer Assessment of Healthcare Provider Systems (CAHPS) and Hospital Consumer Assessment of Healthcare Provider Systems (HCAHPS) service quality data
- 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.
- Approving annual targets for health improvement (including HEDIS and improvement in members' health that contributes to community well being) and service quality (including access to services, the care experience and overall member, patient, and purchaser satisfaction), and monitoring and assessing performance by evaluating results of quality improvement activities
- Accreditation and licensing processes and reports, such as those of the National Committee on Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS), and state agencies
- Integrity of systems related to the selection, credentialing, and competency of physicians and other practitioners, including systems for granting or terminating clinical privileges, professional, medical, or clinical staff membership, peer review, proctoring and continuing education
- Practitioner Selection, credentialing, and competency
- Approving applications for appointments/reappointments to the medical or provider staff, clinical privileges, and other actions related to medical or provider staff membership that require governing body approval
- Approving Professional Staff Bylaws and Rules and Regulations and amendments, ambulatory center Bylaws and amendments, and ambulatory surgery center policies and procedures, when governing body approval is required

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Kaiser Permanente Quality Measures (KPQM)

The KPQM is used to report a comprehensive and integrated view of Kaiser Permanente Quality & Service performance to the QHIC. The KPQM is a repository of quality performance data over time. It is used to better understand, track, and improve the performance of the entire health care system and they provide a view of a core set of whole-system measures in the domains of quality. Those quality domains are:

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

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

KFHP Northern California Quality Oversight Committee Structure

(Attachment C: Key Departments, Resources and Analytical Support)

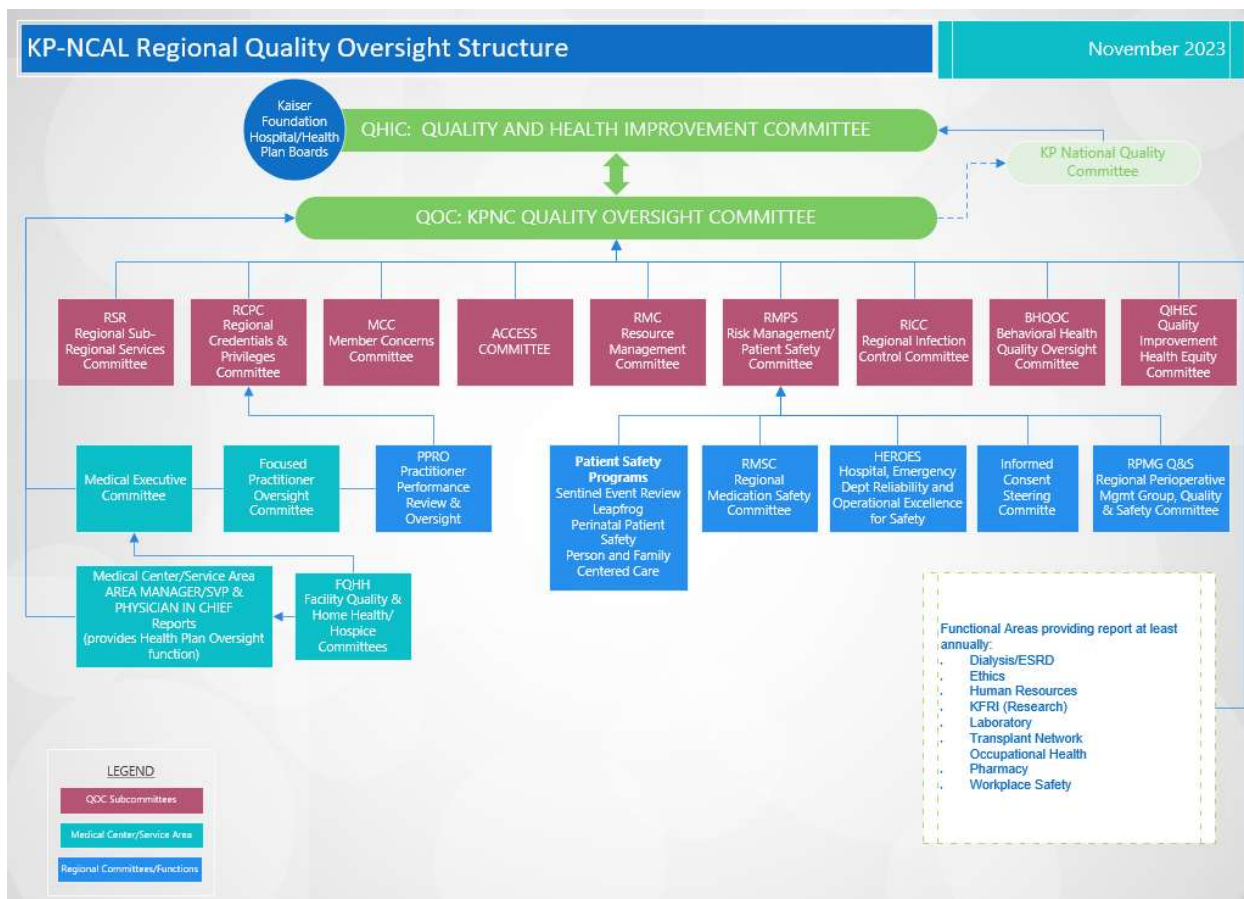
Quality Oversight Committee (QOC)

(Attachment D: QOC Charter)

QOC is KFHP's quality oversight committee for the Northern California Region. It is co-chaired by KFHP's Vice President for Safety, Quality, and Regulatory Services and by TPMG's Associate Executive Director for Quality. As a KFHP peer review committee, at least 51% of QOC's membership is comprised of physicians. Other members include clinical and quality leaders. The QOC reports its activities and functions to the KFHP Board of Directors. The purpose of the QOC is to:

- Evaluate the quality of care and services provided to Kaiser Permanente members and patients in Northern California in all settings
- Support continuous improvement in these areas
- Establish Quality Program direction by identifying and addressing strategic opportunities to establish and maintain KP-NCAL healthcare leadership
- 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 accreditation organizations and meets public expectations

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Confidentiality

All QOC and subcommittee minutes, reports, recommendations, memoranda, and documented actions are considered confidential peer review records. They are maintained in accordance with KFHP Northern California policies/procedures and are protected from discovery in a medical malpractice lawsuit under applicable law. All records are maintained in a manner that preserves their integrity to ensure that patient and practitioner confidentiality is protected. All committee staff receive training on confidentiality at the time they are hired and annually thereafter.

QOC Subcommittees

The QOC assigns certain responsibilities to subcommittees that are required to report to QOC at least quarterly, or more often as necessary. The charters for each subcommittee are updated annually and include group composition, responsibilities, and activities. (Please note, that all charters attached to this program description are replaced as they are approved by the QOC.) QOC membership and subcommittee membership is reviewed annually. The subcommittees of the QOC are:

- Access Committee
- Member Concerns Committee (MCC)
- Regional Credentials and Privileges Committee (RCPC)
 - The Practitioner Review and Oversight Committee (PPRO) is a subcommittee of the RCPC
 - The Focused Practitioner Review Oversight Committee (FPRO) is a subcommittee of the PPRO
- Regional Infection Control Committee (RICC)
- Regional and Sub-Regional Services Committee (RSR)
- Resource Management Committee (RMC)
- Risk Management/Patient Safety Committee (RMPS)

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- Hospital and Emergency Department Reliability and Operational Excellence for Safety (HEROES)
 - Leapfrog Hospital Survey
 - Perinatal Patient Safety Program (PPSP)
 - Person and Family Centered Care
 - Regional Consent Steering Committee (CSC)
 - Regional Medication Safety Committee (RMSC)
 - Regional Perioperative Management Group, Quality and Safety Committee (RMPG Q&S) is a subcommittee of the RMPSC
 - Significant Event Quality Review (SEQR) is a function of the RMPSC
- Behavioral Health Quality Oversight Committee (BHQOC)
 - Medi-Cal Quality Improvement and Health Equity Committee (QIHEC)

Access Committee

(Attachment E: Access Committee Charter)

The KPNC Access Committee is a subcommittee of the QOC established to assist KFHP to ensure members are being seen in a timely manner. Its function is to oversee the adherence to Health Plan and regulatory body requirements around timely access and wait times for appointments, and to proactively address areas at risk for not meeting these requirements. The Access Committee assures systematic monitoring of access to care and services. Monitoring includes but may not be limited to ensuring appointment availability for primary care, specialty care, and imaging noted to be below the threshold for review for initiate-to-seen appointments is addressed through corrective action plans and communicated to both medical Center KFHP and TPMG leadership.

Member Concerns Committee (MCC)

(Attachment F: MCC Charter)

The KPNC MCC is a subcommittee of the QOC. The MCC assures member satisfaction across the continuum of care (including satisfaction with network adequacy and timely access to care) and service delivery and member due process with the functional areas of complaints, grievances, and appeals. The MCC assures compliance with regulatory and accreditation requirements/standards related to member service functions such as pharmacy benefit information, claims processing, quality review processes and accuracy of information, web and telephonic personalized Health Plan services, and proposed member information innovations. The MCC assures that member materials and information provide clear, concise, accurate, and unambiguous information about 1) member rights and responsibilities; 2) benefits and coverage, and 3) access and availability of care and service delivery.

Regional Credentials and Privileges Committee (RCPC)

(Attachment G: RCPC Charter)

The Regional Credentials and Privileges Committee (RCPC) is a peer review subcommittee of the Northern California Region's Quality Oversight Committee (QOC), a Kaiser Foundation Health Plan, Inc. (KFHP) peer review committee. The purpose of the RCPC is to: (1) make credentialing decisions on behalf of KFHP in its Northern California Region concerning practitioners and organizational providers; (2) implement and oversee KFHP credentialing policies, procedures, and processes; (3) promote uniformity and consistency in the application of credentialing policies, procedures and processes; and (4) oversee the Practitioner Performance Review and Oversight (PPRO) program.

Practitioner Performance Review and Oversight Committee (PPRO) & Focused Practitioner Review Oversight Committees (FPROC)

(Attachments H & I: PPRO & FPROC Charters)

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The Practitioner Performance Review and Oversight (PPRO) Committee is a subcommittee of Northern California Regional Credentials and Privileges Committee (RCPC), a Kaiser Foundation Health Plan Inc. (KFHP) peer review committee. Its function is to provide oversight of the practitioner performance review processes, including Peer Review, Department Review, and Focused Practice Review (FPR), designed to continually assess and improve the quality of care provided to KFHP members. The Focused Practitioner Review Oversight Committee is a subcommittee of the Regional Practitioner Performance Review & Oversight Committee (PPRO Committee), a KFHP peer review committee, which is accountable to Regional Credentials and Privileges Committee (RCPC). The purpose of the Focused Practitioner Review Oversight Committee is to oversee the focused review process of licensed independent practitioners and Allied Health Practitioners.

Regional Infection Control Committee (RICC)

(Attachment J): RICC Charter

The RICC provides oversight for the infection prevention and control initiatives and priorities identified in the Northern California Region. The scope of the committee is to increase safety and reduce harm from infections/communicable diseases associated with the delivery of health services in all settings of care including inpatient, ambulatory, contracted services, home health, Kaiser Permanente Post-Acute Care Center, and Kaiser Permanente Psychiatric Health Facility – Santa Clara. To fulfill its goal the RICC directs regional and medical center entities involved in the delivery of health care services to implement new practices and/or change existing practices as indicated to enhance safety and reduce the risk of harm to members from infections and communicable diseases.

Regional and Sub-Regional Services Committee (RSR)

(Attachment K: RSR Charter)

The Regional Sub-Regional Services Committee (RSR), Kaiser Permanente Northern California, is a subcommittee of the Northern California Quality Oversight Committee (QOC). Its function is to oversee the quality of Regional and Sub-Regional health care services provided in the Northern California Region.

The functions of RSR include, but may not be limited to, providing oversight of Regional and Sub-Regional health care services as prioritized by KP-NCAL Leadership. Oversight includes assessing quality performance monitoring processes to ensure that the monitoring indicators address issues related to service, access, clinical quality metrics, and compliance with applicable regulatory standards.

Regional Resource Management Committee (RMC)

(Attachment L: RMC Charter)

The Northern California Regional Resource Management Committee (RMC) serves as a sub-committee of the Quality Oversight Committee (QOC). The RMC identifies and promotes utilization strategies and activities, oversees Health Plan Utilization Management through its regulatory and accreditation work, monitors utilization across the health care continuum, consults with Area Medical Centers on Utilization Management (UM) issues and facilitates performance improvement.

Risk Management Patient Safety Committee (RMPSC)

(Attachment M - RMPSC Charter)

The **Regional Risk Management Patient Safety Committee (RRMPSC)** provides health plan oversight for all locations where members receive care, supports the vision, goals, and priorities for Risk Management and Patient Safety, and oversees related activities and outcomes. The Hospitals/Medical Centers present their programs, including outcomes and opportunities for improvement, at least annually. The committee incorporates Program and Medical Center-wide Risk Management and Patient Safety priorities into its planning. This process is designed to reduce risk and improve patient safety and quality

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outcomes by utilizing the five principles of High Reliability: 1. Preoccupation with Failure 2. Sensitivity to Operation 3. Reluctance to Simplify 4. Commitment to Resilience, and 5. Deference to Expertise. The Health Plan Executive Director of Regional Risk and Patient Safety and the TPMG Medical Director of Risk and Patient Safety co-chair the RRMPS.

The RRMPS provides oversight and supports a culture of High Reliability for the following four patient safety programs:

- The Sentinel Event Quality Review (SEQR) process provides oversight and consultation for the management of significant patient safety events. This process includes investigation and resolution of the events, an expedited communication process and the timely creation and dissemination of event learnings throughout the Northern California Region. This process is designed to reduce risk and improve patient safety and quality outcomes. Health Plan Risk Management and Patient Safety team members perform thorough and credible reviews of all facilities' Comprehensive Systems Analysis (CSA) and assist the facilities in implementing risk reduction strategies.
- The Perinatal Patient Safety Program (PPSP) is a multidisciplinary collaboration between NCAL Health Plan Risk Management and Patient Safety and Maternal Child Health to eliminate harm for mothers and newborns. The PPSP works to create a highly reliable organization using performance improvement tools, evidence-based practices and fostering a culture of safety with an infrastructure that supports equity, inclusion, and diversity. The PPSP develops standardized processes and outcome measures for maternal morbidity/ mortality and birth injuries.
- The RMPSC provides oversight and consultation for the Leapfrog Hospital Survey process and performance improvement activities aiming at making giant "leaps" forward in reducing errors, injuries, accidents, and hospital-associated conditions. The Leapfrog Hospital Survey compares hospitals on standards of safety, quality, and efficiency. The Leapfrog Hospital Safety Grade survey assigns A, B, C, D, and F grades based on the hospital's quality outcomes and ability to prevent harm, including the rate of inpatient injuries, the prevalence of inpatient infections, and medical and medication errors.
- The Person and Family Centered Care (PFCC) program incorporates an approach to healthcare that emphasizes putting the patients and their families at the center of their care. As an organizational priority, Northern California Medical Centers have developed Patient Advisory Councils that are built on these core values. The PFCC has developed a strong focus on equity, inclusion, and diversity. Partnering with our patients/members in this way nourishes joy and meaning in the workplace.

There are four sub-committees of the RRMPS:

- The Regional Medication Safety Committee (RMSC) is an integrated, multidisciplinary oversight committee that works in collaboration with medical centers to identify, evaluate, and analyze specific trends and patterns in medication errors as well as to develop and implement strategies to reduce errors.
- The Regional Perioperative Management Group (RPMG) oversees regional Perioperative initiatives and priorities as they pertain to the quality of care and safety of members undergoing procedures, as identified by Northern California Regional leadership. The committee identifies trends and system issues that identify opportunities for improvement. The committee oversees improvement action plans and shares learnings from region-wide activities.
- The Hospital and Emergency Department Reliability and Operational Excellence for Safety (HEROES) program exists to sustain focus and build upon gains from process and performance improvements designed to achieve safe and reliable patient care. The HEROES Collaborative is the platform used to implement and drive the evidence-based practices designed, tested, and then spread in the medical centers. The current HEROES portfolio includes Falls, Pressure Ulcer Injuries, and HAI events such as HAP, CLABSI, CDI, and CAUTI. The HEROES Collaborative also provides

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consultation and oversight to ensure local robust committees and activities that support practice change.

- The Regional Consent Steering Committee (CSC) provides Health Plan oversight, guidance, and recommendations for the informed consent process for Kaiser Foundation Hospitals and other Kaiser facilities and programs where Kaiser Foundation Health Plan members and other patients receive care and services. The CSC reports activities and issues to the Regional Risk Management Patient Safety Committee on an annual basis or as needed if issues require discussion. The CSC provides leadership and strategic direction for the consent process in Northern California in consultation with Health Plan legal counsel and other Subject Matter Experts.

Behavioral Health Quality Oversight Committee (BHQOC)

(Attachment N: BHQOC Charter)

The Behavioral Health Quality Oversight Committee (BHQOC), Kaiser Permanente Northern California (KPNC), is a subcommittee of the Quality Oversight Committee. Its function is to oversee and monitor the performance of Behavioral Health (BH) care inpatient and outpatient initiatives, priorities, and programs within KPNC and promote excellence of quality in all aspects of BH care. Membership includes representatives from The Permanente Medical Group (TPMG), Kaiser Foundation Health Plan (KFHP) and Kaiser Foundation Hospitals (KFH).

The functions and responsibilities of BHQOC include:

- Provide quality oversight and recommendations on BH program
- Provide regulatory and accreditation guidance and oversight for BH care as required by regulatory and accrediting agencies.
- Review, approve, promote and monitor performance on BH quality improvement initiatives/activities (e.g., HEDIS).
- Report on trends related to complaints, grievances, and appeals to collaboratively address quality issues that arise.
- Oversee and monitor progress of technological investment in outcomes measurement strategy (e.g., Tridium to EPIC initiative, online tools, etc.).
- Review trends related to BH patient safety events and identify systems-level opportunities for improvement.
- Oversee external BH provider network, including issues related to expansion, contracting, access, and quality.
- Evaluates the quality of clinical care and service across all settings for the full spectrum of BH services provided.
- Makes recommendations to relevant leadership and stakeholder groups for actions to improve BH clinical quality and service quality.
- Reviews HEDIS and other quality metrics relevant to the provision of BH services.
- Identifies opportunities for improvement and establishes priorities among them.
- Reviews and approves, from a quality assurance perspective, the implementation of new BH policies and procedures across all departments where BH services are provided.
- Escalates matters where serious quality concerns arise directly to relevant leadership and stakeholder groups.
- Documents meeting activities, distributes meeting materials and follows standard agenda formats and templates for reporting.

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Medi-Cal Quality Improvement and Health Equity Committee (QIHEC)

(Attachment O: QIHEC Charter)

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

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

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

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

The plan shall consist of the following elements, at a minimum:

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

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Other Key Committee(s)

KFHP Local Service Area's Quality Oversight Committee Structure
(Attachment P: Health Plan Quality Oversight Committee Charter)

The purpose of the Service Area Health Plan Quality Oversight Committee ("Committee") is to oversee the quality of care and services provided to Kaiser Foundation Health Plan ("Health Plan") members in the Service Area's outpatient setting. The Committee shall not perform peer review of individual practitioners, as that is the responsibility of the Health Plan peer review committees at the individual service areas.

The scope of the Committee shall:

- Monitor whether the provision of services in the outpatient setting meets professionally recognized standards of practice via the review and analysis of data and metrics aligned with the quality priorities and strategic initiatives established by the Health Plan Regional Quality Oversight Committee ("QOC").
- Assure the timely review, ongoing monitoring, and successful completion of performance improvement activities targeted at improving access, quality, member experience, and appropriate utilization for Health Plan members in the outpatient setting.
- Assure that problems associated with the quality of care in the outpatient setting are identified and appropriately addressed.
- Assure oversight of new services that may impact quality, access, or member satisfaction in the outpatient setting.
- Assure appropriate access to outpatient services and institute mitigating strategies when necessary.
- Facilitate compliance with regulatory and accreditory requirements relating to quality assurance and quality improvement activities in the outpatient setting.
- Oversee resolution of findings reached by regulatory and accreditory bodies.
- Monitor Complaint/Grievance data and recommend actions to improve member experience.
- Recommend actions to facilitate market-leading quality of care.
- Review and recommend performance goals for quality assurance and performance improvement activities.

4. STRATEGIC PRIORITIES

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

Health Plan Performance Goals

Northern California Health Plan leadership aligned this year's strategy with the framework found in the National Strategic Plan. Our strategy is designed to elevate quality, improve affordability, and generate care transformation. The plan highlights include:

- Commitment to Affordability
The Northern California Region has been able to reduce the percent of GDP spent on healthcare in the Bay Area, but more work remains to be done. To lead the way to affordability, we will endeavor to minimize rate increases and continue to improve expense trends.
- Sustainable Growth

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The Northern California Region will continue to: increase and retain membership in all lines of business, balance our portfolio, and address cost structure redesign. The Region will also consider the impact of ensuring more Californians and as membership grows, we will continue to address our responsibilities in the communities we serve.

➤ Financial Performance

The Northern California region will continue with efforts to reduce cost structure while maintaining a strong operating margin. Targeted reductions in unit costs as well as assuring care is provided in the most appropriate setting will enable us to address expense trends over time. Our targeted efforts to improve quality outcomes and promote health and wellness are key contributors to our financial performance.

➤ Care Transformation

The Northern California Region will continue to focus on key initiatives to maintain and evolve quality and efficiency in all lines of business, considering: the social determinants of health, complex chronic conditions, and clinical variation. Quality improvement work will focus on reducing clinical variation, leveraging technology, adopting evidence-based medicine, reducing health disparities and transforming behavioral health in both the outpatient and inpatient settings.

➤ Lead as a Region

The Northern California Region will focus on Total Health and address the social determinants of health in the communities we serve. This focus will include: an ongoing commitment and engagement in the health of the communities we serve, spreading a robust Medi-Cal care model throughout our Region that will address the social and medical needs of our Medi-Cal members, and explore and implement strategies to meet the total health requirements of our senior population.

5. PERFORMANCE IMPROVEMENT ACTIVITIES

KFHP Northern California executives identify performance improvement opportunities and set goals with respect to the:

- Quality, safety, and timeliness of the care we deliver
- Exceptional Care experience of our members and patients
- Coordination of care we deliver
- Health equity, inclusion, and diversity of those we serve
- Development and capabilities of our workforce

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

Prioritization of Performance Improvement Activities

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

- Linkage with strategic goals
- Clinical quality
- Service and access
- Risk Management/Patient Safety
- Legal/regulatory and accreditation requirements

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- Performance gaps
- Member complaints
- High volume diagnoses and procedures
- Problem prone diagnoses and procedures
- Leapfrog safe practices criteria
- Healthcare disparities

Performance Improvement Methodology

KFHP utilizes the Institute for Health Care Improvement (IHI) Model for Improvement as well as other performance improvement models (e.g., Lean, Six Sigma, Plan-Do-Study-Act, etc.) and tools are utilized to organize efforts that improve the quality of health care delivered and the processes that support quality care. The Model for Improvement includes setting aims, forming teams, establishing measures, and selecting and testing changes. Medical Center and Regional staff are encouraged to achieve improvement continuously by using evidence-based improvement methodologies.

Performance Measure Data

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

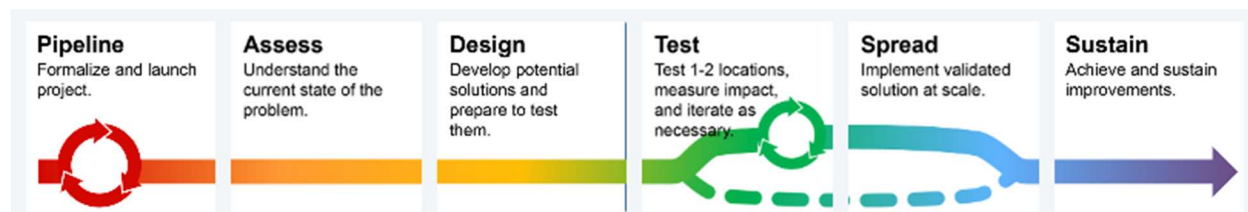
Performance Review/Benchmarks

KFHP Northern California compares its quality performance and outcomes against internal and external benchmarking organizations when relevant criteria exist. Additionally, the Quality Program evaluates:

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

Spreading Best or Successful Practices

KFHP has developed a spread and sustainability methodology. When a performance improvement practice supports our organizational ability to meet our strategic priorities, we move to embed the practice throughout the organization. Sustainability is accomplished by “spreading,” or actively disseminating, the best practice and the improvement intervention components to all care settings. This methodology (Model for Improvement) is based on the Institute for Healthcare Improvement (IHI) framework for spreading local improvements systemwide using the project lifecycle approach below.



6. KFHP NORTHERN CALIFORNIA OVERSIGHT OF QUALITY FUNCTIONS

Quality Assurance Program (QAP)

The KFHP Northern California Region administers its Quality Assurance Program (QAP) and oversees and monitors the quality activities performed by its network providers including KFHP, TPMG, and contracted providers to ensure the provision of quality care and timely and appropriate utilization of services is in accordance with professionally recognized standards of practice and legal requirements. Additionally, KFHP oversees the performance of quality functions at the regional and service area levels.

The QAP is designed to identify, thoroughly review, and resolve quality issues in a timely manner and reflects the following goals and principles:

- Effectively identify, evaluate, and respond to each potential quality issue in a timely manner
- Consistently apply a standard set of review criteria to each case evaluation and document findings conclusions and actions, as appropriate, in common QAP systems
- The QAP will generate an effective system of reports that will enable KFHP to monitor, audit and evaluate the efficacy of the quality assurance process (including any findings, conclusions, and recommendations, as well as the execution and follow-up of plans of correction/improvement, and the final disposition of quality issues)
- Feedback from the QAP to clinical operations and involved service area leaders at the site of service ensures that actions will be taken to resolve the issue with sustained improvement through follow-up as needed
- The Utilization Management (UM) program is an integral part of the Health Plan's QAP. Quality, risk and safety processes and program initiatives are incorporated into KFHP's UM program
- Quality and risk issues, patterns and trends identified through UM clinical review processes are escalated to the quality department in a timely manner. Results of monitoring and analysis of utilization of services and local and regional performance related utilization management are reported and reviewed by local and regional utilization and quality committees

KFHP continuously oversees and evaluates performance of quality and UM functions that are performed by TPMG and KFHP. This occurs by:

- Conducting formal evaluations of capacity to perform the assigned activities in accordance with state and federal regulatory and accreditation standards
- Tracking and analyzing provider and member complaints, grievances, and other performance indices
- Conducting periodic reviews of systems, staff, and policies and procedures
- Analyzing routine and periodic quality and utilization management reports
- Designating Health Plan Area Managers as accountable for specific service area providing oversight activities
- Establishing the role of regional Health Plan Quality and Utilization Management committees for oversight activities
- Designating the Health Plan's Physician Advisor in conjunction with the appropriate Health Plan utilization management and quality committees for oversight activities

As noted, KFHP Northern California oversight occurs through its quality and utilization management committees. KFHP Northern California's primary quality committee is the QOC. The QOC is responsible for evaluating the effectiveness of all aspects of the QAP. In evaluating the QAP, the QOC:

- Recommends to senior leadership actions to improve clinical and service quality
- Identifies opportunities for improvement and establishes priorities
- Determines accountability and ensures quality issues are identified and resolved
- Reviews and approves quality policies

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- Monitors corrective action plans
- Sets quality strategies in alignment with KFHP strategic priorities and mission
- Recommends actions based on reviews of regional quality reports
- Identifies region-wide trends, outliers, and quality issues
- Annually approves the Quality Program description, work plans, and annual evaluations and provides feedback and requires follow-up as appropriate
- Reviews and acts on results of the KP quality measures
- Oversees and coordinates the functions of its subcommittees

Quality Assurance Program Agreement (QAPA)

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

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

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

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

Delegation Statement – Contracted Providers

KFHP has direct responsibility and accountability for quality improvement, access and availability, credentialing, member experience, claims, and utilization management functions. Under certain circumstances, KFHP may delegate responsibility for conducting one or more functions to a provider, provider group, agency, facility, health plan, or other supplier of services with whom it contracts.

Delegation occurs only in instances in which KFHP has predetermined the delegate's capability and capacity to perform the function(s) and meet KFHP's requirements and expectations. KFHP has a systematic method for conducting a pre-delegation audit and data collection to evaluate a delegate's capacity to perform certain functions before delegation begins. Based on the results of pre-delegation evaluation, the QOC makes a final decision to approve or deny delegation of specific functions to a practitioner or provider organization.

Our KFHP delegation agreement clearly outlines all reporting requirements and performance expectations. KFHP retains the right to revoke delegation if the delegated entity does not fulfill its

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obligations. The Regional Credentials and Privileges Committee (RCPC) and Resource Management Committee (RMC) have significant roles in the delegation oversight process and make recommendations to the QOC. For delegated quality oversight, QOC receives the delegation reports directly.

KFHP conducts an annual oversight audit to assure the delegate's continuing ability to meet requirements and expectations. In addition, according to the reporting submission requirements, there will be an ongoing review of submitted documents and activity reports. Although the QOC's subcommittees have an active role in the delegation oversight process, the QOC ultimately has responsibility to oversee delegation.

The QOC reviews:

- Results of pre-delegation audits
- A summary assessment of the annual oversight audit and recommends corrective action plans, if needed
- Follow-up plans as indicated
- Recommendations to continue or terminate delegation

Contracted External Provider Services

(Attachment W: Skilled Nursing Facility and Long-Term Care Quality Oversight Program Description)

In limited situations, KP contracts with non-KFH providers and non-TPMG practitioners including selected specialty hospitals, ambulatory surgery centers, skilled nursing facilities, home health and hospice agencies, and practitioners. The terms of participation in the KFHP provider network are outlined in contractual agreements between KFHP and/or TPMG and the providers. The contract includes providers' obligations to cooperate with KFHP's quality improvement program, to support member and practitioner communication, to provide access to medical records, and to maintain confidentiality of member and personal health information. These providers are credentialed and recredentialed by the Regional Credentialing and Privileging Committee. The KFHP quality program evaluates the care provided by these contracted providers. Compliance with the requirements of the quality program is set forth in the Provider Manual and other written communications to the contracted providers. In the event of the termination of the provider's contract, members receive timely notification, as applicable, to comply with continuity of care and legal requirements.

Credentialing and Recredentialing

The KFHP, Northern California Credentialing \ Policies and Procedures govern the Credentialing \ process. All Licensed Independent Practitioners (LIPs), Allied Health Professionals (AHPs), and Organizational Providers (OPs) are credentialed prior to treating Health Plan members.

Credentialing/Recredentialing of LIPs and AHPs

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

KFHP ensures that the credentials of all LIPs and AHPs, within the scope of the policy, are verified, evaluated, and acted upon, either directly or by delegation. As a condition of continued credentialing in KFHP, a practitioner must continue to meet the criteria set forth in the policy and procedures. Re-verification and re-evaluation for LIPs/AHPs who also hold hospital privileges occurs at least every twenty-four months. LIPs/AHPs who do not have hospital privileges are recredentialed at least every thirty-six months.

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RCPC makes decisions regarding delegation of credentialing, oversees compliance of delegates, and makes credentialing/recredentialing recommendations regarding contracted practitioners. Additionally, each Medical Center's C&P Committee makes credentialing/recredentialing recommendations within its respective Service Area. The KFHP Board of Directors reviews recommendations and makes the final decision.

Credentialing and recredentialing decisions are separate and independent from employment actions or decisions made by TPMG or privileging actions taken by KFHP.

Credentialing/Recredentialing of Organizational Providers (OP):

KFHP ensures that the credentials of all KFHP-owned or contracted OPs within the scope of the policy are verified and evaluated. No OP shall be permitted to provide covered services to KFHP members until that OP's credentialing application has been evaluated and approved.

The Medical Services Contracting Department supports credentialing and recredentialing of OPs. OPs without accreditation from an approved organization require an on-site quality assessment using defined criteria. OP contract language requires:

- Cooperation and participation with quality improvement activities
- An affirmative statement that there be open communication between the patient and their practitioner
- KFHP has access to KFHP member medical records
- The OP to agree to maintain member confidentiality

As a condition of continued credentialing, an OP must continue to meet the criteria set forth in the KFHP policies and procedures. OP credentials are re-verified and re-evaluated at least every thirty-six months.

The Continuum Administrator (CA), CA designee, or appropriate health plan representative reviews site survey results and makes recommendations to RCPC for final credentialing and recredentialing determinations. If at any time issues of quality of care/service are identified, a Corrective Action Plan (CAP) may be implemented and may include referral suspension or referral restriction by acuity. CAP status reports are made to the RCPC until all deficiencies are satisfactorily remedied. Failure to satisfactorily complete a CAP may result in the RCPC taking additional action, including CAP extension or credentialing termination. No contract for OP services shall be executed unless OP credentialing has been approved by the RCPC. No additional sites may be added to an existing contract until each site's credentials are approved by the RCPC.

Monitoring of Credentialed Practitioners

KFHP has an ongoing monitoring process to track the following elements, as applicable, to ensure credentialed practitioners maintain compliance with credentialing criteria at all times: 1) currency of license to practice in California, 2) currency of malpractice insurance coverage if applicable, 3) currency of DEA and/or other prescribing authority, 4) currency of board certification, 5) currency of the California Department of Public Health, Radiologic Health Branch certificates and permits, 6) Medicare and Medicaid sanctions/limitations/exclusions, 7) Medicare Opt Out status, and 8) member complaints.

Notification of Practitioner Conduct Agreement

(Attachment R: Notification of Practitioner Conduct)

The "Notification of Practitioner Conduct" Agreement is a mechanism for implementing KFHP oversight of the quality of clinical services provided by licensed independent practitioners to members. Pursuant to the "Notification of Practitioner Conduct" Agreement KFHP and TPMG are required to notify KFHP when a practitioner's conduct comes within the scope of the conduct delineated in the Agreement. Health Plan

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may take disciplinary action against a licensed independent practitioner, when appropriate, through a Credentials and Privileges Committee acting on behalf of KFHP.

Practitioner Input into Quality

Practitioners are encouraged to actively participate in the Quality Program as it relates to member care and services. Input may be accomplished through participation on quality committees and designated quality improvement activities.

Conflict of Interest Statement

No physician or other individuals involved in performance improvement, utilization management, or risk management shall have the direct responsibility for the review of the quality of patient care or appropriate utilization of resources for a patient with whom the individual is professionally or personally involved. Decisions related to care are made by the member's physicians and other members of the care team and are based only on appropriateness of care and service and existence of coverage. Kaiser Permanente does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization. The health plan does not use incentives to encourage barriers to care and service. This does not preclude the use of appropriate incentives for fostering efficient, appropriate care.

Peer Review Process

The Peer and Quality Review process is a mechanism by which KFHP continuously assesses the care provided to KFHP members. This process evaluates potential quality of care concerns involving licensed practitioners to determine whether standards of care are being met. KFHP oversees compliance with the "Peer Review & Evaluation of Licensed Independent Practitioners Performance" and the "Quality and Systems Review for Allied Health Professionals" policy through its PPRO Committee.

Health Plan Oversight of Clinical Services

New or Changed Clinical Services

(Attachment K: RSR Charter)

The Clinical Service Agreement sets forth Health Plan's process to review and approve the provision of new services or a change in the way services are provided under the following circumstances:

- Services that require regulatory review or approval and/or
- Services that require capital expenditures of \$1 million or more

Any service that meets the criteria in the Agreement must be approved by the KFHP Board of Directors prior to its implementation. These services are monitored through the oversight of the RSR Subcommittee, which reviews quality, service, and access metrics. The RSR Subcommittee reports findings and makes recommendations to the QOC.

Utilization of Clinical Services

The KFHP quality assurance program is accountable to monitor resource use within the clinical delivery system. This includes directing activities in collaboration and coordination with the Resource Management Committee to achieve prudent and clinically appropriate allocation of resources in the provision of health care services and to ensure reporting of these activities to the Quality Oversight Committee. Additionally, the quality assurance program oversees the Utilization Management process to assure that it is in accord with applicable state laws and regulations. Utilization Management is a process that determines whether a health care service recommended by a treating provider is medically necessary. If it is medically necessary, the service will be authorized, and the member will receive the services in a clinically appropriate place consistent with the terms of the member's health coverage. Utilization Management (UM) activities and functions include the prospective, retrospective, or concurrent review of health care service requests submitted by providers. The decision:

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- Involves a review of the requested service that may result in the modification, delay, denial, or approval of it, *based in whole or in part on medical necessity*, and
- Is made by a non-treating, third party that is either a physician or a committee of physicians.

Such an authorization decision is a UM Decision. UM Decisions are based upon criteria that have been developed to be applicable to a specific service, plan of treatment or diagnosis. These criteria are formalized in writing as the UM Criteria used as the basis for guiding the UM Decision. Under applicable state law, UM Criteria must be:

- Developed with the involvement of, and collaboration with, actively practicing TPMG physicians,
- Consistent with sound clinical principles and processes, and
- Evaluated, and updated, if necessary, at least annually

Key Regional Quality Initiatives and Processes – The Health of Member Populations

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

Equity, Inclusion, and Diversity (EID)

(Attachment U: Equity, Inclusion, and Diversity Program Description)

(Attachment X: TPMG Equity, Inclusion, and Diversity Program Description)

Kaiser Permanente (KP) believes in equity and inclusion for all. KP strives to weave equity, inclusion, and diversity into the fabric of our organization and communities to promote positive change and superior performance.

Equity is critical in our journey to bring high-quality, affordable care and coverage and total health to the people and communities it serves.

For the greatest impact, KP applies equity, inclusion, and diversity strategy fully across three interdependent areas that collectively advance equity: Workplace, Care Delivery, and Community. Kaiser Permanente has established equity principles of Inclusion, Accountability and Advocacy that guide our practices, behaviors and reflect our mission and vision.

EID Vision – Equity and Inclusion for All

Within Kaiser Permanente's 2025 five overarching goals, is Quality and Equitable outcomes. The enterprise-wide foundational commitment of Equity leads to the Equity Execution plan with Commitments. The Equity Execution Plan (EEP) is a multi-year plan using an enterprise strategy execution framework. The EEP includes goals and measures in the following areas: Workforce equity, Health equity, Community: Systemic Racism, Economic Impact.

Finally, within the EID function, cross cutting areas to support the KP EEP includes: 1) Inclusion, Belonging and Empowerment for all People; 2) Fairness and Equity in All Systems; 3) Community and Societal Impact, and 4) EID Excellence and Infrastructure.

KP Equity Principles

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

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actions to uphold the racial, health, and workforce equity standards that reflect our mission, values, and history.

Kaiser Permanente's Equity principles

Equity is the ideal of fairness and justice. These principles guide our practices and behaviors, reflecting our mission and vision.

 Inclusion	 Accountability	 Advocacy
I foster inclusive environments where everyone feels safe sharing ideas, concerns, and aspects of their identity without fear.	I am accountable for my individual action or inaction that leads to others being harmed.	I advocate for equity and inclusion for all people and amplify the voices of the most impacted and unheard.
Principles in Action		
• I encourage and celebrate self-expression and model authenticity that builds trust, safety, and a sense of belonging for all. • I respect the basic human right to fair and dignified treatment free of bias, racism, and oppression. • I act with personal integrity, transparency, and understanding.	• I am accountable for acting with integrity and respect. • I seek to demonstrate a commitment to learn, understand, and disrupt the influence of bias, stereotypes, and racism, in my thoughts, actions, and words. • I name and speak out on actions and processes that produce unfair, unjust, and preventable outcomes.	• I take personal accountability and act for fairness, justice, and inclusion for all. • I boldly commit to support everyone's equal right to belong and reach their full potential at Kaiser Permanente. • I actively use my voice, resources, and influence to support equity for all people.



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

KFHP is committed to the delivery of quality and equitable health care services and ensures that quality and health equity activities are aligned with the Department of Health Care Services (DHCS) Comprehensive Quality Strategy. KFHP maintains responsibility for the quality and health equity of all

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

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Medi-Cal covered services, even if those services are delegated to a Network Provider, Subcontractor, or Downstream Subcontractor.

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

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

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

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

Patient Centered Medical Home (PCMH)

The Patient Centered Medical Home (PCMH) recognition from National Committee for Quality Assurance (NCQA) is given to primary care provider practices that meet specific standards and provide high-quality care while managing the overall health of their patients. All Northern California primary care office settings are recognized annually by NCQA as PCMH sites. As new KP primary care sites open, KP applies to NCQA to add these sites to the PCMH program.

To maintain PCMH recognition, primary care practitioners must ensure that:

- Comprehensive health assessments are completed and well-documented in the medical record.
- Patient specific communication requirements due to hearing, vision, or cognition issues are documented in the medical record.
- Advance care planning discussions with members occur and are documented in the medical record.
- Discussions occur with members and are documented in the medical record with respect to risky and unhealthy behaviors beyond physical activity and smoking status (e.g., nutrition, oral health, dental care, familial behaviors, risky sexual behaviors, and secondhand smoke exposure).
- Patients who have been identified and placed in care management have care management plans that are placed in the medical record.
- Care management plans:
 - Are developed in collaboration with the patient
 - Incorporate patient preferences and functional/lifestyle goals
 - Identify treatment goals
 - Assess and address potential barriers to meeting goals
 - Include a self-management plan
 - Are provided in writing to the patient

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Crossing the Quality Chasm (CQC)

Each year the Northern California Region identifies a group of focus areas/quality goals to be displayed on the Crossing the Quality Chasm (CQC) dashboard. CQC goals are chosen based on impact to the health of our members, the health of the communities we serve, our ability to improve overall performance, and our ability to reduce undesirable variation. Performance monitoring includes a quarterly comparison of results for the Region overall to medical centers and facilities. CQC goal results are reviewed by Quality Leaders on an ongoing basis, by the relevant leadership for each measure at the medical center and facility and are reported to QOC.

The CQC measures a variety of high impact clinical quality initiatives across facilities and service lines:

- Hospital Quality: Ambulation, sepsis, blood management, stroke care, care experience, supportive care services, core measures (tobacco, breastfeeding)
- Outpatient Quality: Cancer screening, tobacco cessation, cardiovascular health, asthma, end stage renal disease, depression, chemical dependency, pediatric immunization, osteoporosis
- Patient Safety: Hospital acquired infections, hospital acquired pressure ulcers, falls, surgical safety, and the safety priority index.

Healthcare Effectiveness and Data and Information Set (HEDIS)

HEDIS is a group of standardized performance measures designed to ensure that the Centers for Medicare and Medicaid Services and the public have the information needed to accurately compare the performance of managed health care plans. The performance measures in HEDIS are related to many significant public health issues such as cancer, heart disease, smoking, asthma, and diabetes. HEDIS measures are an integral part of health plan accreditation by the National Committee for Quality Assurance. The Northern California Region's performance is reported to the QOC annually.

Select HEDIS measures are publicly reported by the Center for Data Insights and Innovation (CDII) California Office of Patient Advocate (OPA). The California OPA represents the interests of health plan members by publishing an annual Quality of Care Report Card. The Report Card can be found on CDII's website: <https://www.cdii.ca.gov/consumer-reports/>

Member/Patient Safety

- (Attachment S: KFHP Risk Management & Patient Safety Program Description) - The focus of the KFHP Risk & Patient Safety Program is to promote reliable, consistent, and safe care for KFHP members and patients receiving health care services in a KP facility, including but not limited to Kaiser Foundation Hospitals, KP ambulatory surgery units, KP skilled nursing facilities, and TPMG medical offices. The program also includes health care services provided to KP members by contracted Providers within the Health Plan network.
- . The program is founded on the philosophy that patient safety is every patient's right and everyone's responsibility. The Health Plan Risk Management & Patient Safety Program utilizes both patient safety and risk management principles as part of its Health Plan oversight accountabilities.

Clinical Practice Guidelines (CPGs) Process

Clinical Practice Guidelines (CPGs) are developed to assist clinicians by providing an evidence-based analytic framework for the evaluation and treatment of selected common problems in patients, and to support clinical decisions by practitioners at the point of care in the provision of acute, chronic, preventive care, and behavioral health services. The use of CPGs by practitioners assists KFHP by ensuring that the care provided to members is evidence-based and consistent with professionally recognized standards of care. Development of CPGs is prioritized based on established criteria, which

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include number of patients affected by a particular condition/need, quality of care concerns and/or excessive variation in clinical practice, regulatory issues, payor interests, cost, operational needs, leadership priorities and prerogatives. CPGs are not used to make utilization management determinations regarding the medical necessity of a member's care.

KPNC is committed to supporting the KP National Guideline Program by maintaining its representation on the on the National Guideline Committee and its Subject Matter Expert Workgroups.

CPGs are available on an internal Kaiser Permanente intranet website. Guidelines are updated with the two-year review schedule and when significant changes are made, they are distributed via email, the intranet site, and other communication venues.

In addition to CPGs authored by KP, the internal KP intranet website (Clinical Library) provides KP users with access to numerous evidence-based clinical information resources that include current guidelines that address a comprehensive set of topics.

Population Health Management

Population Health Management (PHM) programs leverage our integrated delivery system to provide population-based care that assures our members get all the care they need from primary care providers and medical subspecialists. By using a 'high tech' and a 'high touch' approach to care, we strive to make optimal care easy, personal, and reliable.

Population Health programs are coordinated under the supervision of physician directors, with oversight being divided according to patient acuity and complexity. Programs targeted toward the general population or members with chronic conditions (e.g., diabetes, hypertension, or asthma) are managed by the Medical Director for Population Care and Medical Director for Outpatient Quality, while programs directed to members with complex needs are managed by the Medical Director and Regional Director for Continuum and Complex Needs.

The Population Care strategy is based on several key concepts, including:

- Evidence-based care supported by clinical practice guidelines
- Member registries based on our access to extensive clinical data for our members
- Customized information technology to support the program with tracking and feedback
- Member-centered medical home-based care that supports the physician-member relationship
- Involvement of the member in his/her own care
- Interventions and care designed and tailored to address specific and special needs of members, including social determinants of health, age-specific opportunities, different abilities, and serious and persistent mental illness
- Periodic performance assessments and annual population analysis regarding program resources and activities

There are four areas of focus for the PHM Program. Each area of focus defines the population it is targeting and sets the goals specific to the population. The focus areas are:

- Keeping members healthy
- Managing members with emerging risks
- Patient safety
- Managing multiple chronic illnesses

A separate comprehensive Population Health Management Strategy is maintained outlining the details of the program. It includes the four areas of focus described above and considers the following five factors:

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- Goals and populations targeted for each of the focus areas
- Programs or services offered to members
- Activities that are not direct member interventions
- How member programs are coordinated
- How members are informed about available PHM programs

The Population Care Programs include, but are not limited to:

- Asthma
- Immunization
- Diabetes
- Complex Needs Care

Data registries are maintained for all eligible members with these conditions to assist with outreach and tracking care provided. Population health management program effectiveness is annually evaluated for member satisfaction by obtaining feedback from members and analyzing member complaints and inquiries. Performance reports are reviewed for compliance, quality, efficiency and effectiveness by regional and service area leadership.

Kaiser Permanente has many activities that are conducted by the organization to support the PHM programs and focus areas although are not direct patient interventions. They include:

- Data and information sharing with physicians and physician leadership
- Documentation integrated into electronic medical record for all care providers to document and review
- Decision support tools at the point of care
- Program inclusion information available at the point of care/in the electronic medical record
- Collaborating with hospitals to improve patient safety
- Collaborating with community-based organizations and hospitals to improve transitions of care from the post-acute setting to home
- Integrating with community resources

Each population health management program has regional physician leadership as well as physician champions in each service area. Use of clinical practice guidelines is a critical component of population care management.

Practitioners are informed about program services through a variety of media such as newsletters, mailings, preventive health prompts, and other in-reach and outreach efforts, such as continuing medical education, brochures, in-services and local quality committees/structures. Programs are coordinated through referrals that occur between population health management programs. In addition, referrals from hospital utilization management staff discharge planners, practitioners (including the PCP), members and caregivers to care management programs support coordination. Practitioners and members are notified about how members can opt-out of receiving services from the programs.

Depending on specific operations of a particular program, newly eligible members will be contacted either by program staff or via centralized outreach, which can include information about how to access program services, how they became eligible for the program, and how they can opt-out of the program. Members are initially informed of available population care programs with new member enrollment materials. The Member Resource Guide is made available to all new members and is updated on an annual basis, while initial engagement with specific programs is managed according to each program's operational preferences.

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The following methods are leveraged to inform members of necessary care:

- Proactive telephonic outreach to members: Members with prevention screening needs or chronic conditions care gaps are outreached by qualified health care practitioners. (Example: Immunizations)
- In-person management: Members are informed by KP care team members of population health services both in the outpatient clinics and in the hospital. (Example: Primary Care physician informs patient about Diabetes care)
- Informative Online Content: KP.org the KP website includes information on various PHM programs. (Example: Health Education materials)

Program effectiveness is evaluated by leadership annually. Clinical quality leaders highlight quality metrics and determine goals based on several factors, including current and projected performance, external benchmarks, and organizational priorities. These quality metrics include widely recognized external measures, but also may include non-standard metrics that follow specific populations, such as a specific ethnic group or a subset of members in a specific disease state.

An assessment of Kaiser Permanente Northern California's population is used to understand the overall composition of our membership and illuminate disease prevalence. This assessment is discussed with Population Health leadership annually.

Health Education Programs

Kaiser Permanente invests in Health Education programs and services that focus on empowering members to live healthier lives through disease prevention and management of chronic health conditions. Services and information for members are available in Health Education departments at local facilities, online, and through printed materials. Many are available in multiple languages. Health education is available throughout primary care, either by direct consultation with a Clinical Health Educator, or via information shared by secure message in the electronic medical record by primary care physicians. The Health Engagement Consulting Services department works in partnership with other regional departments and medical facility staff to support TPMG with strategies and solutions that help patients understand their health, be active partners in their care and take steps to engage in healthy behaviors. In 2020, KP transitioned in-person classes to online offerings and started offering 1:1 Health Education appointments by video visits. In-person 1:1 consultations with a Clinical Health Educator continue to be available as an alternative to telehealth, and some in-person classes are now available.

Health Engagement is:

- **Knowledge.** Culturally responsive information and shared decision making for digital and print platforms, and clinical encounters
- **Skills and Ability.** Patient-centered approaches to increase confidence to change behaviors that address underlying causes of disease
- **Engagement.** Patient experience research to inform innovation and optimize systems, to influence health behaviors

The department provides expertise on:

- CQC priorities, employer engagement, and disease management
- Health coaching strategies for behavior change, chronic conditions management, prevention, and behavioral health education
- Behavioral science evidence, to support member healthy choices

The department develops, produces, and maintains:

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- Content for member classes, print and on-line resources that are consistent, understandable, actionable, culturally responsive and updated on a regular basis to reflect accurate, current standards
- Resources and practice tools for clinicians and trainings for care managers, class instructors, individual consultations with Clinical Health Educators, and other clinicians who assist Members in developing behavior change skills

Chronic Care Improvement Program (CCIP)

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) requires Medicare Advantage Organizations (MAOs), as part of their quality improvement efforts, to implement a Chronic Care Improvement Program (CCIP). The Centers for Medicare and Medicaid Services (CMS) also requires MAOs to have ongoing CCIPs. MAOs must conduct CCIPs that have a favorable effect on health outcomes and member satisfaction. These projects focus on clinical and non-clinical areas and involve measurement of performance, interventions, and performance improvement activities.

CCIPs must promote effective management of chronic disease, improve care and health outcomes for enrollees with chronic conditions, and be conducted over a three-year period. MAOs choose their focus area for each three-year cycle. Each CCIP project must report on Non-SNP and SNP enrollees. Effective management of chronic disease is expected to slow disease progression, prevent complications and development of comorbidities, reduce preventable emergency room (ER) encounters and inpatient stays, improve quality of life, and save costs for the MAO and for the enrollee. The goals of the CCIP are to:

- Support the CMS Quality Strategy
- Include interventions that are above and beyond MAOs' inherent care coordination role and overall management of enrollees
- Engage enrollees as partners in their care
- Increase disease management and preventive services utilization
- Improve health outcomes
- Be universally applicable to MAOs
- Facilitate development of targeted goals, specific interventions, and quantifiable, measurable outcomes
- Guard against potential health disparities
- Produce best practices

The 2022-2024 CCIP for Northern California is focusing on diabetes, specifically Diabetes Control and Disparity Reduction for Hispanic/Latino members.

The Quality Oversight Committee (QOC), Health Plan Quality (HPQ), and TPMG Consulting Services Departments are responsible for monitoring the CCIP for compliance.

Special Needs Plan

KFHP offers a Medicare Advantage special needs plan enrolling beneficiaries who are eligible for Medicare and full benefits under Medi-Cal. As a special needs plan ("SNP"), KFHP is required to provide a model of care (MOC) that addresses the special needs of these members. All SNP MOCs must include the following elements:

- Description of SNP-specific Target Population
- Description of Subpopulation – Most Vulnerable Beneficiaries
- SNP Staff Structure
- Health Risk Assessment Tool
- Face-to-Face Encounter

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- Individualized Care Plan
- Interdisciplinary Care Team
- Care Transition Protocols
- Enhanced Care Management
- Specialized Expertise for Provider Network
- Use of Clinical Practice Guidelines and Care Transition Protocols
- Model of Care Training for Provider Network
- Model of Care Quality Performance Improvement Plan
- Measurable Goals and Health Outcomes for the Model of Care
- Measuring Patient Experience of Care (SNP Member Satisfaction)
- Ongoing Performance Improvement Evaluation of the Model of Care
- Dissemination of SNP Quality Performance Related to the Model of Care

SNPs must collect data on quality indices as required and in concert with the KP program plan. SNPs must also provide a chronic care improvement program (CCIP) which has methods to identify beneficiaries with multiple or severe chronic conditions who would benefit from the CCIP and a mechanism to monitor beneficiaries in CCIPs.

Access & Service Program (The Care Experience)

KFHP Northern California engages in a variety of performance improvement interventions and strategies aimed at enhancing the availability and accessibility of health care services and increasing satisfaction of its members. Strategic service priorities are set based on identified areas of opportunity to address the service needs of members. Comprehensive strategies and measurements are assessed at least annually to assure the effectiveness of strategic goals and imperatives relating to improving member satisfaction. The five key imperatives set by leadership are:

- Members will be satisfied with the appointment wait times for primary care
- Members will be satisfied with the appointment wait times for specialty care
- Members will be satisfied with the appointment wait times for behavioral health care
- Members will have the ability to see their own PCP when they come in for primary care
- Members will be satisfied with phone services associated with their medical office visit
- Members will be satisfied with their medical office visit care experience

KFHP has established access and availability standards as required by State or Federal statutes and/or regulations. Standards are reviewed and approved at least annually by the MCC, the BHQOC and/or directly by the QOC.

KFHP assures the adequacy and availability of the Kaiser Permanente Northern California network by establishing and monitoring performance of:

- Appointment access standards for primary care, specialty care, behavioral health care and ancillary services
- Geographic accessibility and provider/enrollee ratios
- Customer service calls and telephone triage or screening wait times
- Coordination of interpreter services

The QOC and its subcommittees reviews and evaluates compliance with the access and availability standards through performance monitoring of:

- Quarterly appointment access data
- Annual geographic accessibility and provider/enrollee ratio analysis for primary, specialty, and behavioral health care, as well as ancillary services
- Regular or annual complaint, grievance, and appeal data

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- Annual enrollee satisfaction survey results
- Annual provider satisfaction survey results
- Annual customer service performance reporting by the Member Service Call Center (MSCC)
- Regular or annual telephone triage or screening performance monitoring reports by the Appointment & Advice Call Center (AACC) and Psychiatric After-Hours Call Center (PACC)
- Regular or annual subcommittee reports

MSCC and AACC leadership develop telephone services standards which are monitored regularly through operational reports and member satisfaction surveys that are presented to the QOC. With respect to Behavioral Health access and availability standards, PACC leadership develop telephone services standards which are monitored regularly through operational reports and member satisfaction, complaint, grievance, and appeal reports that are presented to the BHQOC and to the QOC via Mental Health Administration semiannual reports. On a quarterly basis, the MSCC presents summarized findings of monitoring activities, action plans and recommendations to the QOC.

Availability of Practitioners

KFHP in cooperation with TPMG has defined which practitioners are included in the definitions of a primary care and specialty care practitioners, as well as high-volume, and high impact practitioners for outpatient services. The cultural, ethnic, racial, and linguistic needs of members are assessed, and the availability of practitioners is adjusted to meet those needs. The availability of practitioners for primary care, high impact specialty care, and high-volume specialty care, including behavioral health, will be analyzed and reported to the Access Committee, at least once a year. Geographic availability of practitioners is analyzed at the regional and service area levels. The geographic analysis provides details such as the percentage of members who are within a specified time and distance of their Primary Care Provider's office.

Behavioral Health (BH)

(Attachment S: Behavioral Health Care Program Description)

KFHP offers behavioral health and chemical dependency treatment services. The components of the Behavioral Health services are outlined in the attached Behavioral Health Care Program Description.

Members have “open” direct access to behavioral health (BH) services. Members may access behavioral health services by calling the BH Department directly and requesting an appointment with a BH practitioner. Services available include outpatient and inpatient psychiatry and counseling services, chemical dependency and recovery services, intensive outpatient, partial day and residential services. A PCP may also refer a member for behavioral health services. On-call behavioral health practitioners are available 24 hours a day to assist members who require emergency services in the medical offices or hospitals, including emergency departments. The Chiefs of Psychiatry and BHQOC monitor the availability of practitioners for on-call services on an ongoing basis.

Standards for appointment access are established, approved, analyzed, and monitored by the KPNC Access Committee, a subcommittee of the QOC. KFHP has established the expectation that immediate access to care is applicable to emergent life threatening and emergent non-life-threatening situations. Other routine and urgent appointment access standards adhere to the DMHC regulations. BH telephone access standards are established for the PACC and are monitored on an on-going basis.

Member Input into Quality

Members are encouraged to take an active role in managing their health. KFHP Northern California promotes member input into its Quality Program regarding the members' care experience. Depending on the specific program, project or topic, this input may be accomplished through member focus groups and

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member surveys, for example. Members can read about the KFHP Northern California Quality Program at kp.org/quality. Members are notified via the Member Guidebook of the availability of this summary.

Additionally, the KFHP Board of Directors establishes public policy for the Health Plan. Members who would like to provide input for consideration by the Board about Health Plan public policy do so by sending comments in writing to the Office of Board and Corporate Governance Services, One Kaiser Plaza, 19th Floor, Oakland, CA 94612. The Board's public policy process includes a review of members' letters sent to the KFHP Board. A Board member reports to the entire KFHP Board on "next steps" for issues identified as a result of the letters.

Member Satisfaction

Measuring how well KFHP meets or exceeds members' expectations is a critical activity for quality assessment and improvement. Member Satisfaction is measured through a variety of sources. These include:

- CAHPS
- Complaint, grievance, and appeal data
- Member Experience Tracking Evaluation and Opinion Research (METEOR) Survey
- Care Experience Management (CareXM) Survey
- Home health survey
- Skilled nursing facility survey

To assess member satisfaction, a comprehensive analysis of data is conducted quarterly, semi-annually, and annually at service area and regional levels. These data are analyzed and translated into specific trends which are used to provide relevant member feedback for services delivered at every level in the organization. Corrective action plans are requested for outliers, and opportunities for improvement at regional and service area levels are identified. Based on these reviews, recommendations for performance improvement are provided to Member Concerns Committee (MCC). Based on MCC recommendations, Executive Leadership sets strategic organizational priorities and identifies focus areas for performance improvement strategy development.

Consumer Assessment of Healthcare Providers Systems (CAHPS)

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

Oversight of Member Complaint/Grievance/Appeal Data

Member complaints, grievances and appeals, and their outcomes are recorded and tracked. The Member Concerns Committee (MCC) identifies trends and opportunities for improvement and makes recommendations regarding potential systemic quality issues, assists in setting priorities, and analyzes aggregate data at least annually. Complaints, grievances and appeals that raise quality-related issues are referred directly to the facility for tracking and for follow-up on peer review issues. To help ensure oversight of the member grievance process, periodic reports from the MCC are submitted to the QOC. Additional oversight occurs when a member's complaint is a component of KFHP's credentialing process. Specifically, Member complaints are reviewed when deciding whether to re-credential a practitioner.

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Member Rights and Responsibilities

Members are informed about access to services and benefits through their Evidence of Coverage (EOC). The EOC is made available at the time of enrollment. Members may request a copy of the EOC through the Member Service Contact Center, through the Local Member Services departments typically located on the KP Medical Center campuses, or through the member's employer group. Also, members are notified annually through the Annual Notice on how to obtain a copy of their EOC. Marketing materials to members are evaluated through satisfaction surveys.

Member Rights and Responsibilities are distributed to members upon enrollment, as part of their New Member Packet, and annually in the Member Resource Guide. Members may also access them on kp.org or request a copy by contacting the MSCC. The Member Resource Guide describes the organization's commitment to the member's rights and responsibilities. Members may make recommendations regarding the policies. In addition, members receive information regarding KFHP's Notice of Privacy Practices which fully comply with state and federal law requirements.

Continuity and Coordination of Care

Coordination of Care

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

Coordination of Care for Medi-Cal Managed Care Enrollees

Eligibility for Continuity of Care (also known as Completion of Covered Services) is determined in accordance with California Department of Health Care Services (DHCS) guidance and described in the Plan's Completion of Covered Services Policy and Procedure (P&P). New Medi-Cal enrollees of KFHP undergoing active treatment may be eligible to continue to receive that care from their current provider even if the provider is not in the Plan's provider network, upon request and where certain requirements are met. In other circumstances, a health service that was previously only offered outside of Medi-Cal Managed Care must later be covered by Medi-Cal Managed Care Plans (MCP). Eligible enrollees are typically able to continue to receive the eligible treatment from their pre-existing, out-of-network provider for up to 12 months following enrollment with the Plan. In still other circumstances, specific to the 2024 Medi-Cal MCP Transition, transitioning enrollees are eligible for additional Continuity of Care protections.

New Enrollees and Non-Plan Practitioners. Practitioner Terminations, Retirement and Change in Practice. Transition of Care When Benefits End

Pursuant to KFHP's Completion of Covered Services Policy and Procedure which addresses regulatory compliance for the Commercial, Medi-Cal, and Medicare lines of business, and its Medi-Cal Network Provider and Subcontractor Terminations and Changes in Availability or Location of Covered Services Policy and Procedures, KFHP provides timely written notification to members who are affected by the contract termination of their primary or specialty care physician/practitioner/medical group/hospital. KFHP complies with all regulatory requirements to notify Commercial members at least 60 days prior, and Marketplace, Medi-Cal, and Medicare members at least 30 days prior to a primary care practitioner, medical group or hospital contract termination, and for all lines of business at least 30 days prior to a specialty care practitioner's contract termination; and with other changes to providers' practices, such as a change in practice location or practice type. KFHP assists all members in transition from pediatric to adult

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care, as needed. Current enrollees who are pregnant or postpartum may continue treatment with their OB/GYN group practice.

Member Services and other staff may assist members in selecting a suitable replacement practitioner; members who do not select a new primary care practitioner are assigned one and notified of the assignment by mail. A member may change their primary care practitioner at any time for any reason.

New enrollees undergoing active treatment may continue to receive care from their current practitioner/medical group/hospital, upon request and subject to review according to the regulations governing their form of coverage as described in the *Completion of Covered Services Policy and Procedure*.

Organizational Providers (OPs)

OP contract language requires that OPs participate in KFHP's Quality Program and that there is open communication with the member and his/her treating practitioner and permits KFHP to have access to OP medical records where care provided to KFHP members is documented.

7. MEDICAL RECORDS, KP HEALTHCONNECT & ELECTRONIC MEDIA

Medical Records

KFHP requires that each KFHP hospital, TPMG physicians, and contracted providers maintain medical records in a manner that is current, detailed and organized and which permits effective and confidential patient care and quality review. KFHP ensures that policies and procedures are in place to monitor medical record keeping and requires that the policies and procedures be distributed to practice sites. Policies and procedures include the following information:

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

Kaiser Permanente HealthConnect™ Program Overview

KP HealthConnect is Kaiser Permanente's comprehensive health information system that includes one of the most advanced electronic medical records available. It securely connects people to their health care teams, their personal information, and the latest medical knowledge, leveraging the integrated approaches to health care available only at Kaiser Permanente.

KP HealthConnect:

- Helps make health care more convenient and efficient for patients by allowing them to get the right care, when they need it
- Facilitates communication between members and Kaiser Permanente professionals to help make getting well and staying healthy even more convenient
- Enhances patient safety
- Assists physicians, nurses, and staff in delivering care that improves our members' health and quality of life, strengthening communications between health care teams and patients, and enhancing the ability to practice personalized health care that is based on the best medical practices
- Gives physicians and health teams the full picture of a patient's history and medical condition by providing comprehensive information at the point of care

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- Helps providers to coordinate patient care at every step of the way—between the physician's office, the hospital, radiology, the laboratory, and the pharmacy
- Protects the privacy and security of our patients' health information
- KP Online: The website, kp.org, provides secure access to member-facing online tools that empower members to manage their health care and wellness. Our members have direct online access to their personal health information, allowing them to:
 - Send and receive secure emails to their doctors and health care teams
 - View key information from past office visits in after-visit summaries
 - Send non-urgent medication questions directly to a pharmacist, order prescription refills, sign up for medication refill reminders, and view our drug formulary
 - Schedule or cancel appointments and view upcoming appointments
 - Act for family members through proxy access
 - View lab test results, health care reminders, immunizations, ongoing health conditions, allergies, and prescriptions
 - View preventive care reminders and gaps in care with recommendations for action. Members are encouraged to take action by scheduling preventive screening tests and immunizations or talking to their doctors about plans that are right for their needs
 - View and receive publications (eNewsletters) and health information materials on prevention, chronic conditions, making care decisions, and much more
 - View physicians' home pages - these pages include physicians' biographic information and member education resources
- Personal Health Records: All members may access the “My Health Manager” tool on kp.org. This tool is a personal health record (PHR) that is populated by real-time clinical information from KP HealthConnect.
- Portable Electronic Record: The Northern California Region also offers members a portable electronic record, stored on a flash drive. The portable record includes summary information about a member's health and medical conditions. The data on the drive is encrypted and password-protected to safeguard privacy.
- Mobile Applications (‘Apps’): Members have the ability to download mobile apps for the Android and iOS platforms to access their kp.org accounts. These apps allow a secure view into personal health records and access to My Health Manager's health management tools, including the ability to:
 - View lab results
 - View diagnostic information
 - Email physicians
 - Order prescription refills
 - Receive timed alerts and references for needed preventive health screenings and immunizations
 - Receive appointment Sa
 - View appointment details
 - Manage upcoming primary care appointments with one-click cancellations
 - View locations, maps, and hours for our facilities

8. OTHER QUALITY PROGRAM DESCRIPTIONS

Attachment S: Risk Management and Patient Safety Program Description

Attachment T: Behavioral Health Care Program Description

Attachment U: Equity, Inclusion, and Diversity Program Description

Attachment V: Culturally and Linguistically Appropriate Services (CLAS) Program Description

Attachment W: Skilled Nursing Facility and Long-Term Care Quality Program Description

Attachment X: TPMG Equity, Inclusion, and Diversity Program Description

9. ATTACHMENTS

Kaiser Foundation Hospitals and Health Plan Boards of Directors

Gregory A. Adams

Ramón Baez

David J. Barger

Regina M. Benjamin, MD, MBA

Jeffrey E. Epstein

Leslie S. Heisz

David F. Hoffmeister

Judith A. Johansen, JD

Jenny J. Ming

Matthew T. Ryan

Richard P. Shannon, MD

Vivek Sharma

A. Eugene Washington, MD, MPH

Northern California Leaders

Carrie Owen Plietz, FACHE

President, Kaiser Foundation Health Plan, Inc. and Hospitals, Kaiser Permanente Northern California

Maria Ansari, MD, FACS

CEO and Executive Director, The Permanente Medical Group

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 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.

Key Northern California Departments/Programs Participating in the Quality Program

Safety, Quality and Regulatory Services

Northern California’s Safety, Quality and Regulatory Services department works in partnership with regional and medical center leadership to support programs related to the quality, clinical initiatives, risk management, patient safety, licensing, accreditation, and regulatory agency compliance programs throughout the Northern California region. The department is responsible for continuous performance assessments that keep Region and facility operations continuously prepared for accreditation, regulatory, certification, and licensing surveys. The department oversees core health plan quality programs including, but not limited to, credentialing, peer review, and departmental quality review.

As an integral part of the organization's Quality Program, the Health Plan Risk Management and Patient Safety Program exists to ensure that Kaiser Permanente is providing person and family-centered care that is reliable, effective, consistent, and safe. The Regional Health Plan Risk Management and Patient Safety Department leads the program.

Enterprise Regulatory Services

For Northern and Southern California Regions, Enterprise Regulatory Services (ERS) is Kaiser Foundation Health Plan's (KFHP's) primary liaison to the Department of Managed Health Care (DMHC). In addition, ERS collaborates with Medi-Cal Policy and Medi-Cal Compliance on State Programs topics where DMHC oversight overlaps with that of the Department of Health Care Services (DHCS). ERS's responsibilities include:

- Policy development and implementation oversight in the legislative, regulatory, and benefit areas for commercial products
- Advocacy on behalf of KFHP and KPIC with DMHC
- Overall management responsibility for KFHP’s Knox-Keene license, including compliance with applicable statutes and regulations
- Regulatory submissions to DMHC
- Responses to inquiries from DMHC Help Center related to member complaints
- Preparation of KFHP position statement and case file information to support Independent Medical Review (IMR)

TPMG Consulting Services

TPMG Consulting Services provides operational performance improvement expertise to enable sustained excellence in quality, service, and reputation. Our work is guided directly by executive sponsorship. This sponsorship enables TPMG Consulting Services to contribute to those leadership initiatives targeted at delivering exceptional service and quality care, making our members and communities healthier, long-living, and more productive.

TPMG Consulting Services

Consulting	➤ Develop playbooks and toolkits to support facility implementation of operational and clinical best practices ➤ Leverage KP HealthConnect tools and technology to drive consistent, successful performance ➤ Work with physician leaders and peer groups to review performance metrics, benchmark medical center performance, and share successful practices ➤ Provide project management and consulting support to region-wide performance improvement initiatives
Information and Analysis	➤ Use data to inform decision making by regional and facility leaders ➤ Provide reports that identify performance gaps and opportunities for operational improvement ➤ Produce and interpret reports to support performance improvement ➤ Create and maintain data repositories and related applications supporting specified initiatives

2024 KPNC Key Departments, Resources and Analytical Support

Credentialing	➤ Provide credentialing and recredentialing services for practitioners on behalf of Kaiser Foundation Hospitals and Health Plan (KFH/HP) ➤ Explore, recommend, deploy, and support new credentialing and privileging (CP) technologies ➤ Produce and interpret reports to support regulatory requirements and performance improvement ➤ Work with C&P leaders on implementing region-wide credentialing strategies and operational changes

Regional Compliance, Ethics & Integrity Office (RCO) and Health Plan Compliance

Kaiser Foundation Hospitals and Health Plan (KFH/HP) hereby sets forth a Charter for its Ethics and Compliance Program. KFH/HP’s adherence to the provisions of the Charter is intended to establish the standards by which KFH/HP will operate its Ethics and Compliance Program in service to its mission to provide high quality, affordable healthcare services and to improve the health of our members and the communities we serve. The Charter shall apply to any facility, health plan, or business in which KFH/HP owns a significant interest or for which KFH/HP manages the day-to-day operations of the facility, health plan, or business.

Through collaboration with The Permanente Medical Group and the Market Compliance Officers the Ethics and Compliance Department shall focus its efforts on overseeing and supporting compliance in the following key areas: (1) fraud, waste, and abuse; (2) privacy and security of protected health information; (3) member, patient, and student rights; (4) regulatory requirements impacting care delivery; (5) regulatory requirements impacting human subject research (6) regulatory requirements impacting the operation of our health plan products, particularly government programs; (7) documentation, coding, charging and billing; and (8) adherence to the organization’s compliance policies and code of conduct.

NCO will:

- Ensure there is an effective compliance infrastructure implemented within operations
- Assess and prioritize risks, including the development and deployment of remediation activities within operations, compliance, and other risk management units in support of risk mitigation. Develop reports and metrics to support risk identification and management activities
- Ensure timely awareness and analysis of federal and state regulatory requirements including:
 - implementation support, assessment and monitoring of compliance requirements, and on-going evaluation of how these laws relate to business processes, systems, key controls, and performance metrics
- Provide support for federal and state regulatory audits to determine operational readiness, review audit findings, support preparation and implementation of corrective action plans. Evaluate internal and external audit findings, as well as other data, to identify trends and make recommendations for process improvement
- Establish effective metrics/monitoring standards to evaluate LOB compliance
- Manage compliance governance committees which provide oversight and drive the change necessary to mitigate compliance risk in the health plan organization
- Conduct compliance investigations as necessary

Division of Research

The Division of Research transforms health through research and by finding the best ways to deliver health care for Kaiser Permanente members and society. Founded in 1961, it conducts, publishes, and disseminates high-quality epidemiologic, interventional, and health services research with the large, diverse population of Kaiser Permanente Northern California. Areas of recent development include health care delivery science, clinical trials, genomic and environmental research, and predictive analytics using augmented intelligence. DOR has more than 60 faculty-level research scientists and >600 staff members and its work is sponsored by NIH and other external funders as well as TPMG and KFH. DOR is committed to providing a supportive research environment that fosters independent

thinking, creativity, continued learning, equity, inclusion, and diversity, and adherence to the highest scientific standards.

Hospital, Continuing Care Services, and The Permanente Medical Group (TPMG)

Hospital, Continuing Care Services, and TPMG representatives partner with KFHP & KFHP Senior Leadership in an effort to provide a seamless system of care to members as they navigate through key settings including emergency department, hospital, skilled nursing facility, acute rehabilitation, home health and hospice. In addition, this team provides leadership and partnership in areas that include palliative care, life care planning, durable medical equipment, medical transportation, resource management and care management/coordination functions across the continuum. The system of care is overseen and monitored by the Kaiser Permanente Northern California (KPNC) Resource Stewardship (RS) Program which continuously reviews the quality of care, utilization of services and facilities to promote the delivery of high quality, affordable health care to all Kaiser Permanente members.

Evaluation of New Technology

Kaiser Permanente has an established, rigorous process for evidence-based health care technology assessment. In Northern California, TPMG New Medical Technology addresses technology inquiries from TPMG physicians and Health Plan administrators with syntheses of pertinent scientific evidence and TPMG clinical expert opinion on the safety and effectiveness of different treatments and tests. Northern California also participates in the Interregional New Technologies Committee for timely and objective evaluations of new technologies to help practitioners Program-wide make informed health care technology choices. TPMG clinical leaders decide which new technologies to integrate into their practice. As necessary, California's Benefit, Contract, and Policy Committee reviews these decisions for their impact on Health Plan benefits.

Member Relations

Health Plan Member Relations primary role in KFHP is "Creating and Realizing Excellent Service" (CARES) for our Members. Member Relations is a California Statewide Department. The Member Services Operating Model includes the handling of member inquiries, complaints, grievances and appeals through five primary customer service channels: Member Service Contact Centers (MSCC), Local Member Services (LMS) at Kaiser Permanente Medical Centers and Medical Office Buildings, Member Case Resolution Centers (MCRCs), the Expedited Review Unit (ERU) and the Part D Unit (PDU).

- > **Contact Centers** – Contact Center Customer Service Representatives (CSRs) assist members with a variety of questions related to Kaiser Foundation Health Plan, Inc., including assistance with benefits interpretation, enrollment and eligibility questions, claims status, facility locations and information, demographic updates, ID card and literature requests, and [KP.org](https://www.kp.org) web support. In addition, CSRs assist members with the intake of complaints, grievances and appeals. Once a case is documented, it is reviewed and downloaded to the applicable Member Services Unit for processing.
- > **Local Member Services (LMS) at Kaiser Permanente Medical Centers (MC) and Medical Office Buildings (MOB)** – LMS is focused on addressing members and patients who present at the MC or MOB with inquiries, requests for assistance, complaints, grievances and/or appeals. LMS also process member cases downloaded from the Contact Centers that can be resolved by the End of Next Business Day ("ENB Cases"). Complaints and grievances that cannot be resolved by ENB are transferred to the MCRC, ERU, or PDU for further investigation and resolution. In addition, LMS actively partners with Medical Center Leadership and Administration and Regional stakeholders to resolve member issues at the point-of-service, and to enhance the members overall experience using Member Services' "Voice of the Member" monthly data reports.
- > **Member Case Resolution Centers** – MCRC Case Managers process complaints, grievances and appeals that cannot be resolved at the Medical Centers. Processing the case includes investigation, documentation, review and closure.
- > **Expedited Review Unit (ERU)** – ERU Case Managers receive and process urgent grievances and appeals that must be resolved within 24, and up to 72 hours
- > **Part D Unit (PDU)** – PDU Sr. Consultants/Case Coordinators receive and process Medicare Part D complaints, grievances and appeals that cannot be resolved at the Medical Centers.

Medicare Compliance

Medicare Compliance is responsible for developing and implementing a program that promotes the efficient monitoring of compliance with all applicable Medicare health plan requirements, including but not limited to regulations around the following KFHP functions:

- Enrollment and Disenrollment
- Sales and Marketing
- Benefits and Beneficiary Protections
- Provider Contracts
- Credentialing
- Claims
- Organization Determinations, Appeals, and Grievances
- Ineligible Providers and Entities Identification and Reporting

Medicare Compliance is also accountable to:

- Maintain relationship and interactions with Centers for Medicare & Medicaid Services (CMS) Account Management team
- Interpret and provide guidance on Medicare health plan regulations for operations
- Coordinate CMS health plan audits

Medi-Cal & State Sponsored Programs Departments

The Medi-Cal Line of Business operates statewide and sets Medi-Cal strategic direction, focuses on economically sustainable growth, fosters strong relationships with state regulators and stakeholders, and manages Medi-Cal and state sponsored program contracts, ensuring full implementation and technical support.

The Medi-Cal Care Delivery and Operations Department operates statewide and leads, manages and coordinates all aspects of Kaiser Permanente's Medi-Cal health plan strategy, operations, care delivery and performance, ensuring a robust network of care for Medicaid members and oversight of plan access, quality, compliance, and financial performance.

Program Office Legal Department (Public and Professional Liability Claims)

The Public and Professional Liability Section (Program Office Legal Department) is staffed by attorneys and Claims Examiners who are responsible for managing general and professional liability claims. Case information is shared with the Health Plan Risk Management department to identify patterns, trends, and opportunities for improvement. Attorneys who work in the Professional Liability Section provide consultation regarding risk management issues, healthcare law and litigation. Attorneys and Claims Examiners may also provide education regarding claims management, potential areas of risk and opportunities for improvement.

KP Insight

KP Insight provides a variety of reporting and analytical services to the communities that KP serves through the decision support standard reporting platform which comprises of dashboards, standard report libraries and self-service utilities. In addition, KP Insight also provides analytic products for key regional and program office strategic priorities. Major areas of KP Insight focus include:

- Quality Regulatory Reporting
- Accreditation Reporting
- Capital Planning
- Business Line Reporting
- Performance Reporting
- Financial Regulatory Reporting
- Community Benefit Reporting
- Financial Reporting
- Utilization Reporting
- Functional Affordability Initiatives
- Health Delivery and Hospital/Continuum Operation Initiatives

Analytic support to processes such as:

2024 KPNC Key Departments, Resources and Analytical Support

- Strategic Planning Support
- External Benchmarking
- DRG Cost Analysis
- Budgeting & Forecasting, Modeling, Targets
- Rate Setting Support
- Program Office Support
- Research Projects
- Enabling other National and Regional Teams

Health Engagement Consulting Services (formerly Regional Health Education) Department

Health Engagement Consulting Services is a consulting and content management department that supports the strategy to gain and retain the trust of our patients and to support our physicians and other clinicians. The department consultants have a special expertise in behavior change and build tools and resources intended to empower patients in taking care of their own help, and training clinicians to help patients find motivation for healthy changes. Working in partnership with other regional departments and medical facility staff, Health Engagement Consulting Services builds and integrates into care innovative tools and services for members and clinicians to support members' self-care efforts and supports efficiency imperatives to reduce costs while maintaining quality, access and service. Health Engagement Consulting Services employs professionals with health communications backgrounds, social workers, nurses, health educators and others trained in communications, public health, nutrition, health education and administration.

Regional Ethics Department

Recognizing that the practice of medicine leads to many morally complex issues, the Regional Ethics Department (RED) serves all of Kaiser Permanente, including KFH, KFHP and TPMG. The RED assists local medical center ethics committees with policy development, education and individualized patient ethics consultations that arise due to moral conflict or moral uncertainty as well as providing moral analysis and direction in regard to strategic regional initiatives for the entirety of Northern California.

KAISER PERMANENTE
KAISER PERMANENTE NORTHERN CALIFORNIA
QUALITY OVERSIGHT COMMITTEE
2024 CHARTER

MISSION

To provide market leading, publicly recognized quality.

PURPOSE

The purpose of the Kaiser Permanente Northern California (KPNC) Quality Oversight Committee (QOC) is to

- evaluate the quality of care and services provided to Kaiser Permanente members and patients in Northern California in all settings,
- support continuous improvement in these areas,
- establish Quality Program direction by identifying and addressing strategic opportunities to establish and maintain KPNC healthcare leadership,
- ensure that the quality priorities are aligned and integrated with other key organizational strategic priority areas of work, and
- ensure that the organization meets the standards established by regulatory agencies and accreditation organizations and meets public expectations.

AUTHORITY AND SCOPE

The QOC has authority to speak and act on behalf of Kaiser Foundation Hospitals (KFH), Kaiser Foundation Health Plan (KFHP), and The Permanente Medical Group (TPMG) senior leadership on quality improvement issues including, but not limited to, the following:

- ❑ Responsible for oversight of the Kaiser Permanente Quality Measures (KPQM), which include Clinical Effectiveness, Clinical Risk Management, Safety, Service, and Resource Stewardship metrics.
- ❑ 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 Quality and Health Improvement Committee (QHIC) and the Kaiser Permanente 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 1) the Regional President/TPMG Executive Director and the Medical Centers; 2) the entities that make up Kaiser Permanente in Northern California and the QHIC and KPNQC.
- ❑ Determines accountability and ensures quality issues are investigated and resolved.
- ❑ Serves as the final decision-making body on impasse issues and policy decisions.
- ❑ Commits the organization to action and monitors progress relative to the action plan.
- ❑ Sets quality strategy in alignment with KPNC Strategic Priorities, Mission & Vision, and directions from the Boards of Directors.
- ❑ Recommends action based on reviews of regional quality reports (crossing quality chasm, access, member/patient satisfaction, complaints/grievances, sentinel/significant events, EMTALA [Emergency Medical Treatment and Labor Act] compliance, etc.) identifying region-wide trends, outliers, and quality issues.
- ❑ Approves KFHP, KFH submissions to QHIC.
- ❑ Approves Hospital Quality Improvement & Patient Safety plans, work plans, and annual evaluations and provides feedback and follow-up as appropriate.
- ❑ Recommends action based on reviews of quality performance of affiliated providers and alliances.
- ❑ Provides oversight, coordination of activities and functions, and communication to and from the QOC Subcommittees.

REPORTING STRUCTURE

The Quality Oversight Committee reports its activities and functions to the Kaiser Foundation Health Plan and Hospitals, Inc., Boards of Directors. The Quality Oversight Committee provides oversight, coordination of activities and functions, and communication to and from the QOC Subcommittees: Regional/Sub-Regional Services Committee (RSR), the Regional Credentials and Privileges Committee (RCPC); the Member Concerns Committee (MCC); the Resource Management Committee (RMC), the Risk Management/Patient Safety Committee (RMPSC); the Access Committee; the Behavioral Health Quality Oversight Committee (BHQOC); the Medi-Cal Quality Improvement Health Equity Committee (QIHEC), and the Regional Infection Control Committee (RICC) for issues that have quality implications. The reporting structure is diagrammed in the KPNC Key Quality Reporting Relationships flowchart. Sub-committee reports are submitted on a quarterly and ad-hoc basis.

MEETING PROCESS

The Quality Oversight Committee will meet monthly, for no less than ten months of the year. Membership includes representatives from KFH, KFHP, and TPMG and a quorum is a simple majority of the members. Co-chair leadership is shared with at least one co-chair from KFHP. QOC actions and decisions are documented in contemporaneous minutes of the meeting proceedings.

CONFIDENTIALITY

Participation in QOC 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 QOC. Members of the QOC 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 QOC activities.
3. Notify the QOC 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.

QOC MEMBERSHIP

Sponsors:

Executive Director and CEO, The Permanente Medical Group
President, Northern California Region, Kaiser Foundation Health Plan & Hospitals

QOC Chairs:

TPMG Associate Executive Director for Quality
KFH/P Vice President of Safety, Quality, and Regulatory Services

QOC Members:

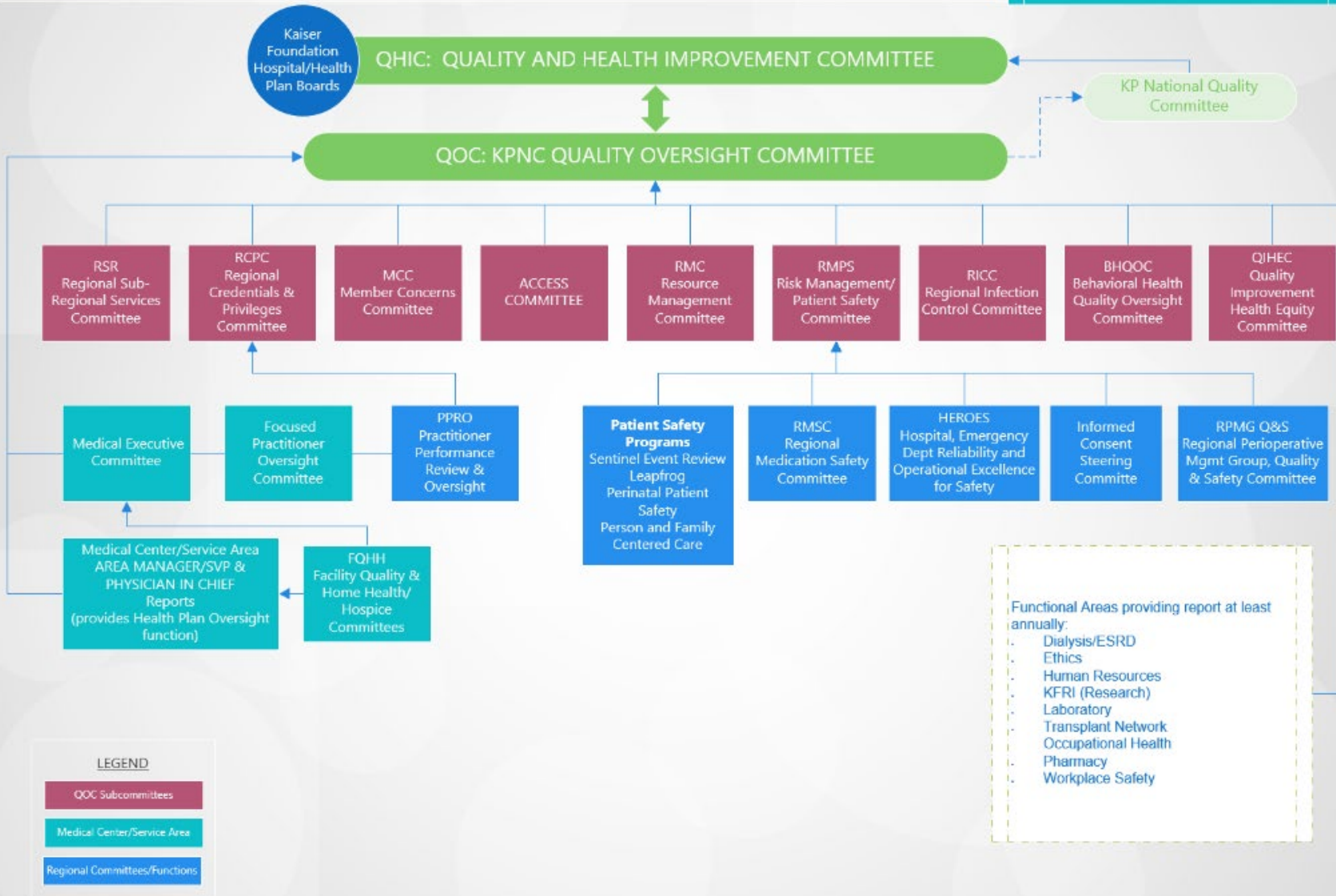
- KFH/P Area Safety and Quality Officer
- TPMG Associate Executive Director for Hospital Operations
- TPMG Associate Executive Director for Maternal Child Health
- TPMG Associate Chair of Psychiatry for Behavioral Health
- KFH/P Vice President, Chief Nursing Executive, & Clinical Integration
- TPMG Chief of Quality
- KFH/P Vice President Pharmacy Operations and Services
- KFH/P Health Plan Physician Advisor
- TPMG Medical Director for Accreditation, Regulatory, and Utilization Management Compliance
- TPMG Physician-in-Chief (PIC)
- TPMG PIC Liaison for Quality
- KFH/P Regional Compliance & Privacy Officer
- KFH/P Senior Vice President/Area Manager
- KFH/P Senior Vice President, Clinical Services
- KFH/P Senior Vice President, Hospital and Health Plan Area Operations
- TPMG BOD (Board of Directors) Representative
- TPMG Medical Director of Risk and Patient Safety
- TPMG Medical Director of Outpatient Quality
- KFH/P Vice President, Continuum of Care
- KFH/P Vice President, Health Plan Regulatory Services
- KFH/P Senior Vice President, Hospital and Health Plan Area Operations
- TPMG Regional Interim Leader for Hospital Operations, Hospital Quality and Continuing Care

QOC Non-Voting Staff:

- KFH/P Executive Director Quality and Regulatory Services
- KFH/P Executive Director Risk & Patient Safety
- KFH/P Senior Director, Accreditation, Regulatory, and Licensing
- KFH/P Chief Operating Officer, Pharmacy Operations & Service
- TPMG Associate Executive Director for Care Experience
- KFH/P Vice President, Consumer Experience

KP-NCAL Regional Quality Oversight Structure

November 2023





KAISER PERMANENTE NORTHERN CALIFORNIA

ACCESS COMMITTEE 2023 CHARTER

PURPOSE

The Access Committee, Kaiser Permanente Northern California (KPNC), is a subcommittee of the Northern California Quality Oversight Committee (QOC). Its function is to oversee the adherence to Health Plan and regulatory body requirements around timely access and wait times for appointments, and to proactively address areas at risk for not meeting these requirements. Kaiser Foundation Health Plan is ultimately accountable for ensuring members are being seen in a timely manner.

AUTHORITY AND SCOPE

The Access Committee assures systematic monitoring of access to care and services. Monitoring includes, but may not be limited to, ensuring appointment availability for primary care, specialty care, and imaging noted to be below the threshold for review for initiate-to-seen appointments is addressed through corrective action plans and communicated to both Medical Center KFHP (Kaiser Foundation Hospital/Health Plan) and TPMG (The Permanente Medical Group) leadership. Other areas for review may include such reports as geo-access requirements, practitioner availability reports, mental health follow up appointments, member access to care complaints, and ad hoc reports from other committees, etc. Membership will include representation by both KFHP and TPMG regional leadership.

REPORTING STRUCTURE

- The Access Committee is a subcommittee of the QOC and will report appropriate activities and issues to that committee on a quarterly basis. It will request and review action plans on behalf of the QOC and escalate concerns and report resolution of corrective action plans to the QOC.
- The Access Committee maintains ongoing reporting and communication with the local KPNC medical center departments, committees, and/or leaders responsible for oversight of access to care.
- KFHP Vice President of Safety, Quality, & Regulatory Services and TPMG Associate Executive Director for Quality are committee sponsors.

ROLES & RESPONSIBILITIES

1. Understand requirements set forth by regulatory and accrediting organizations.
2. Standardize definitions of metrics used to determine whether access standards are being met.
3. Review access data to identify and understand trends, distributions and outliers in wait times at the regional, medical center, and department levels. Such data includes, (a) components related to the Annual MY (Measurement Year) Access DMHC (Department of Managed Health Care) filing, which looks at the following measurement categories: Provider Survey; Access Complaints; and the Provider Appointment Availability Survey (PAAS) (b) KP's internal measurements of the percentage of appointments that are actually scheduled within the time elapsed standards set forth in the DMHC's timely access regulation.
4. Understand our current systems and processes to determine whether unintended consequences of the system currently exist or have the potential to develop.
5. Oversee the development and implementation of corrective action plans to address gaps in access and ensure business continuity plans have been developed/adhered to.
6. Oversee the coordination and response to regulatory surveys related to access.
7. Escalate concerns and report resolution of corrective action plans to the QOC.

MEETING PROCESS

The committee will meet monthly, for no less than ten months of the year. Membership includes representatives from KFH, KFHP, and TPMG, with a quorum being a simple majority of the members. Co-chair leadership is shared with at least one co-chair from KFHP and one from TPMG. Actions and decisions of the Access Committee are documented in contemporaneous minutes of the meeting proceedings.

ANNUAL EVALUATION

The committee will perform an annual evaluation against goals established and use this evaluation as a basis for future goal setting. 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 either, or both, the Committee Chair or Co-Chair in the event any person or entity seeks to compel disclosure of privileged information
- Not create or retain any copies or reproductions of discussions or information except as required for participation

MEMBERSHIP

Co-Chairs

- KFH/P Vice President, Safety, Quality, & Regulatory Services
- TPMG Associate Executive Director for Quality & Regulatory Services

Voting Members:

- TPMG Associate Executive Director for Mental Health
- TPMG Associate Executive Director for Primary Care
- TPMG Associate Executive Director for Specialty Care
- TPMG Associate Executive Director for Specialty Care
- KFH/P Director, Health Plan Regulatory Services
- KFH/P Executive Director, Quality & Regulatory Services
- TPMG Co-Regional Director Specialty Access
- KFH/P Vice President, Clinical Services
- KFH/P Senior Counsel
- KFH/P Vice President, Behavioral Health & Specialty Services

Non-Voting Members:

- KFH/HP Executive Director, Market Delivery Clinical Technology
- KFH/P Managing Director, Regional Hospital & Health Plan Quality
- Senior Manager for Regulatory and Accreditation Compliance, TPMG Consulting Service
- TPMG Regional Director of Mental Health Services
- TPMG Physician Chair Radiology

- A quorum consists of at least 7 members, including one physician.
- All members have the authority to vote and voting is ruled by consensus.
- If at any time between meetings, urgent business is needed, effort will be made to communicate with all members.

Quorum

- A quorum consists of at least 7 members, including one physician.
- All members have the authority to vote and voting is ruled by consensus.
- If at any time between meetings, urgent business is needed, effort will be made to communicate with all members.

NCAL Member Concerns Committee

2024 Charter

Purpose:

The Member Concerns Committee (MCC) is a Northern California Regional Quality Oversight Committee (QOC) subcommittee. The purpose of the MCC is to provide oversight of member satisfaction processes across the continuum of care. The MCC does this through the review of:

- Regional and statewide reports from departments with a role in patient/member satisfaction work
- Complaints and grievances data
- Regulatory, accreditation, and member satisfaction surveys
- Medical center reports

Authority & Scope:

The MCC is sponsored by the KFH/HP Vice President of Safety, Quality, and Regulatory Services and the TPMG Associate Executive Director for Quality.

The Committee has authority for the following:

- Reviewing volume, type, and outcome of all business lines' member complaints/grievances for all business lines.
- Reviewing facility-specific member complaints, grievance, and appeal data and performance improvement plans.
- Recommending the development of action plans for improvement, where appropriate.
- Communicating findings, conclusions, and recommendations to appropriate leadership and stakeholder groups.
- Escalation, as necessary, to senior leaders and the QOC.

Strategic Execution:

- Advise the development of action plans for improvement based on data trends.
- Develop an accountability plan for follow-up action plans.
- Communicate findings, conclusions, and recommendations to appropriate leadership and stakeholder groups.

Reporting Structure:

The MCC reports outcomes and analysis of oversight activities quarterly to the QOC. When issues arise beyond the scope of the MCC or the MCC cannot resolve concerns, they are elevated to the QOC and/or their leadership.

Meeting Cadence:

The MCC shall meet at least six times per year, with the requirement to convene a meeting in each quarter of the year.

Meeting Structure:

MCC membership includes representatives from KFH, KFHP, and TPMG leadership. The MCC has designated its quorum as a simple majority of voting members. Voting by email is permitted for actions on issues previously discussed at a live meeting conducted in person, by telephone or video conference. An electronic 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 email vote will include the names, approval date, decision date, and shall be entered into the following regular meeting's record.

Key responsibilities of members include:

- Provide input and guidance on committee activities including identification, prioritization and follow-up on issues.
- Act as a liaison between the committee and the groups you represent.
- Read and be familiar with the committee Charter and responsibilities.
- Review meeting materials in advance.

NCAL 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 accessible and candid communication necessary to fulfill the activities and functions of the MCC. Members of the MCC 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 MCC activities.
- Notify the MCC chairs if 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 and/or mandated regulatory reporting.

Membership

Chairs

- KFH/HP Executive Director, Member Relations
- TPMG Regional Director, Chief Experience Officer
- KFH/HP Vice President, Northern California Consumer Experience

Voting Members

- KFH/HP Area Safety and Quality Officer
- KFH/HP Executive Director, Member Relations Grievance Operations
- KFH/HP Senior Director, Enterprise Regulatory Services, Regulatory Investigation & Response
- KFH/HP Executive Director, Member Services, Co-Chair
- KFH/HP Executive Director, Quality and Regulatory Services
- KFH/HP Data Reporting and Analytics Consultant, Member Services
- TPMG Physician Advisor
- KFH/HP Senior Director, Quality and Safety Oversight
- KFH/HP Senior Director, Accreditation, Regulatory, and Licensing
- TPMG Medical Director, Accreditation, Regulatory, And Utilization Management
- TPMG Regional Director, Chief Experience Officer
- TPMG Representative, Chief of Quality
- KFH/HP Representative, Medical Center Member Services Leader
- KFH/HP Vice President, Northern California Consumer Experience
- KFH/HP Vice President, Member Relations
- KFH/HP Area Director, Local Member Services

Non-Voting / Ad hoc

- KFH/HP Director, Legal, Regulatory & Compliance Intelligence
- KFH/HP Senior Director, Compliance
- TPMG Manager, Medicare Compliance
- TPMG Director, Managerial Consulting
- KFH/HP Senior Director, Program Management Strategy Execution
- KFH/HP Senior Consultant, NCAL Local Member Services



**KAISER FOUNDATION HEALTH PLAN, INC.
NORTHERN CALIFORNIA REGION**

**REGIONAL CREDENTIALS AND PRIVILEGES COMMITTEE
CHARTER**

1. PURPOSE

The Regional Credentials and Privileges Committee (RCPC) is a peer review subcommittee of the Northern California Region's Quality Oversight Committee (QOC), a Kaiser Foundation Health Plan, Inc. (KFHP) peer review committee. The purpose of the RCPC is to: (1) make credentialing decisions on behalf of KFHP in its Northern California Region concerning practitioners and organizational providers; (2) implement and oversee KFHP credentialing policies, procedures, and processes; (3) promote uniformity and consistency in the application of credentialing policies, procedures, and processes; and (4) oversee the Practitioner Performance Review and Oversight (PPRO) program.

2. AUTHORITY AND SCOPE

2.1 The functions of the RCPC will include, but are not limited to:

- 2.1.1 Assuring KFHP complies with legal, accreditation, and other requirements pertinent to activities within the scope of the RCPC
- 2.1.2 Reviewing and approving KFHP credentialing policies, procedures, and processes
- 2.1.3 Overseeing the Delegated Credentialing Program, which shall be reviewed each year
- 2.1.4 Overseeing the management, use, and content of credentialing, privileging, peer review, and databases
- 2.1.5 Making credentialing decisions and overseeing the credentialing decisions of other Credentials and Privileges Committees concerning practitioners and organizational providers made on behalf of KFHP, as applicable
- 2.1.6 Reporting to the QOC regularly its activities, issues, and recommendations
- 2.1.7 Designating workgroups to carry out activities within the scope of the RCPC, including the facilitation of new initiatives
- 2.1.8 Overseeing the functions of the Credentials Verification Service
- 2.1.9 Reviewing and approving, when required, the actions, decisions, and documentation, such as minutes, of the PPRO committee(s)

2.2 On a regular basis, the RCPC, as part of its oversight responsibility, will audit the credentialing actions of Kaiser Permanente medical center Credentials and Privileges Committees (committees) taken on behalf of KFHP to ensure compliance with the organizational policies and legal and accreditation requirements, as applicable. The RCPC will review the minutes of the committees, including a summary of the committees' decisions, and review the files of practitioners with sanctions, action plans, or medical malpractice experiences that exceed the threshold for review. As appropriate, the RCPC will provide consultation to the committees and/or their representatives on applications for Professional Staff membership and/or clinical privileges at hospitals and other sites of care operated by or under the subject to the authority of Kaiser Foundation Hospitals.

2.3 The Physician Co-Chair of the RCPC (or their designee) with the concurrence of the KFHP Co-Chair of the RCPC (or their designee) may approve on an expedited basis the applications of office-based practitioners and organizational providers if such applications meet all applicable criteria. The minutes of the next meeting of RCPC will reflect the Co Chairs' expedited review actions.

3. REPORTING STRUCTURE

The RCPC, as a peer review subcommittee of the QOC, regularly reports, as required, its activities, issues, and recommendations to the QOC. The RCPC maintains ongoing communication with medical center Credentials and Privileges Committees and Credentials & Privileges Committee chairpersons and staff involved in credentialing and privileging activities to ensure compliance with applicable organizational, legal, and accreditation requirements.

4. PRIORITIES AND GOALS

The RCPC will develop annual goals and a workplan for implementation of its goals.

5. MEETING PROCESS

The RCPC will meet monthly no less than ten (10) months of the year. A quorum is fifty (50) percent of the voting membership present either in person or electronically. The majority of the quorum shall be physicians. The RCPC minutes are contemporaneous.

6. ANNUAL EVALUATION

The RCPC will review and revise its charter annually. The RCPC will perform an annual evaluation against goals established and use this evaluation as a basis for future goal setting.

7. CONFIDENTIALITY

RCPC members, consultants, staff, and participants shall maintain the confidentiality of information designated by KFHP as confidential, such as RCPC records and proceedings and other quality assurance and peer review information.

8. MEMBERSHIP

Membership of the RCPC shall consist of physicians and non-physicians who represent Kaiser Foundation Health Plan, Inc. who have expertise pertinent to the purpose of the RCPC. The physician members are The Permanente Medical Group, Inc. (TPMG) physicians. The non-physician members are representatives of Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, and The Permanente Medical Group, Inc. RCPC membership is subject to approval by the QOC. The RCPC will be composed of physician members (at least 50%) and other non-physician members with expertise including, but not limited to, credentialing, privileging, quality assurance, risk management, outside contracting, accreditation, licensing, and medical/ legal affairs. The RCPC will be co-chaired by a KFHP representative and a TPMG physician.

Attachments:

- RCPC Membership Roster
- KFHP Credentialing and Privileging Policy 4, *Credentials and Privileges Committees*



**KAISER FOUNDATION HEALTH PLAN, INC.
NORTHERN CALIFORNIA REGION**

PRACTITIONER PERFORMANCE REVIEW AND OVERSIGHT (PPRO) COMMITTEE

2024 CHARTER

PURPOSE

The Practitioner Performance Review and Oversight (PPRO) Committee is a subcommittee of the Northern California Regional Credentials and Privileges Committee (RCPC), a Kaiser Foundation Health Plan Inc. (KFHP) peer review committee. Its function is to provide oversight of the practitioner performance review processes, including Peer Review, Department Review, and Focused Practitioner Review (FPR), designed to continually assess and improve the quality of care provided to KFHP members.

AUTHORITY AND SCOPE

The functions of the PPRO Committee will include, but are not limited to:

- The review and approval of the meeting records and charter of the Focused Practitioner Review Oversight Committee (FPROC) of each medical center in order to ensure adequacy, fairness, appropriateness and timeliness of PPRO process.
 - Communicate potential process issues to a medical center's FPROC.
- Review the aggregate reports and assessments of practitioner and department review and analyze variation against prioritized metrics with a goal of identifying potential sources of variation.
- Communicate identified issues of concern to medical centers.
- Monitor and evaluate effectiveness of process improvement.
- Escalate significant issues, trends, and variation to RCPC and the KFHP Quality Oversight Committee (QOC).
- Support compliance with policies & procedures and regulatory and accreditation standards related to practitioner performance review and department review.
- Provide input into the review and approval process of policies and procedures related to Licensed Independent Practitioner and Allied Health Professional Review processes.

REPORTING STRUCTURE

The PPRO Committee is a subcommittee of the RCPC and will regularly report appropriate activities and issues to that committee. The PPRO Committee maintains ongoing communication with the medical center departments and committees responsible for practitioner review and will provide feedback to the medical centers on their performance at least biannually. The Permanente Medical Group (TPMG) Associate Executive Director for Quality and KFHP Vice President of Quality, Clinical Effectiveness & Regulatory Services are PPRO Committee sponsors.

MEETING PROCESS

The PPRO Committee will meet monthly, for no less than ten months of the year. A quorum is a simple majority of the members, with a minimum of two physicians and one KFHP representative. For urgent issues requiring action by the committee between scheduled meetings, voting may occur by electronic vote. A quorum must participate, and any single dissenting vote shall nullify the action. Documentation of the electronic vote will be contained in the following scheduled meeting minutes. The PPRO minutes are documented contemporaneously.

ANNUAL EVALUATION

The PPRO Committee will annually review its charter and revise as needed.

CONFIDENTIALITY

PPRO Committee members, consultants, staff and participants shall maintain the confidentiality of information designated by KFHP as confidential and/or privileged, such as quality assurance and peer review information, which includes PPRO Committee records, proceedings and findings.

MEMBERSHIP

Membership shall consist of physicians and non-physicians representing KFHP and TPMG recommended by the RCPC and approved by the QOC. The PPRO Committee will be composed of physician members (at least 50%) and other non-physician members with expertise that includes, but is not limited to, credentialing, privileging, quality, risk management, accreditation, licensing and medical legal. The PPRO Committee will be co-chaired by a KFHP representative and a TPMG physician.



**KAISER FOUNDATION HEALTH PLAN, INC.
NORTHERN CALIFORNIA REGION
FOCUSED PRACTITIONER REVIEW OVERSIGHT COMMITTEE
(Insert Medical Center or Service Area Name)**

2024 CHARTER

PURPOSE

The Focused Practitioner Review Oversight Committee (FPROC) of Kaiser Foundation Health Plan, Inc.- **(insert Service Area Name)** ("KFHP") and Kaiser Foundation Hospital (KFH) - **(insert Medical Center Name)** ("KFH Professional Staff"), is a peer review committee of both the KFHP Professional Staff and KFHP. The FPROC is a subcommittee of the KFHP Regional Practitioner Performance Review & Oversight (PPRO) Committee, which is accountable to the KFHP Regional Credentials and Privileges Committee (RCPC). The purpose of the FPROC is to oversee the focused review process for Licensed Independent Practitioners (LIPs) and Allied Health Professionals (AHPs).

AUTHORITY AND SCOPE

The functions of the FPROC include, but are not limited to:

- Overseeing focused reviews of LIPs and AHPs who are credentialed by KFHP and/or privileged by the KFHP Professional Staff
- Assuring compliance with the policies for Peer Review and Evaluation of Licensed Independent Practitioner Performance or Quality and System Review for Allied Health Professionals, and related policies and procedures and other requirements related to the focused practitioner review (FPR) process
- Reviewing considerations for FPR of LIPs and AHPs
 - Coordinating and cooperating with other medical centers or service areas in the region for practitioners under FPR consideration who are known to practice at other medical centers or services areas in the region
- Authorizing and documenting decisions to proceed or not to proceed with FPR including the rationale for such decisions of LIPs and AHPs
- Reviewing and documenting FPR design and results for LIPs and AHPs
- Overseeing, reviewing and documenting FPR practitioner improvement plan design and results for LIPs and AHPs
- Providing FPR findings to the KFHP and KFHP Professional Staff Credentials and Privileges Committee
- Providing referrals or recommendations to duly constituted peer review bodies and/or committees (such as the KFHP Professional Staff Executive Committee or the KFHP and KFHP Professional Staff Credentials and Privileges Committee) when such action is recommended by the FPROC or requested by a peer review body or committee or its designated representative(s)
- Performing or assisting in the performance of peer review functions on behalf of a duly constituted peer review body or committee such as focused practice evaluations on behalf of a KFHP or KFHP Professional Staff committee

REPORTING STRUCTURE

The FPROC reports to the Regional PPRO Committee. Decisions to proceed with an FPR, the FPR Results, and Closure of FPR PIPs, will be reported to the Credentials and Privileges Committee within 60 days of the action.

MEETING PROCESS

Membership includes representatives from Kaiser Foundation Hospitals/Health Plan (KFH/HP) and The Permanente Medical Group, Inc (TPMG). Membership may not be delegated to others. The committee will meet as necessary to discuss active cases, but no less than once annually. To establish a quorum, a KFH/HP member must be present, and a majority of the TPMG physician members must be present. Voting is by a simple majority.

Voting by email is permitted for actions on issues previously discussed at a live meeting conducted in person, by telephone or video conference. An electronic 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 email vote will include the names

of the voting members and the decision date, and shall be entered into the following regular meeting's record and noted on the relevant FPR worksheets. Should a regular meeting not be scheduled in the 30 days following the email vote, documentation of the email vote and any relevant FPR worksheets will be submitted to PPRO.

MINUTES

FPROC actions are documented in the FPROC Meeting Record. The FPROC meeting agenda, Meeting Record and worksheets for all practitioners discussed during the meeting will be completed by the FPROC chair and forwarded by the Quality Department to the PPRO Committee within 30 days of the FPROC meeting.

CONFIDENTIALITY

FPROC members, consultants, staff and participants shall maintain the confidentiality of information designated by KFHP as "confidential and/or privileged," including quality assurance and practitioner/peer review information, FPROC agendas, meeting records and FPR worksheets, as well as FPROC records, proceedings, and findings.

MEMBERS:

Voting members shall consist of the following senior area representatives:

- Area Manager & Senior Vice President
- Area Safety and Quality Officer
- Assistant/Associate Physician-in-Chief for Risk
- Chair of Credentials and Privileges Committee
- Chief of Quality (FPROC Chair)
- Medical Legal Chief
- Physician-in-Chief

CHARTER REVIEW

The FPROC will annually review and adopt the charter. The FPROC will notify PPRO within 30 days of charter adoption.



KAISER PERMANENTE NORTHERN CALIFORNIA
REGIONAL INFECTION CONTROL COMMITTEE
2024 CHARTER

PURPOSE

The Regional Infection Prevention and Control Committee (RICC), Kaiser Permanente Northern California, is a subcommittee of the Northern California Quality Oversight Committee (QOC). Its function is to provide oversight for the infection prevention and control initiatives and priorities identified in the Northern California Region.

AUTHORITY AND SCOPE

The Quality Oversight Committee has granted RICC its authority to direct both the regional and medical center entities to implement new, or change existing practices designed to enhance safety and reduce the risk of harm from infections/communicable diseases.

The scope of the committee is to increase safety and reduce harm from infections/communicable diseases associated with the delivery of health services in all settings of care including inpatient, ambulatory, contracted services, home health, Kaiser Permanente Post-Acute Care Center, and Kaiser Permanente Psychiatric Health Facility – Santa Clara.

REPORTING STRUCTURE

- The RICC is a subcommittee of the QOC and reports activities and issues to that committee on a quarterly basis.
- The RICC maintains ongoing communication with the local KPNC Infection Prevention and Control Departments, Infection Prevention and Control Committees, and leaders responsible for oversight of the KPNC infection prevention and control related initiatives and priorities.
- TPMG Associate Executive Director and KFHP Vice President of Quality and Regulatory Services are executive committee sponsors.
- TPMG and KFHP NCAL Regional Executive Director Risk Management and Patient Safety are operational committee sponsors.

ROLES & RESPONSIBILITIES

1. Develops strategy for NCAL Regional Infection Prevention Program.
2. Examines and analyzes local and regional infection prevention outcomes, including publicly, reported data.
3. Makes recommendations for improvement in infection prevention practices in response to performance metrics.
4. Facilitates standardization of infection prevention practices where appropriate.
5. Recommends and approves Infection Prevention policies and procedures for regional and medical center adoption.
6. Communicates directly with medical centers to execute QOC decisions and monitor performance improvement as directed by QOC.
7. Provides oversight for review and approves KPNC standardized Infection Prevention and Control related policies & procedures.
8. Elevates problematic issues and resolution directly to Executive Sponsors (e.g., need for patient notification after breaches in patient equipment disinfection or sterilization).
9. Oversees regulatory and accreditation activities related to infection prevention.

10. Analyzes management of remediation for sentinel events, significant events and exposure incidents related to infection prevention.
11. Review action plans submitted by Medical Centers to QHIC.
12. Guides and supports remediation of infection prevention issues identified by the KPNC Infection Prevention Peer Group, TPMG Infectious Disease Chiefs Group, and other interested parties.
13. Engages workgroups and/or individuals to explore infection prevention issues to provide the Committee with recommendations.

MEETING PROCESS

The committee will meet every month and based on annual evaluation, will determine continuing meeting frequency. Membership will include representatives from KFH/HP and TPMG (see membership below), and a quorum is a simple majority of the voting members (51%) with at least 1 of the co-chairs or designees in attendance. RICC actions and decisions are documented in contemporaneous minutes of the meeting proceedings.

ANNUAL EVALUATION

The committee will perform an annual evaluation of and review and revise as necessary its Charter and Membership.

CONFIDENTIALITY

Participation in RICC 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 RICC. Members of the RICC explicitly agree, as a condition of membership, to:

1. Respect and maintain the confidentiality of all data, discussions, and information.
2. Make no voluntary disclosures of discussions and information except to persons authorized to receive it in the conduct of RICC activities.
3. Notify the RICC 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 reproductions of discussions or information except as required for participation.
5. RICC members are expected to attend and participate in **at least 8 committee meetings** a year.
6. Attendance will be reviewed at the beginning and towards the end of the meeting.

MEMBERSHIP (Voting and Non-Voting Members) – Key committee membership responsibilities include:

1. Attend and actively participate in majority of meetings.
2. Provide input and guidance on committee activities, including identification, prioritization, and follow up on issues.
3. Act as a liaison between the committee and groups represented on the committee.
4. Read and be familiar with committee charter and responsibilities.
5. Review meeting materials in advance.

Voting Members:

1. Infectious Disease Physician appointed by TPMG Leadership
2. Regional Director, Infection Prevention & Control
3. Executive Director, Regional Risk Management/Patient Safety
4. TPMG Medical Director, Regional Risk Management & Patient Safety
5. Clinical Practice Consultants (variable), Regional Infection Prevention Program
6. Quality Nurse Consultant (1), Regional Infection Prevention Program
7. Pediatric Infection Prevention Physician Lead from Regional Infectious Disease Physicians
8. One Area Safety and Quality Officer
9. Two Medical Center Infection Prevention Program Managers
10. Two representatives from Regional Infectious Disease Physicians
11. One representative from Regional Patient Care Services
12. One representative from Regional Perioperative Services Director
13. One representative from Regional MCH
14. One representative from Outpatient Directors of Nursing Practice
15. One representative from Regional Support Services
16. One representative from Regional Employee Health
17. One representative from TPMG Operations
18. One representative from Regional Continuum of Care
19. One representative from CNE Peer Group
20. One representative from Regional Inpatient Pharmacy
21. One representative from Sterile Processing

Non-voting Members:

Determined based on strategic priorities and initiatives requiring additional expertise.

1. One representative from Regional AR&L
2. One medical center Surgeon
3. One representative from Regional Emergency Management
4. One representative from Laboratory service
5. One medical center Hospital Based Specialist Physician
6. One medical center Support Services Administrator
7. One medical center Environmental Services Manager

See Appendix A Membership Roster





Regional/Sub Regional Services Committee 2024 CHARTER

PURPOSE

The Regional Sub-Regional Services Committee (RSR), Kaiser Permanente Northern California (KPNC), is a subcommittee of the Northern California Quality Oversight Committee (QOC). Its function is to oversee the quality of Regional or Sub-Regional health care services provided in the Northern California Region.

AUTHORITY AND SCOPE

The functions of RSR include but may not be limited to, providing oversight of Regional or Sub-Regional health care services as prioritized by KPNC Leadership. Oversight includes assessing quality performance monitoring processes to ensure that the monitoring indicators address issues related to service, access, clinical quality metrics, and compliance with applicable regulatory standards.

REPORTING STRUCTURE

- RSR, as a sub-committee of the QOC, will report appropriate activities and issues to the QOC on a quarterly basis, and escalate issues of concern to the QOC whenever issues arise beyond the scope of the committee or concerns can not be resolved by the RSR committee.
- RSR maintains ongoing reporting and communication with the local KPNC medical center Departments, Committees, and/or leaders responsible for oversight of the KPNC initiatives and priorities.
- TPMG Associate Executive Director for Quality, and KFHP/H Vice President, Safety, Quality, & Regulatory Services, are committee sponsors.

ROLES & RESPONSIBILITIES

1. Works with the responsible leadership of the Regional or Sub-Regional Services (including new or changed services) to ensure appropriate quality oversight with standardized performance metrics.
2. Examines prioritized performance metrics for Regional or Sub-Regional Services (including new or changed services) to include:
 - a. Performance metrics/success indicators to be used to measure, to monitor and to improve quality, clinical outcomes, access, and service.
 - b. Metrics must include established benchmarks, and/or thresholds (e.g. industry/community/KP standards) or, if necessary, baseline performance levels.
 - c. All metric and performance indicators should be evidence based and linked to existing indicators if possible.
3. Reviews performance and analyzes variation by medical centers involved in the RSRs for prioritized clinical quality metrics.
4. Communicates directly with medical centers to execute QOC decisions related to the RSRs and monitors performance improvement.
5. Identifies high and low performers and facilitates diffusion of successful practices.
6. Elevates vexing or problematic issues directly to QOC.
7. Documents and distributes meeting records and follows standard agenda formats and templates for reporting.

MEETING PROCESS

The committee will meet monthly, for no less than eight months of the year. Membership includes representatives from KFHC, KFHP, and TPMG. The RSR quorum shall consist of 1/3 of the RSR membership with representation of all three entities. Co-chair leadership is shared between TPMG leadership and KFHP leadership. RSR actions and decisions are documented in contemporaneous minutes of the meeting proceedings.

ANNUAL EVALUATION

The committee will perform an annual evaluation against goals established and use this evaluation as a basis for future goal setting. RSR will review and revise as necessary, its Charter and Membership annually.

CONFIDENTIALITY

Participation in RSR 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 RSR.

Members of RSR 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 RSR activities.
3. Notify the RSR 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.

MEMBERSHIP

Membership represents stakeholders who will have valuable input on the oversight of these programs and/or represent groups that will be involved in these programs in the Medical Centers.

MEMBERSHIP STRUCTURE

Co-Chairs:

TPMG Leadership
KFHP Leadership

Voting Members:

Area Safety and Quality Officer
Chiefs of Quality
Health Plan Physician Advisor
Physician Chair of RCPC
Regional Continuum of Care
Regional Risk & Patient Safety
Hospital and Health Plan Quality

Non-Voting Members

Regional Planning
Regional Data Consulting



Regional Resource Management Committee 2024 Charter

I. Purpose:

The Northern California Regional Resource Management Committee (RMC) serves as a sub-committee of the Quality Oversight Committee (QOC). The RMC identifies and promotes utilization strategies and activities, oversees Health Plan Utilization Management through its regulatory and accreditation work, monitors utilization across the health care continuum, consults with Area Medical Centers on Utilization Management (UM) issues and facilitates performance improvement.

A. Definitions:

- Resource Management (RM) is the collective set of actions Kaiser Permanente undertakes to assure the affordability and quality of health care services delivered to Kaiser Permanente members. The activities that comprise RM are not subject to direct regulation under the Knox-Keene Act as is the utilization management activity described below. RM is the activity concerned with the prudent and clinically appropriate allocation of resources in the provision of health care services. i.e., hospitals, prescription drugs, diagnostic imaging services. KFHP has a comprehensive program of RM that supports the delivery of affordable quality health care services.

RM is an essential component of providing appropriate and affordable health care to members as part of Kaiser Foundation Health Plan, Inc. (KFHP) quality improvement program. TPMG physicians and other health care professionals provide the majority of care to KFHP members. The Health Plan and Hospital non-physician RM staff are available to support the clinical staff as they manage member health care needs throughout the care continuum by providing a variety of services, including discharge planning and care management. Together, KPNC provides and coordinates high quality and affordable care for Health Plan members through effective medical and resource management.

- Utilization Management (UM) activities and functions include the prospective, retrospective, or concurrent review of health care service requests submitted by providers and the decisions to approve, modify, delay, or deny the request based in whole or in part on medical necessity. Kaiser's utilization review program is subject to direct regulation under the Knox-Keene Act and must adhere to managed care accreditation standards.¹ Appropriate subject matter experts from selected clinical arenas will routinely present utilization reports to the RMC which will analyze Over/Under Utilization. The reports will include metric analysis and action items of potential over- and/or under-utilization of services to ensure professionally recognized standards of practice are maintained. The RMC will review over/under utilization using the lens below:
- Overutilization:** providing clinical services that are not clearly indicated, or providing services in excessive amounts, or in a higher level of setting that is required
- Underutilization:** failure to provide appropriate or indicated services, or provisions of an inadequate quantity or lower level of services than required

Kaiser Foundation Health Plan (KFHP) in partnership with TPMG and KFHP has a UM program focused primarily on prospective review of requests for out-of-plan and in-plan referrals for a variety of outpatient ambulatory services. A full list of services that require prior authorization in Northern California may be found here: [RM-UM Wiki Site Link: NCAL UM Criteria and Prior Auth List](#)

*Reference: Kaiser Foundation Health Plan, Inc. Quality Assurance Program Agreement (QAPA)

¹ Section 1367.01 of the Knox-Keene Act

II. Functions:

- Engage in the coordination and prioritization of RM and UM activities.
- Oversee the RM activities throughout the facilities within NCAL.
- Ensure UM compliance with regulatory and accreditation requirements.
- Encourage RM/UM considerations in other activities throughout the organization.
- Regular review of Over/Under Utilization in select clinical arenas.

III. Accountability, Authority and Scope:

- The work of the RMC is reported quarterly to the QOC and accountable to the QOC.
- Partners with key departments to accomplish the functions of the RMC. The key departments are listed under Membership.

- **Membership Structure:**

Members will serve indefinitely based on annual committee evaluation and must attend at least 8 meetings per year. All members have the authority to vote and voting is ruled by consensus.

- **Co-Chairs:**

- Health Plan Physician Advisor (HPPA), NCAL
- KFH/HP Senior Director, Quality and Safety Oversight, Utilization Management
- TPMG Medical Director of Accreditation, Regulatory and Utilization Management Compliance

- **Voting Members:**

- Co-Chair: KFH/HP Health Plan Physician Advisor (HPPA), NCAL
- Co-Chair: KFH/HP Senior Director, Quality and Safety Oversight, Utilization Management
- Co-Chair: TPMG Medical Director of Accreditation, Regulatory and Utilization Management Compliance
- TPMG Assistant Medical Director, Accreditation, Regulation, Licensing, and Medi-Cal Programs Chair, Chiefs of Quality
- KFH/HP Executive Director Quality and Regulatory Services
- KFHP, Vice President, Associate Chief Medical Officer, National Medicaid and State Programs.
- KFH/HP Regional Vice President, Resource Stewardship
- KFH/HP Regional Vice President, Continuum of Care
- TPMG, Senior Director for Regulatory, TPMG Consulting Services
- KFH/HP Resource Stewardship, Regional Director, Care Coordination
- TPMG Chair of Resource Management Chiefs
- TPMG Geriatrics and Continuing Care
- KFH/HP Executive Director, Outside Medical Services and Medical Transportation
- TPMG Regional Director, Inpatient Psychiatry Services and Integrated Urgent Services (IUS)
- TPMG APIC for Outside Services, Regional Director for DME
-

A. Quorum:

A quorum consists of at least 5 members, including two physicians. Membership includes KFH, KFHP & TPMG representation. All members have the authority to vote and voting is ruled by consensus. If at any time, between meetings, urgent business is necessary; an effort will be made to communicate with all members. Action requires 5 members, including two physicians.

IV. Confidentiality Statement:

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 RMC 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 authorize persons.
- Notify any of the RMC Co-Chairs in the event any person or entity seeks to compel disclosure of privileged

information.

- Not create or retain any copies or reproductions of discussions or information except as required for participation.

VI. Meeting Frequency:

No less than monthly for a minimum of eight meetings per year. Meetings may be conducted in person, by telephone, teams meeting, or electronically. Contemporaneous minutes of each meeting will be reviewed and approved by members of subsequent meetings.



Kaiser Foundation Health Plan & Hospitals, Northern California

REGIONAL RISK MANAGEMENT PATIENT SAFETY COMMITTEE 2024 CHARTER

The Kaiser Permanente Northern California Regional Risk Management Patient Safety Committee (RRMPSC), is a subcommittee of the Northern California Quality Oversight Committee (QOC). The, Vice President, Safety, Quality & Regulatory Services, Kaiser Foundation Health Plan & Hospitals, Northern California, and the TPMG Associate Executive Director for Risk and Patient Safety, are Executive Sponsors of the committee.

PURPOSE

The RRMPSC provides Health Plan oversight and guides both regional and medical center leaders in implementing new or changing existing, practices designed to enhance patient safety and reduce the risk of harm.

SCOPE

The scope of the committee is to increase patient safety and reduce patient harm associated with the delivery of health services in all settings of care, including but not limited to acute care hospitals, behavioral health centers, medical offices, ambulatory surgery centers, skilled nursing facilities, home health agencies, advice call centers, ambulance services, and contracted facilities.

REPORTING STRUCTURE

- The RRMPSC is a subcommittee of the QOC and will report appropriate activities and issues to that committee on a quarterly basis.
- The RRMPSC oversees the following sub-committees that report on a quarterly or biannual basis:
 - Regional Medication Safety Committee (RMSC)
 - Regional Perioperative Management Group (RPMG) and Laser Safety Committee
 - Hospital and Emergency Department Reliability and Operational Excellence for Safety (HEROES) Committee
 - Regional Informed Consent Steering Committee (RICSC)
- The RRMPSC oversees the following programs that report on a quarterly, biannual, or annual basis:
 - Sentinel Event Quality Review (SEQR)
 - Perinatal Patient Safety Program (PPSP)
 - Person and Family Centered Care (PFCC) Program
 - Leapfrog Hospital Survey Process and Performance Improvement Activities
- Hospital/Medical Centers reports to the RRMPSC annually.

ROLES & RESPONSIBILITIES

- Provides Health Plan oversight for regional RRMPSC programs and local facilities.
- Reviews and provides guidance to Hospital/Medical Center RMPS programs.
- Examines performance and analyzes variation by medical centers using prioritized clinical quality metrics.
- Identifies Hospitals/Medical Centers that have opportunities for improvement, invites action plans for improvement and shares learnings from performance improvement activities throughout the region.
- Identifies and shares successful practices at the local, regional, and national KP levels.



Kaiser Foundation Health Plan & Hospitals, Northern California

**REGIONAL RISK MANAGEMENT PATIENT SAFETY COMMITTEE
2024 CHARTER**

ROLES & RESPONSIBILITIES

- Facilitates standardization, where appropriate, to adopt best practices and match the performance of the best programs.
- Identifies opportunities and leverages performance improvement strategies and technology.
- Oversees compliance with internal and external regulatory bodies for Risk Management and Patient Safety standards.
- Oversees the effectiveness of its four sub-committees.
- Promotes risk prevention/patient safety research projects.
- Reviews KPNC Risk Management and Patient Safety related policies and procedures.
- Escalates problematic issues directly to QOC or the appropriate committee.
- Documents and distributes meeting materials and follows standard agenda formats and templates for reporting.

MEETING PROCESS

The committee will meet monthly, for no less than ten months of the year. Membership includes representatives from KFH, KFHP, and TPMG. Co-chair leadership consists of one co-chair from KFHP/KFH and one from TPMG. RRMPSOC actions and decisions are documented in contemporaneous minutes of the meeting proceedings.

ANNUAL EVALUATION

The committee will perform an annual evaluation and use this evaluation as a basis for future committee improvement and project expansion. The RRMPSOC will review and revise its Charter and Membership annually, as necessary.

CONFIDENTIALITY

Participation in the RRMPSOC 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 RRMPSOC.

Members of the RRMPSOC 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 this information in the conduct of RRMPSOC activities.
3. Notify the RRMPSOC KFHP co-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 reproductions of discussions or information except as required for participation.



Kaiser Foundation Health Plan & Hospitals, Northern California

**REGIONAL RISK MANAGEMENT PATIENT SAFETY COMMITTEE
2024 CHARTER**

MEMBERSHIP (Key committee membership responsibilities include):

1. Attend and actively participate in majority of meetings.
 - a. Provide input and guidance on committee activities, including identification, prioritization, and follow-up of patient safety issues.
2. Act as a liaison between the committee and group(s) represented on the committee.
 - a. Present issues, share ideas and successful practices.
3. Review and become familiar with the committee charter.
4. Review meeting materials in advance.

• Kaiser Foundation Health Plan & Hospitals Executive Director of Risk Management, Patient Safety (Co-Chair) • TPMG Medical Director of Risk and Patient Safety (Co-Chair) • APIC for Risk • Area Safety and Quality Officer • Chief of Quality • HEROES Program Lead • Director, Patient Care Services • Director, Pharmacy Quality and Medication Safety • DONCP • Hospital Chief Nursing Executive • Hospital Chief Operating Officer • Medical Center RMPS Director • Medical Group Administrator • NCAL Physician Lead for Simulation and Interprofessional Patient Safety Training • NCAL Regional Health Plan Physician Advisor	• Patient Safety Fellows (ex officio) • Program Director, KP NCAL Patient Safety Fellowship • Regional Continuum Administrator • Regional Leaders, Risk and Patient Safety ○ Leader, Risk Management & Patient Safety ○ Leader, Risk Management & Patient Safety ○ Leader, Risk Management & Patient Safety ○ Leader, Infection Prevention & Control and HEROES Program • Strategic Leader, KPHC • TPMG Consulting Services Director • TPMG Regional Director, Risk Management and Patient Safety • TPMG Medical Director, Risk and Medical Legal for KPHC • TPMG Medical Director, Medical Legal • Workplace Safety H/HP Lead, Executive Director, Regional Safety Operations • Workplace Safety TPMG Lead, Senior Regional Director of TPMG Consulting Services



KAISER PERMANENTE NORTHERN CALIFORNIA BEHAVIORAL HEALTH QUALITY OVERSIGHT COMMITTEE CHARTER

PURPOSE

The Behavioral Health Quality Oversight Committee (BHQOC), Kaiser Permanente Northern California (KPNC), is a subcommittee of the Quality Oversight Committee. Its function is to oversee and monitor the performance of Behavioral Health (BH) care inpatient and outpatient initiatives, priorities, and programs within KPNC and promote excellence of quality in all aspects of BH care.

AUTHORITY AND SCOPE

The functions of the BHQOC will include the following:

- Provide quality oversight and recommendations on BH program
- Provide regulatory and accreditation guidance and oversight for BH care as required by regulatory and accrediting agencies.
- Review, approve, promote and monitor performance on BH quality improvement initiatives/activities (e.g., HEDIS).
- Report on trends related to complaints, grievances, and appeals to collaboratively address quality issues that arise.
- Oversee and monitor progress of technological investment in outcomes measurement strategy (e.g., Tridium to EPIC initiative, online tools, etc.).
- Review trends related to BH patient safety events and identify systems-level opportunities for improvement.
- Oversee external BH provider network, including issues related to expansion, contracting, access, and quality.

REPORTING STRUCTURE

- The BHQOC is a subcommittee of the NCAL Quality Oversight Committee.
- The BHQOC reports quarterly to the Quality Oversight Committee on relevant activities.
- The BHQOC maintains ongoing communication with the local KPNC medical center Departments, Committees, and/or leaders responsible for oversight of the KPNC initiatives and priorities.

ROLES AND RESPONSIBILITIES

1. Evaluates the quality of clinical care and service across all settings for the full spectrum of BH services provided.
2. Makes recommendations to relevant leadership and stakeholder groups for actions to improve BH clinical quality and service quality.
3. Reviews HEDIS and other quality metrics relevant to the provision of BH services.
4. Identifies opportunities for improvement and establishes priorities among them.
5. Reviews and approves, from a quality assurance perspective, the implementation of new BH policies and procedures across all departments where BH services are provided.
6. Escalates matters where serious quality concerns arise directly to relevant leadership and stakeholder groups.
7. Documents meeting activities, distributes meeting materials and follows standard agenda formats and templates for reporting.

MEETING PROCESS

The BHQOC will meet monthly, with a minimum of six (6) meetings per calendar year. Membership includes representatives from The Permanente Medical Group (TPMG), Kaiser Foundation Health Plan (KFHP) and Kaiser Foundation Hospitals (KFH). A quorum is a simple majority of the members. Leadership is shared by a representative TPMG and a representative of KFHP. BHQOC actions and decisions are documented in contemporaneous minutes of the meeting proceedings.

ANNUAL EVALUATION

On an annual basis, the BHQOC will perform an evaluation against goals established and use this evaluation as a basis for future goal setting. In addition, the BHQOC will annually review and revise (as needed) its Charter and Membership.

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 communications necessary to fulfill the activities and functions of the BHQOC. Members of the 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 discussions and information except to persons authorized to receive it in the conduct of BHQOC activities.
3. Notify a BHQOC co-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 reproductions of discussions or information except as required for participation.

BHQOC MEMBERSHIP

Co-Chair KFHP/H Vice President Behavioral Health and Specialty Services
Co-Chair TPMG Associate Chair of Psychiatry for Quality
TPMG Chair of Chiefs of Psychiatry and Behavioral Health
KFHP/H Vice President Behavioral Health and Wellness
TPMG Regional Medical Director, Mental Health Virtual Care Programs and External Provider Network
KFHP/H Managing Director Hospital and Health Plan Quality Services
TPMG Chair, Addiction Medicine Recovery Services
KFHP Health Plan Physician Advisor, KPNC Representative
KFHP/H Regional Risk and Patient Safety
TPMG Regional Director, Inpatient Psychiatry and Continuing Care

CONSULTANTS (non-voting)

KFHP Senior Manager, Behavioral Health Quality Management
KFHP Vice President, Enterprise Regulatory Services
KFHP/H Executive Director, Behavioral Health and Wellness
TPMG Regional Medical Director for Outpatient BH Quality
TPMG Regional Medical Director, Inpatient Psychiatry and Continuing Care
KFHP Executive Director, Member Relations
KFHP Executive Director, Commercial Compliance
KFHP/H Patient Care Services Representative
TPMG Peer Group Lead, Mental Health Directors
TPMG Chiefs, TPMG Psychiatry Departments



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

PURPOSE

The Kaiser Permanente Northern California (NCAL) Medi-Cal Quality Improvement Health Equity Committee (QIHEC) is a subcommittee of the Quality Oversight Committee (QOC), 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 NCAL Medi-Cal Quality Improvement Health Equity Committee is a multidisciplinary, cross-functional program committee that provide 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 NCAL 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 Quality Oversight Committee (QOC).
- Monitoring quality, clinical, and health equity activities for implementation and improvement.
- Escalating potential quality concerns to the QOC.
- 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 NCAL Medi-Cal QIHEC is a subcommittee of the QOC and reports findings, recommendations, and action to the QOC after each meeting. The QOC in turn report to QHIC after each meeting.
- The NCAL Medi-Cal QIHEC will also report to the QOC the Medi-Cal QIHEC activities of its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, if applicable.

MEETING PROCESS

- The NCAL Medi-Cal QIHEC will meet at least quarterly.
- NCAL Medi-Cal QIHEC activities will be made publicly available on the website at least quarterly.
- The NCAL Medi-Cal QIHEC charter, goals, and membership will be set and evaluated annually.
- All views will be represented.
- A quorum shall consist of one-third 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.
- NCAL 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 NCAL Medi-Cal QIHEC uses standard agenda formats and reporting and documents and distributes meeting records.

CONFIDENTIALITY

Participation in NCAL 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 NCAL 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 NCAL 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 NCAL Medi-Cal QIHEC membership (or their designees):

Co-Chairs:

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

TPMG Regional Medical Director, Accreditation, Regulatory, and Utilization Management Compliance

Voting Members:

- KFHP/H Chief Health Equity Officer, Vice-Chair (role may not be delegated)
- KFHP/H Senior Vice President, Area Manager
- TPMG Physician in Chief
- State/County Partner
- TPMG Medical Director, Geriatrics, Continuing Care, and Complex Needs
- Subcontractor/Downstream Subcontractor Representative
- TPMG Chair, Chiefs of Pediatrics
- 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
- TPMG Regional Director, Behavioral Health and Addiction Medicine
- KFHP/H Executive Director, Quality and Regulatory Services
- TPMG Chair, Chiefs of Quality
- KFHP/H Executive Director, Continuum Administrative Operations
- TPMG Regional Director, Continuing Care and Complex Needs
- KFHP/H Executive Director, Medicaid Care Delivery and Operations



- TPMG Regional Medical Director, Quality
- TPMG Senior Manager, TPMG Consulting Services Regulatory and Accreditation

Non-Voting Members:

- KFHP/H Vice President, Behavioral Health and Wellness
- KFHP/H Vice President Consumer Experience
- TPMG Patient Experience Leader
- KFHP/H Regional Director, Medicaid
- KFHP/H Medi-Cal Quality Regional Director
- KFHP/H Medi-Cal Quality Sr. Manager
- KFHP/H Medi-Cal Quality Project Manager, QIHEC
- KFHP/H Medi-Cal Quality Data Analyst

Meeting Support:

KFHP/H Regional Medi-Cal Quality



KAISER PERMANENTE®

Service Area Health Plan Quality Oversight Committee Charter

PURPOSE:

The purpose of the Service Area Health Plan Oversight Committee is to provide oversight of Health Plan quality and performance improvement across the continuum and monitor performance to ensure quality of care and services provided to our members by Kaiser Permanente and contracted vendors.

The purpose is:

- To assess Health Plan quality through the review and analysis of data and metrics, and to assure that performance improvement activities are being carried out when problems are identified in health care delivery or clinical performance.
- To monitor the Health Plan program across the continuum of care designed to improve the quality, assure access, appropriateness of care, and to monitor and evaluate the effectiveness of corrective actions taken and identify opportunities to improve health care.

Our priority is to promote wellness by continuously improving quality of care. The measurements of our success are high quality of care and our members' good health.

AUTHORITY AND SCOPE:

The committee shall be multidisciplinary. Membership shall include, but need not be limited to, representatives of The Permanente Medical Group, Kaiser Foundation Health Plan, and the Continuum

REPORTING STRUCTURE:

The committee shall report to the Regional Quality Oversight Committee (QOC) through reports that are reviewed by the QOC or their subcommittees. .

PRIORITIES AND GOALS:

- Quality: Provide market leading clinical quality that distinguishes us from the competition.
- Service: Personalize the care we provide to our members so that their satisfaction with KP quality and service is superior to the competition.
- People: Become the employer of choice in health care by attracting and retaining physicians, nurses and staff who are the best in their profession and committed to KP.
- Efficiency: Manage our resources efficiently to maintain our financial stability and generate the capital we need for investment in our facilities, equipment and technology.
- Growth: Ensure long-term sustainable growth and maintain a balanced risk pool.
- Reputation: Deliver, promote and protect our reputation as a leader in health care.

QUORUM:

A quorum shall consist of one-third of the voting members of the. All members of the committee shall have voting privileges.

MEETING FREQUENCY:

The committee shall meet monthly.



KAISER PERMANENTE®

Service Area Health Plan Quality Oversight Committee Charter

COMMITTEE RESPONSIBILITIES:

The committee shall facilitate the following activities:

- Review of quality assessment and improvement activities
- Recommend actions necessary or desirable for market leading quality.
- Review and recommend performance goals for quality assurance and performance improvement activities.
- Oversee Performance Improvement Plans for specific functional areas or activities that are not meeting targets.
- On behalf of Kaiser Foundation Health Plan, oversee the quality of patient care and performance activities for contracted services.

CONTEMPORANEOUS STATEMENT:

Minutes of all meetings shall be prepared and shall include a record of the attendance of members and the results of votes on each matter upon which a vote is taken. The minutes shall be signed by the committee co-chairs and forwarded to the Regional Quality Oversight Committee after review and approval.

CONFIDENTIALITY STATEMENT:

Participation in the Health Plan Quality Oversight Committee 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 Health Plan Oversight Committee 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 committee activities.
3. Notify either, or both, of the Committee 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.

LIST OF CHAIR(S) BY TITLE OR DESCRIPTION:

Physician in Chief
Area Manager

LIST OF VOTING MEMBERS BY TITLE OR DESCRIPTION:

Physician in Chief (co-chair)
Area Manager (co-chair)
APIC for Hospital Operations
APIC for Outpatient Quality
APIC for Outside Services
APIC for Quality
APIC for Risk Management
Area Pharmacy Director



KAISER PERMANENTE®

Service Area

Health Plan Quality Oversight Committee Charter

Area Safety and Quality Officer

Continuum Administrator

Director of Nursing Practice

Medical Group Administrator

Med-Legal Chief

ADHOC MEMBERS:

Chiefs of Specialty Areas or Subspecialties

Kaiser Permanente Northern California Region - Medical Center Service Areas & Facilities										
Service Area / Facilities* - sorted by (abbreviation) -	Facility Name	Hosp. / ER.	M.O.B.	Urgent Care**	Plas. Surg.	Street Address	City	St.	Zip	County
Central Valley Service Area (CVL)						http://kpnet.kp.org/centralvalley/				
Manteca (MAN)	Manteca Medical Center	x				1777 W. Yosemite Avenue	Manteca	CA	95337	San Joaquin
Manteca (MAN)	Manteca Medical Offices		x			1721 West Yosemite Avenue	Manteca	CA	95337	San Joaquin
Modesto (MOD)	Modesto Medical Center and Medical Offices	x	x		x	4601 Dale Road	Modesto	CA	95356	Stanislaus
Modesto (MOD)	Modesto Medical Offices		x			3800 Dale Road	Modesto	CA	95356	Stanislaus
Modesto (MOD)	Modesto Medical Offices		x			4125 Bangs Avenue	Modesto	CA	95356	Stanislaus
Stockton (STK)	Stockton Medical Offices		x		x	7373 West Lane	Stockton	CA	95210	San Joaquin
Tracy (TRA)	Tracy Medical Offices		x			2185 W. Grant Line Road	Tracy	CA	95377	San Joaquin
Diablo Service Area (DSA)						http://diablo.ca.kp.org/				
Delta Fair Med. Ofc. Bldg. (ANT)*	Delta Fair Medical Offices		x	A, O, P		3400 Delta Fair Blvd	Antioch	CA	94509	Contra Costa
San Ramon (BSR)	San Ramon Medical Offices		x			2300 Camino Ramon	San Ramon	CA	94583	Contra Costa
Antioch Med. Ctr. (DRV)*	Antioch Medical Center	x		A, O, P, F		4501 Sand Creek Road	Antioch	CA	94531	Contra Costa
Dublin Med. Ctr. (DUB)	Dublin Medical Offices and Cancer Center		x	A, O, P, F		3100 Dublin Blvd	Dublin	CA	94568	Alameda
Livermore (LVM)	Livermore Medical Offices		x			3000 Las Positas Road	Livermore	CA	94551	Alameda
Martinez (MTZ)	Martinez Medical Offices		x	A, O, P		200 Muir Road	Martinez	CA	94553	Contra Costa
Pleasanton (PLS)	Pleasanton Medical Offices		x			7601 Stoneridge Drive	Pleasanton	CA	94588	Alameda
Shadelands (SHA)	Park Shadelands Medical Offices		x			320 Lennon Lane	Walnut Creek	CA	94598	Contra Costa
Walnut Creek (WCR)	Walnut Creek Medical Center and Offices	x	x	A, O, P	x	1425 South Main St.	Walnut Creek	CA	94596	Contra Costa
East Bay Service Area (EBA)						http://kpnet.kp.org/ncal/eastbay/				
Alameda (ALM)	Alameda Medical Offices		x			2417 Central Ave.	Alameda	CA	94501	Alameda
Berkeley	Berkeley Medical Offices		X	A, F, O, P		2621 Tenth Street	Berkeley	CA	94710	Alameda
Oakland (OAK)	Oakland Medical Center	x	x	A, P		280 W. MacArthur Blvd.	Oakland	CA	94611	Alameda
Pinole (PIN)	Pinole Medical Offices		x			1301 Pinole Valley Road	Pinole	CA	94564	Contra Costa
Richmond (RCH)	Richmond Medical Center	x	x	A, P	x	901 Nevin Ave.	Richmond	CA	94801	Contra Costa
Fresno Service Area (FRS)						http://insidekp.kp.org/california/fresno/index.html				
Clovis (CLO)	Clovis Medical Offices		x	P		2071 Herndon Ave.	Clovis	CA	93611	Fresno
Fresno (FRS)	Fresno Medical Center	x	x	A, P	x	7300 North Fresno St.	Fresno	CA	93720	Fresno
Oakhurst (OKH)	Oakhurst Medical Offices		x			40595 Westlake Drive	Oakhurst	CA	93644	Madera
Selma (SEL)	Selma Medical Offices		x			2651 Highland Ave.	Selma	CA	93622	Fresno
Golden Gate Service Area (SFO)						http://kpnet.kp.org/ncal/sfo/ http://marin-sonoma.kp.org/sanrafael/				
Daly City (DLC)	Daly City Medical Offices		x			395 Hickey Blvd.	Daly City	CA	94015	San Mateo
San Bruno (SSF)	San Bruno Medical Offices		x			901 El Camino Real	San Bruno	CA	94066	San Mateo
San Francisco - French Campus (SFO)	San Francisco Medical Center - French Campus		x			4131 Geary Blvd.	San Francisco	CA	94118	San Francisco
San Francisco - French Campus (SFO)	San Francisco Medical Center - French Campus		x			4141 Geary Blvd.	San Francisco	CA	94118	San Francisco
San Francisco - French Campus (SFO)	San Francisco Medical Center - French Campus		x			450 Sixth Ave.	San Francisco	CA	94118	San Francisco
San Francisco - Geary Campus (SFO)	San Francisco Medical Center - Geary Campus			E		1635 Divisadero St.	San Francisco	CA	94115	San Francisco
San Francisco - Geary Campus (SFO)	San Francisco Medical Center - Geary Campus		x	A	x	2238 Geary Blvd.	San Francisco	CA	94115	San Francisco
San Francisco - Geary Campus (SFO)	San Francisco Medical Center and Medical Offices	x	x			2425 Geary Blvd.	San Francisco	CA	94115	San Francisco
San Francisco - Geary Campus (SFO)	San Francisco Medical Center - Geary Campus					350 St. Joseph's Ave.	San Francisco	CA	94115	San Francisco
San Francisco Mission Bay (SFM)	San Francisco Mission Bay Medical Offices		x			1600 Owens St.	San Francisco	CA	94158	San Francisco
San Rafael Downtown (SRD)	Downtown San Rafael Medical Offices - 3rd Street		x	A, P, E		1033 Third St.	San Rafael	CA	94901	Marin
San Rafael (SRF)	San Rafael Medical Center and Medical Offices	x	x	A, P	x	99 Montecillo Road	San Rafael	CA	94903	Marin
San Rafael (SRP)	San Rafael Park Medical Offices		X	A, O, P		1650 Los Gamos Drive	San Rafael	CA	94903	Marin
Greater Southern Alameda Service Area (GSAA)						http://insidekp.kp.org:81/california/gsaa/index.html				
Fremont (FRE)	Fremont Medical Center and Offices	x	x	A, O, P	x	39400 Paseo Padre Parkway	Fremont	CA	94538	Alameda
Sleepy Hollow (SLH)	Hayward-Sleepy Hollow Med. Offices (formerly part of HAY MC)		x	A, O, P		27303 Sleepy Hollow Ave.	Hayward	CA	94545	Alameda
San Leandro (SLN)	San Leandro Medical Center	x	x		x	2500 Merced Street	San Leandro	CA	94577	Alameda
Union City (UNC)	Union City Medical Offices; Building A		x			3555 Whipple Road	Union City	CA	94587	Alameda
Union City (UNC)	Union City Medical Offices; Building B		x			3553 Whipple Road	Union City	CA	94587	Alameda
Santa Rosa Service Area (SRO)						Santa Rosa Medical Center (kp.org)				
Novato (NOV)	Novato Medical Offices		x	A, P		97 San Marin Drive	Novato	CA	94945	Marin
Petaluma (PET)	Petaluma Medical Offices		x	A, P		3900 Lakeville Highway	Petaluma	CA	94954	Sonoma
Rohnert Park (RPK)	Rohnert Park Medical Offices		x			5900 State Farm Drive	Rohnert Park	CA	94928	Sonoma

Kaiser Permanente Northern California Region - Medical Center Service Areas & Facilities										
Service Area / Facilities* - sorted by (abbreviation) -	Facility Name	Hosp. / ER.	M.O.B.	Urgent Care**	Plas. Surg.	Street Address	City	St.	Zip	County
Santa Rosa (SRO)	Mercury Way Medical Offices		x			2240 Mercury Way	Santa Rosa	CA	95407	Sonoma
Santa Rosa (SRO)	Richard Stein Medical Offices		x	P		3925 Old Redwood Highway	Santa Rosa	CA	95403	Sonoma
Santa Rosa (SRO)	Santa Rosa Medical Center and Offices	x	x		x	401 Bicentennial Way	Santa Rosa	CA	95403	Sonoma
Napa/Solano Service Area (NSA) http://kpnet.kp.org/napasolano/index.html										
Fairfield (FLD)	Fairfield Medical Offices		x			1550 Gateway Blvd.	Fairfield	CA	94533	Solano
Kaiser Foundation Rehab Ctr. (KFRC)	Kaiser Foundation Rehabilitation Center					975 Sereno Drive	Vallejo	CA	94589	Solano
Napa (NAP)	Napa Medical Offices		x		x	3285 Claremont Way	Napa	CA	94558	Napa
Vacaville (VAC)	Vacaville Medical Center and Offices	x	x	A, O, P	x	1 Quality Drive	Vacaville	CA	95688	Solano
Vallejo (VAL)	Vallejo Medical Center and Offices	x	x	A, O, P		975 Sereno Drive	Vallejo	CA	94589	Solano
San Mateo Service Area http://kpnet.kp.org:81/ncal/sma/redwoodcity/										
South San Francisco (SSF)	South San Francisco Medical Center and Offices	x	x		x	1200 El Camino Real	South San Francisco	CA	94080	San Mateo
Redwood City (RWC)	Redwood City Medical Center	x	x	A, P		1100 Veterans Blvd.	Redwood City	CA	94063	San Mateo
Redwood City (RWC)	Marshall Medical Offices		x	O, P		905 Maple Street	Redwood City	CA	94063	San Mateo
San Mateo (SMM)	San Mateo Medical Offices		x			1000 Franklin Parkway	San Mateo	CA	94403	San Mateo
Roseville Service Area (ROS) http://kaisersac.kp.org/										
Folsom (FOL)	Folsom Medical Offices		x	A, P		2155 Iron Point Road	Folsom	CA	95630	Sacramento
Lincoln (LNC)	Lincoln Medical Offices		x	A, P		1900 Dresden Drive	Lincoln	CA	95648	Placer
Roseville (ROS)	Roseville Medical Center	x		P		1600 Eureka Road	Roseville	CA	95661	Placer
Roseville (ROS)	Roseville Medical Center		x	P		1840 Sierra Gardens Dr	Roseville	CA	95661	Placer
Roseville (ROS)	Roseville Medical Offices		x	A		1001 Riverside Ave.	Roseville	CA	95678	Placer
Greater Sacramento Service Area (SAC) http://kaisersac.kp.org/										
Davis (DAV)	Davis Medical Offices		x	A, P		1955 Cowell Blvd.	Davis	CA	95616	Yolo
Rancho Cordova (RCO)	Rancho Cordova Medical Offices		x	A, P		10725 International Drive	Rancho Cordova	CA	95670	Sacramento
Sacramento (SAC)	Downtown Commons		x			501 J Street	Sacramento	CA	95814	Sacramento
Sacramento (SAC)	Fair Oaks Boulevard Medical Offices		x	A		2345 Fair Oaks Blvd.	Sacramento	CA	95825	Sacramento
Sacramento (SAC)	Point West Medical Offices		x	A, P		1650 Response Road	Sacramento	CA	95815	Sacramento
Sacramento (SAC)	Sacramento Medical Center and Offices	x	x		x	2025 Morse Ave.	Sacramento	CA	95825	Sacramento
Santa Clara Service Area (SCL) http://insidekp.kp.org/california/santaclara/										
Campbell (CMB)	Campbell Medical Offices		x			200 E. Hacienda Ave.	Campbell	CA	95008	Santa Clara
Campbell (CMB)	Campbell Medical Offices - Psychiatry services					220 E. Hacienda Ave.	Campbell	CA	95008	Santa Clara
Milpitas (MIL)	Milpitas Medical Offices		x			770 E. Calaveras Blvd.	Milpitas	CA	95035	Santa Clara
Mountain View (MTN)	Mountain View Medical Offices		x			555 Castro St.	Mountain View	CA	94041	Santa Clara
Mountain View (MTN)	Mountain View Medical Offices					565 Castro St.	Mountain View	CA	94041	Santa Clara
Santa Clara - Homestead (SCH)	Santa Clara Medical Center and Medical Offices	x	x	A, P	x	700 Lawrence Expressway	Santa Clara	CA	95051	Santa Clara
Skyport (SKY)	Skyport Medical Offices		x			1721 Technology Drive	San Jose	CA	95110	Santa Clara
San Jose Service Area (SJO) http://insidekp.kp.org/ncal/sanjose/										
Gilroy (GIL)	Gilroy Medical Offices		x			7520 Arroyo Circle	Gilroy	CA	95020	Santa Clara
Scotts Valley (SCV)	Scotts Valley Medical Offices		x			5615 Scotts Valley Drive	Scotts Valley	CA	95066	Santa Cruz
Santa Cruz (SCZ)	Santa Cruz Medical Offices		x			115 Locust Street	Santa Cruz	CA	95060	Santa Cruz
San Jose (SJO)	San Jose Medical Center	x	x		x	250 Hospital Parkway	San Jose	CA	95119	Santa Clara
Watsonville (WTV)	Watsonville Medical Offices		x			1931 Main Street	Watsonville	CA	95076	Santa Cruz
South Sacramento Service Area (SSC) http://southsac.kp.org/										
Elk Grove (ELG)	Elk Grove Medical Offices		x	A, P		9201 Big Horn Blvd.	Elk Grove	CA	95758	Sacramento
Promenade (PMB)	Promenade Medical Office		x			10305 Promenade Parkway	Elk Grove	CA	95757	Sacramento
South Sacramento (SSC)	South Sacramento Medical Center and Offices	x	x		x	6600 Bruceville Road	Sacramento	CA	95823	Sacramento
*Sources: Svc. Area & Fac. Abbrv. = internal reports; Facility Name/Address & Hosp./ER/Urg.Care = kp.org ; Svc. Area Intranet Link = insidekp.kp.org/ncal/ ; KPHC Instance = KPHC Team										
**Urgent Care Key: A=Adult; O=Obstetrics/Gynecology; P=Pediatrics; F=Family Medicine; E=Eye (note: may be offered by appointment only or advice/phone appointment only; weekday/weekend hours vary)										

Total # of Hospitals / ERs in NCAL:

21

Total # of Med. Ofc. Bldgs. in NCAL***:

64 ***may be adjacent to Hosp./ER. or as a separate satellite location

Notification of Practitioner Conduct

TPMG, SCPMG and KFH each agree to notify Health Plan and TPMG and KFH each agree to notify each other and SCPMG and KFH each agree to notify each other regarding the professional competence and conduct of practitioners employed by, associated with, or on their respective professional staffs, as follows:

1. Any circumstance that the notifying party reasonably believes will result in a revocation or restriction of a practitioner's license, certification, privileges or credentials;
2. Initiation by any of the reporting entities of a final proposed adverse action against the a practitioner which would be reportable to the applicable licensing board if sustained;
3. A criminal complaint, indictment, arrest, criminal investigation, or criminal conviction of which the reporting entity is aware and which would be material to a consideration of the practitioner's qualifications or licensed authority to practice;
4. Disciplinary action taken by the applicable licensing board resulting in revocation, suspension, restriction, or probation; or charges filed by the Attorney General on behalf of the applicable licensing board;
5. Any of the following allegations or incidents, assuming that an initial investigation conducted by the party employing the practitioner has concluded that the allegation is reasonably likely to be substantiated, or that the incident is reasonably likely to have occurred in an unlawful or other unacceptable manner:
 - 5.1 Unlawful sexual conduct toward patients;
 - 5.2 Bringing a gun or explosive device to a medical office or facility;
 - 5.3 Violence or threat of violence toward staff or patients;
 - 5.4 Practicing while under the influence of drugs or alcohol;
 - 5.5 Self-prescribing of Schedule 2 drugs or diversion of controlled substances;
6. Notices pursuant to this Notification Agreement shall be provided to the Health Plan Area Manager (Northern California) ("Area Manager") or the Executive Director (Southern California) ("Executive Director"), or his/her respective designee(s), as well as to the Credentials Committee/s that credentials the practitioner in question.
7. Information provided pursuant to this Notification Agreement will be maintained by Health Plan, KFH, TPMG, or SCPMG as confidential peer review information consistent with California Evidence Code Section 1157 and California Health & Safety Code Section 1370. The parties acknowledge that the subject matter of the notification will be handled through the quality program processes. Updates to the information subject to the notification shall be provided with the frequency

agreed upon by the Medical Director/Physician-in-Chief and the Area Manager or Executive Director.

8. Health Plan acknowledges and agrees that the respective investigative and fair hearing processes under the KFHP Professional Staff Bylaws, Rules & Regulations, TPMG disciplinary processes and procedures, and SCPMG disciplinary processes and procedures and applicable state and federal law will apply to actions taken by KFHP, TPMG, and/or SCPMG respectively.
9. Even if an investigation results in a conclusion that an allegation or incident referenced in subsections 5.1 through 5.5 above is without merit, TPMG, SCPMG, and KFHP will prepare and retain for 3 years confidential summaries of the investigations. Upon request by KFHP, KFHP, TPMG, or SCPMG on as frequent a basis as necessary, the Area Manager/Executive Director and the Medical Director/Physician-in-Chief (or respective designees) shall meet and confer to ensure that thorough, impartial investigations are occurring and that any material issues are appropriately addressed.

Kaiser Foundation Health Plan, Inc.

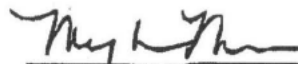


Northern California Region

Southern California Region

Southern California Permanente Medical Group

Kaiser Foundation Hospitals



Northern California Region

Southern California Region

The Permanente Medical Group, Inc.





Kaiser Foundation Health Plan
Northern California Region
Regional Risk Management and Patient Safety Program Description

Regional Risk Management and Patient Safety Program Description

OVERVIEW

As an integral part of the organization's Quality Program, the Health Plan Regional Risk Management and Patient Safety Program exists to ensure that Kaiser Permanente is providing person-centered care that is reliable, effective, consistent, and safe. The program is designed to promote reliable, consistent, and safe care for KFHP members and patients receiving health care services in a KP facility, including but not limited to Kaiser Foundation Hospitals, KP ambulatory surgery units, KP skilled nursing facilities, and TPMG medical offices. The program also includes health care services provided to KP members by contracted Providers within the Health Plan network. As part of this program, each hospital will develop, implement, maintain, and comply with policies and procedures for a written Patient Safety Plan, as required by Title 22. The Hospitals' Patient Safety Plan will be reviewed and revised at least once a year by the Regional Risk Management and Patient Safety Committee, but more often, if necessary, to evaluate and update the plan and to incorporate advancements in patient safety practices. The intention to provide person-centered care is founded on the philosophy that patient safety is every patient's right and every person's responsibility. This process involves an ongoing, relentless commitment to build a culture of safety and safer systems to prevent patient harm using performance improvement methodology.

CULTURAL BELIEFS

Members and patients first: I put our members and patients first.

Own it: I am accountable for my success and the success of Kaiser Permanente.

Live quality: I am relentless in my pursuit of quality to set the standard in health care.

Conversations for success: I speak candidly and listen effectively.

I am KP: I step up, reach out and live one KP.

Be bold: I take courageous action to find and act on even better ways to enhance KP's success.

STRATEGIC THEMES

To ensure responsibility and mutual accountability for patient safety throughout our organization, Kaiser Permanente NCAL will continue to implement activities broadly aimed at the continued expansion of our High Reliability Program across NCAL 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 towards increasing High Reliability and the ultimate objective of eliminating patient harm.
Safe Culture	Create and maintain a strong, unified patient-centric culture, with patient safety and error reduction embraced as shared organizational values and acknowledged prerequisites of "quality you can trust." The Five Principles of High Reliability Organizations -- Preoccupation with Failure, Sensitivity to Operations, Reluctance to Simplify, Commitment to Resilience, and Deference to Expertise serve as guideposts for creating and maintaining a "Collective Mindfulness" in support of safety.

Safe Staff	Ensure staff possesses the knowledge and competence to safely perform required duties with strict adoption of policies and procedures, improved safety performance, and reduced workplace injuries. We work to develop new knowledge, embed error-proofing tools and provide ongoing education on patient and workplace safety best practices for individuals and teams.
Safe Patients	Engage the patient and their family as essential patient safety partners. This process includes Human and Equity Centered Design to reduce medical errors, improve systems and support patients to actively participate in their own safe care. We work to develop programs that ensure equitable and diverse collaborative relationships with patients/members/families in all aspects of the organization.
Safe Place	Design, construct, operate, and maintain a safe environment of care and evaluate, purchase, and utilize equipment and products in a way that promotes the efficiency and effectiveness with which safe healthcare is provided. Ensure processes are in place to address defective or recalled equipment and products.
Safe Systems	Identify, implement, and maintain support systems that provide the right information, to the right people, at the right time. This process includes the distribution of shared learnings, rapid escalation of safety concerns, routine tracking and trending of the Responsible Reporting System, and the development of meaningful metrics.

The foundational elements of all Kaiser Permanente Risk Management and Patient Safety initiatives will continue to be rooted in:

1. An understanding of a safety and High Reliability culture, which includes identifying potential human error and human factors based on Patient Safety Science and the principles of High Reliability.
2. The creation and maintenance of a Psychologically Safe environment in which event reporting occurs in a Just Culture.
3. Proactive and prioritized performance improvement activities to prevent failure, mitigate hazards and improve systems and process reliability.
4. A continuous learning organization.
5. The engagement of patients and families as full partners in their safe care.
6. Maintaining compliance with all state and national Patient Safety standards.
7. Embracing the use of technology to optimize safe systems.
8. Ongoing identification, sharing, and appropriate implementation of successful practices from other parts of the organization, other healthcare organizations, and organizations outside of healthcare.

METHODOLOGY

Program Components	Description
Risk Identification	The program works to identify sources of risk to patients, staff, and the organization from reporting and analysis of patient safety events, adverse events, Good Catch submissions, and near-miss reports. Additional sources of risk are identified through the evaluation of member complaints, trigger tools, proactive audits, surveys, and assessments. Examples include FMEA (Failure Modes Effects Analysis), Patient Safety Leader Rounding, internal clinical surveillance systems, and external sources such as the FDA. The organization internally reports preventable patient safety events through a confidential reporting system that is available to all healthcare practitioners and facility employees, and additionally reports adverse events to the appropriate regulatory agency per their secure electronic web-based portals. Patients and visitors can report safety issues directly to unit leaders and staff or through the Members Services Complaints and Grievances process. The Health Plan Risk Management and Patient Safety program collaborates closely with Health Plan Professional Liability staff to identify trends and provide oversight for effective risk mitigation.
Risk Analysis	This process includes Analyzing high-risk issues from the data sources named above and prioritizing areas for risk mitigation and education. This methodology supports a full assessment of risk to patients (severity of harm, probability of harm, frequency) and risk to the organization (cost of harm, regulatory consequences, public/member impact).
Risk/Injury Prevention	Program leadership sponsors and implements shared learnings and proactive programs, systems, communications, and education designed to reduce or prevent patient and staff injuries and ensure safe patient care.
Risk/Injury Control	Local and regional program staff work to minimize the effects of adverse patient outcomes by involving frontline staff, clinicians and patients in investigations and in designing safer systems. CSA analysis is conducted for any adverse or patient safety event to identify mitigation strategies and learning opportunities.
Infrastructure Effectiveness	An essential part of the program includes tactics to implement and maintain organizational structures and processes that enable all staff to adopt safe care management strategies and detect performance drift, including a Highly Reliable and Safe culture. By maintaining strong support for all staff involved in adverse and sentinel events as well as unanticipated outcomes, we encourage transparency and timely reporting.
Learning Organization	We are committed to maintaining a culture in which we learn from near misses, errors, and evidence-based practice. This “reluctance to simplify” invites us to continually assess and improve systems and culture.

EFFECTIVENESS

The **Regional Quality Oversight Committee (QOC)** reviews and approves the Patient Safety Program Description. Through routine committee reporting the QOC also monitors the progress of activities and programs that ensure reliable, effective, consistent, and safe care.

Organization

The Health Plan Regional Risk Management and Patient Safety Department directs the Safe Care Management Program, as well as other Risk Management and Patient Safety activities within the NCAL organization. The Executive Director leads the department with a team of NCAL Health Plan Regional Leaders, Clinical Practice and Data Consultants, and Administrative Support Staff.

OVERSIGHT

The **Regional Risk Management Patient Safety Committee (RRMPSC)**, as detailed in the Quality Program description, provides health plan oversight for all locations where members receive care, supports the vision, goals, and priorities for Risk Management and Patient Safety, and oversees related activities and outcomes. The Hospitals/Medical Centers present their programs, including outcomes and opportunities for improvement, at least annually. The committee incorporates Program and Medical Center-wide Risk Management and Patient Safety priorities into its planning. The Health Plan Executive Director of Regional Risk and Patient Safety and a physician selected by the Health Plan in consultation with TPMG, co-chair the RRMPSC.

The RRMPSC provides oversight and supports a culture of High Reliability for the following four patient safety programs:

- The Sentinel Event Quality Review (SEQR) process provides oversight and consultation for the management of significant patient safety events. This process includes investigation and resolution of the events and it includes an expedited communication process and the timely creation and dissemination of event learnings throughout the Northern California Region. This process is designed to reduce risk and improve patient safety and quality outcomes. Health Plan Risk Management and Patient Safety team members perform thorough and credible reviews of all facilities' Comprehensive Systems Analysis (CSA) and assist the facilities in implementing risk reduction strategies.
- The Perinatal Patient Safety Program (PPSP) is a multidisciplinary collaboration between NCAL Health Plan Risk Management and Patient Safety and Maternal Child Health to eliminate harm for mothers and newborns. The PPSP works to create a highly reliable organization using performance improvement tools, evidence-based practices and fostering a culture of safety with an infrastructure that supports equity, inclusion, and diversity. The PPSP develops standardized processes and outcome measures for maternal morbidity/ mortality and birth injuries.
- The RMPSC provides oversight and consultation for the Leapfrog Hospital Survey process and performance improvement activities aiming at making giant "leaps" forward in reducing errors,

injuries, accidents, and hospital-associated conditions. The Leapfrog Hospital Survey compares hospitals on standards of safety, quality, and efficiency. The Leapfrog Hospital Safety Grade survey assigns A, B, C, D, and F grades based on the hospital's quality outcomes and ability to prevent harm, including the rate of inpatient injuries, the prevalence of inpatient infections, and medical and medication errors.

- The Person and Family Centered Care (PFCC) program incorporates an approach to healthcare that emphasizes putting the patients and their families at the center of their care. As an organizational priority, Northern California Medical Centers have developed Patient Advisory Councils that are built on these core values. The PFCC has developed a strong focus on equity, inclusion, and diversity. Partnering with our patients/members in this way nourishes joy and meaning in the workplace.

There are four sub-committees of the RRMPS:

- The Regional Medication Safety Committee (RMSC) is an integrated, multidisciplinary oversight committee that works in collaboration with medical centers to identify, evaluate, and analyze specific trends and patterns in medication errors as well as to develop and implement strategies to reduce errors.
- The Regional Perioperative Management Group (RPMG) oversees regional Perioperative initiatives and priorities as they pertain to the quality of care and safety of members undergoing procedures, as identified by Northern California Regional leadership. The committee identifies trends and system issues that identify opportunities for improvement. The committee oversees improvement action plans and shares learnings from region-wide activities.
- The Hospital and Emergency Department Reliability and Operational Excellence for Safety (HEROES) program exists to sustain focus and build upon gains from process and performance improvements designed to achieve safe and reliable patient care. The HEROES Collaborative is the platform used to implement and drive the evidence-based practices designed, tested, and then spread in the medical centers. The current HEROES portfolio includes Falls, Pressure Ulcer Injuries, and HAI events such as HAP, CLABSI, CDI, and CAUTI. The HEROES Collaborative also provides consultation and oversight to ensure local robust committee
- The Regional Consent Steering Committee (CSC) provides Health Plan oversight, guidance, and recommendations for the informed consent process for Kaiser Foundation Hospitals and other Kaiser facilities and programs where Kaiser Foundation Health Plan members and other patients receive care and services. The ICSC reports activities and issues to the Regional Risk Management Patient Safety Committee on an annual basis or as needed if issues require discussion. The ICSC provides leadership and strategic direction for the consent process in Northern California in consultation with Health Plan legal counsel and other Subject Matter Experts.

Measurement

Each activity in the Safe Care Management Program has a specified data collection methodology and reporting frequency. The methodology for data collection is dependent on the type of indicator and data availability. Data sources include but are not limited to clinical and operational data repositories, medical records, and hybrid methodologies using a combination of these systems.



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**KAISER PERMANENTE NORTHERN CALIFORNIA (KPNC)
BEHAVIORAL HEALTH CARE PROGRAM DESCRIPTION
2024**

I. PURPOSE

The purpose of the Behavioral Health Program Description is to describe the scope of Behavioral Health (BH) services, the quality goals, the key leaders and committees, and the utilization program for the Kaiser Permanente Northern California Behavioral Health Program.

II. SCOPE / STRUCTURE

Behavioral Health Services: KPNC offers a comprehensive health care delivery system. BH services available to members include outpatient and inpatient psychiatric services and outpatient and inpatient addiction medicine services. Multiple approaches and levels of care are utilized to deliver medically necessary treatment appropriate to the member's diagnosis, including but not limited to psychotherapy (individual and group), medication management, crisis intervention, residential services, and case management. Inpatient Behavioral Health is provided via a KP Psychiatric Health Facility on the grounds of the Santa Clara Medical Center and Fremont Medical Center and via contracts with a network of non-Kaiser community hospitals.

Behavioral Health Services are available to members in multiple ways throughout our system. Patients can consult with their primary care physicians who are trained to diagnose and treat some behavioral health conditions. Primary care physicians and other medical care physicians can easily refer a patient to their BH colleagues in each area. Behavioral health practitioners provide consultation, assessment, and intervention in KP emergency departments for members with urgent and emergent mental health conditions. Patients can also self-refer to BH departments throughout the region. BH practitioners consult with medical care practitioners on an as-needed basis for patients with co-morbid conditions.

There is no prior authorization required for Behavioral Health Services. There are case management services within both inpatient and outpatient programs. Inpatient case managers review and assist the contracted facilities in discharge planning for individual patients. Outpatient case managers and intensive case managers are used when necessary to coordinate and facilitate the care of at-risk members and members with severe and persistent mental illnesses.

Inpatient Psychiatry Services & Integrated Urgent Services (IUS)

The KPNC Inpatient Psychiatry Program includes services collectively called Integrated Urgent Services (IUS). These services include Inpatient, Intensive Outpatient Program (IOP), crisis stabilization programs, partial hospitalization, case management, and residential hospital alternative programs for adults, teens, older adults, and patients with co-occurring mental health and substance abuse conditions. IOP services are provided at the individual KPNC outpatient Psychiatry Departments for both adults and adolescents. Other IUS services are available via contracts at non-plan facilities. Professional services for these programs are provided by TPMG psychiatrists, contracted community psychiatrists, and other licensed behavioral health providers. Services are organized in five sub-regions: Sacramento Valley, based at South Sacramento; East Bay, based at Martinez; West Bay, based at Redwood City and Central California, in Fresno and Modesto. Each Sub-Regional service is overseen by a Sub-Regional structure that includes a Director and Chief, with overall program responsibility held by the Regional Behavioral Health Director, Inpatient Psychiatry, Continuing Care,

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and Integrated Urgent Services and Addiction Medicine Regional Chair. IUS services are integrated with the outpatient clinics through inpatient and outpatient case managers, and through linkages with the sub-regional Chiefs and outpatient Chiefs of Psychiatry. Local practitioners have access to a centralized Psychiatric Call Center to locate available psychiatric hospital services. These bed location services are provided by a centralized Psychiatric Call Center (PACC) and Behavioral Health phone line (BHPL) that is available 24 hours per day, 365 days per year. This center also provides telephone advice after hours on nights and weekends, 365 days a year. Both phone lines are staffed by licensed behavioral health practitioners.

In 2010, Kaiser Permanente opened its own inpatient psychiatric program, the Santa Clara Behavioral Health Center (BHC). The Behavioral Health Center includes a 24-bed facility, licensed by the State of California Department of Mental Health as a Psychiatric Health Facility (PHF), as well as a 6-station 23-hour Crisis Stabilization Program, which provides an alternative to hospitalization. The facility provides services for members 18 years and older who are medically stable but need immediate treatment for serious mental health problems. The facility serves members primarily from the South and West Bay IUS sub-region. Admission is by clinician and physician referral only. It is staffed by a multi-disciplinary team of licensed behavioral health specialists and other medical providers, such as pharmacists and internists. In October 2019, Kaiser opened a new 18 bed adult psychiatric inpatient facility in Fremont. This unit is focused on those patients who require both mental health as well as medical care and is licensed by the Department of Health Care Service (DHCS).

IUS has continued to expand services providing additional resources to our more seriously ill members. These resources include comprehensive and specialized residential and partial hospital care as well as intensive community treatment and youth and family wrap-around services that are aimed at engaging members in the community to promote resiliency and prevent more serious decline in their mental health condition.

Outpatient Psychiatry Services

Outpatient psychiatry services are provided in departments located at local medical centers where staff are organized into teams that cover Adult Psychiatry, Child Psychiatry, and Addiction Medicine services. Crisis services are also provided by these teams. Practitioners within the Departments of Psychiatry and Addiction Medicine are licensed physicians, psychologists, psychiatric social workers, marriage and family therapists, professional clinical counselors, psychiatric nurse practitioners, psychiatric registered nurses, clinical pharmacologists, pharmacy technicians, and certified alcohol and drug abuse counselors.

Services Outside of Psychiatry

Licensed mental health practitioners (e.g., Behavioral Medicine Specialists, Early Start Specialists, Occupational Medicine Specialists and Chronic Pain Specialists) work within primary care clinics and other specialty areas. These clinicians participate in a quality oversight process led by the facility Department of Psychiatry quality chair. In addition, the outpatient Department of Psychiatry provides consultation/liaison services for medical/surgical inpatients in Kaiser Permanente Hospitals and Emergency Departments.

Adult Services

Adult Psychiatry Services provide medically necessary individual and group outpatient treatment and case management for adult members. The Adult Psychiatry Services provide Intensive Outpatient Program (IOP) services for at-risk patients with urgent mental health problems or those who have been discharged from an inpatient psychiatric unit. Medication management services are available for both outpatients and those in the IOP. Dual diagnosis care is coordinated with the Addiction Medicine Programs.

Child/Adolescent/Family Services

Child/Adolescent/Family Psychiatry Services provide individual, group, and family outpatient treatment for child and adolescent members and their families, as well as parent counseling and education, and crisis intervention services. Medication management services are provided for children and adolescents with mental health problems who can benefit from such services. Adolescent Intensive Outpatient Program services are provided

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for adolescent patients with urgent mental health problems that place them at risk. Case management services are provided for child/adolescent patients who have serious and ongoing mental health problems. Consultation/liaison services are provided to both inpatient and outpatient Pediatrics, the Emergency Department, and other departments that deliver medical care to children and adolescents.

Addiction Medicine and Recovery Services (AMRS)

AMRS provides outpatient level of services, including evaluation, medication management (i.e., detox and medication assisted treatment) support group treatment, case management, co-dependency, and dual diagnosis treatment for adult and adolescent patients. There are two levels of care which are consistent with the American Society of Addiction Medicine (ASAM) guidelines, 1 and 2. AMRS Level 2 are located in ten sites throughout the region and provide a higher intensity of outpatient care for members who need it. AMRS Levels 1 and 2 provide inpatient and emergency department consultations for patients requiring care related to their substance use disorder. AMRS programs authorize referrals to Transitional Residential Recovery Services (TRRS) and Residential Treatment Programs (RTP) in addition to Brief Residential Detox (BRD) for patients who are in need of that service based on ASAM guidelines.

Case Management Services

Case Management provides coordinated services for high-risk and high utilizing members with severe chronic disabling psychiatric illness or dual diagnosis conditions. The role of the case manager includes both primary and adjunctive functions to meet the needs of the patient. Each level of Case Management works to coordinate care across the continuum of services including inpatient, outpatient, and hospital alternative programs.

The goal of case management is to assist patients in navigating internal and external systems to ensure they utilize resources to their greatest benefit. The role of a Case Manager is to help a patient with the coordination of all the services that are required for that patient's care.

Levels of Mental Health Case Management:

- Outpatient Case Management - Provides services in our KP outpatient psychiatric clinics to coordinate care for patients with serious mental illness.
- Inpatient Case Management - Provides on-site coverage in psychiatric hospitals and hospital alternative programs to ensure quality of facility treatment and to provide coordination of care, administrative oversight, and linkage with KP outpatient programs.
- Intensive Case Management (ICM) – Provides services and administrative oversight to high-risk patients who have had multiple inpatient psychiatric hospitalizations. ICMs reach out to our patients and engage them in the community in order to enhance their treatment and link services both in psychiatry and the community.

Regional Sub-Regional (RSR) Services/Tertiary Care Services

RSRs/Tertiary Care Services are specialized intensive outpatient sub-regional services/programs, including AMRS Level 2, Eating Disorder Intensive Outpatient Programs (ED IOP), Electroconvulsive Therapy (ECT) Services and Autism Spectrum Disorder (ASD) Evaluation Centers.

Addiction Medicine and Recovery Services (AMRS) Level 2

AMRS Level 2 programs provide intensive outpatient (IRP {Intensive Recovery Program}, 9 -12 hours/week), day treatment services (6 - 8 hours/day, up to 7 days/week) and a full range of outpatient detoxification services. These programs receive referrals from the outpatient AMRS Level 1, Adult Psychiatry, Child and Adolescent Psychiatry, Pediatrics, and Adult Medicine and the Emergency Department and provide treatment for patients with addiction medicine and dual diagnosis problems. In addition, patients can self-refer to these

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services. Upon completion of AMRS Level 2 program, patients may be referred to their local AMRS Level 1 program. The AMRS Level 2 authorizes all referrals of patients to contracted services for Transitional Residential Recovery Service (TRRS) and Residential Treatment Program (RTP). (Integration of care at this level is not typical – typically patients resume integrated care when they have completed the intensive treatment track in AMRS 2).

Eating Disorder Intensive Outpatient Programs (ED IOPs)

The Eating Disorder Intensive Outpatient Programs (ED IOPs) are designed for adult and teen patients with moderate to severe anorexia nervosa or bulimia who are either at high-risk for medical or psychiatric hospitalization or who have not responded well to lower levels of treatment. Patients are typically referred to an ED IOP by an outpatient therapist from a psychiatry department. Patients are also referred by pediatricians, primary care physicians, or may be admitted directly from the hospital. The ED IOP meets 2-3 times per week to provide treatment, including medical monitoring, psychological counseling, and nutritional therapy, as well as follow-up care after graduation. Treatment typically lasts for 12 to 16 weeks. In addition to medical stabilization, a primary goal of treatment is to help individuals acquire adequate coping skills and address issues contributing to the eating disorder. Treatment is provided in an outpatient group setting, allowing individuals to share a meal as part of a group thereby helping them face their food fears together and helping them transfer this ability to their home environment. Currently, there are three ED IOPs in Northern California in Sacramento, Walnut Creek, and Redwood City and six enriched outpatient programs in Oakland, San Jose, San Rafael, Santa Rosa, Stockton, and San Francisco.

Electroconvulsive Therapy (ECT)

KPNC provides outpatient ECT in Santa Clara, South Sacramento, and Fremont. ECT is administered in the Ambulatory Surgical Center at all three sites.

Goals of the RSR program are as follows:

1. Provide high-quality ECT services to members in need of this treatment.
2. Meet the State of California mandated requirements for reporting and reviewing cases on a quarterly basis.
3. Provide an organized ECT Review Committee that monitors the number of ECTs administered and reviews complications.
4. Coordinate and integrate ECT review committees with the local Quality departments.
5. Develop uniform protocols and procedures for all ECT sites.

Autism Spectrum Disorders (ASD) Evaluation Centers

The ASD Evaluation Centers provide diagnostic evaluation and referral for treatment, as well as specialized consultation to TPMG providers who follow children and adolescents with ASD diagnoses. The ASD Evaluation Centers' multidisciplinary teams offer ASD assessments that not only determine whether an ASD diagnosis is present but also to evaluate the child's level of cognitive and adaptive functioning. In addition, the teams at the ASD Evaluation Centers determine the presence of medical and psychiatric co-morbidities commonly present in this clinical population.

Members with ASD diagnoses are referred as appropriate for services which they are eligible, including Behavioral Health Therapy (such as Applied Behavioral Analysis, where appropriate), case management, medication evaluation and management, and other services within child psychiatry departments region wide. Currently, there are three ASD Evaluation Centers in Northern California: Rancho Cordova, San Jose, and San Francisco.

Transcranial Magnetic Stimulation (TMS)

TMS is an FDA approved treatment for resistant depression. The Permanente Medical Group has developed an extensive external network of providers for treating its KP members. In order to expand the ability and increase access for our members, Oakland, Santa Clara, and South Sacramento started providing TMS at their medical centers beginning in 2018. Since then, TPMG has expanded the internal availability of TMS to 12

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medical centers in 9 service areas. A robust network of contracted providers ensures that access to this treatment option is readily available in all locations. Weekly rounds between TPMG psychiatrists and contracted providers allow for care coordination and quality oversight of IV Brexanolone for postpartum depression. Brexanolone is a neurosteroid that has FDA approval for the treatment of postpartum depression. It is administered intravenously over 60 hours, requiring an inpatient stay. In August 2023 KP Roseville became the 4th site in California where this treatment is administered. As of February 2024, the program has successfully treated 5 patients, including members from other regions.

Behavioral Health Treatment Services for Medi-Cal Members

BHT services include applied behavioral analysis (ABA) and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction. The goal is to promote, to the maximum extent practicable, the functioning of a beneficiary, including those with or without a diagnosis of ASD. Examples of BHT services include behavioral interventions, cognitive behavioral intervention, comprehensive behavioral treatment, language training, modeling, natural teaching strategies, parent/guardian training, peer training, pivotal response training, schedules, scripting, self-management, social skills package, and story-based interventions. For Medi-Cal members to receive BHT services, the member must be under 21 years of age, have a recommendation from a licensed physician and surgeon, a licensed mental health therapist or a qualified, licensed provider, such as speech and language pathologist (SLP) that evidence-based BHT services are medically necessary. Kaiser Permanente also provides continuity of care for Medi-Cal members transitioning from a county Regional Center (RC) for receipt of BHT services.

Psychiatry After Hours Call Center (PACC)

The Psychiatry After Hours Call Center answers calls from members for the Department of Psychiatry after the clinics have closed. After hours calls to Departments of Psychiatry roll over to the call center to support this member service function. The PACC is available from 5 PM to 9 AM and is a 24-hour service on weekends and holidays. The PACC provides assistance to KPNC medical center Emergency Departments and Medical Advice Call Centers by providing telephone consultation or locating an on-call practitioner to consult in an emergent situation. The PACC also receives warm call transfers from Medical Advice Call Centers when a member requires mental health advice. The call center is staffed by licensed behavioral health providers, including licensed Psychologists, Clinical Social Workers, Marriage & Family Therapists, and Registered Psychiatric Nurses. When members call, their needs are assessed, and they are either provided advice, advised to proceed to a KPNC Emergency Department or the nearest ED for evaluation, or advised to call 911. For management purposes, the After-Hours Call Center and the IUS bed location services have been merged under the management of a single manager, overseen by the Regional Behavioral Health Director, Inpatient Psychiatry, Continuing Care, and Integrated Urgent Services and Addiction Medicine Regional Chair.

Connect to Care Telepsychiatry Center (“C2C”)

There are three Connect to Care Telepsychiatry Center (“C2C”) hubs located in San Leandro, Livermore and Rancho Cordova staffed by licensed mental health clinicians. Appointments with Regional C2C are integrated with services in the medical centers to provide rapid availability to virtual assessment and connection to services across the NCAL system of care. C2C is available to members from 8 AM to 6 PM Monday to Friday.

Kaiser Permanente Post-Acute Care Center (KPPACC) Behavioral Health Program (BHP)

In October 2003, KPPACC initiated a BHP designed to serve two distinct patient populations: 1) patients with psychiatric illness and medical conditions, and 2) patients who are medically or neurologically ill who have behavioral disturbances. The BHP care team includes: a full-time psychiatrist; the program director, who is a licensed clinical social worker; and internal medicine support. Other disciplines are involved as needed, e.g., nursing, therapy services, etc. Families and caregivers are a key component of the care plan.

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Behavioral Health Education Program

The Behavioral Health Education (BHE) program offers classes for members experiencing mild to moderate depression or anxiety, anger management problems, sleep problems, life-transition problems, or general stress. The classes are led by instructors with mental health backgrounds or licensed mental health providers. The BHE program forms one component in the spectrum of care for patients needing behavioral health services. Classes are offered at low or no cost to members and, in some locations, for a nominal fee to others in the community.

Services for Medi-Cal Members

The Medi-Cal benefit for Mental Health services includes non-specialty, outpatient behavioral health services, labs, medications, and consults. In Solano and Sacramento Counties Serious Mental Health Services (SMHS) are carved in as a benefit, while in all other counties that contract with KP, SMHS are carved out to County Mental Health. Under new CalAIM legislation, Kaiser has adopted policies consistent with 'No Wrong Door' to ensure that any Medi-Cal member seeking services is assessed irrespective of whether they have a Non-Specialty Mental Health or Specialty Mental Health Condition. KP collaborates with County Mental Health Departments to arrange and support the transfer of care for those members with a SMI or SED conditions to the appropriate venue of care.

Mental Health

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

Covered services are to include:

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

Addiction Medicine or Substance Use Disorder (SUD) Services

Some Addiction Medicine also known as Substance Use Disorder (SUD) services are covered Medi-Cal benefits. When necessary, KP provides Medi-Cal members with Alcohol Use Disorder (AUD)/SUD screening and referral to county or other treatment programs and long-term recovery support. Treatment services are available to Medi-Cal members through county alcohol and drug programs.

Limited addiction medicine services are covered Health Plan benefits:

- Emergent Acute Inpatient Detoxification- the medical management of active withdrawal and emergency overdose symptoms. Coverage for emergent inpatient detoxification would be the same as any other medical condition that requires inpatient hospitalization.
- Medically Assisted Treatment – When a member requires detoxification or maintenance for their addiction KP provides medication services.
- Facilitated Access to Voluntary Inpatient Detoxification Services- When a Medi-Cal member presents for detoxification services but does not meet criteria for acute or emergent inpatient detoxification, KP provides the member with a hand-off to the appropriate county alcohol and drug program.
- Alcohol Misuse Screening Services - Alcohol misuse screening and counseling services (AMSC) for members ages 18 and older as follows:
 - One expanded screening for risky alcohol use per year; additional screenings when medically indicated.
 - Three 15-minute brief intervention sessions to address risky alcohol use per year; additional screenings when medically indicated.

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Medical Services

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

III. KEY LEADERS

Chiefs of Psychiatry

The Chiefs of Psychiatry, as a group, are responsible for policy decisions regionally, approval and implementation of new programs, and oversight of quality and utilization for outpatient and inpatient services at their medical centers. They are the senior practitioner and management personnel onsite in the outpatient clinics or inpatient sub-regions.

Chiefs of Addiction Medicine

The Chiefs of Addiction Medicine are physicians who are Chiefs of AMRS Level 2. They oversee medical issues and the creation of practice guidelines for Addiction Medicine, working closely with the AMRS Program Directors. (Five AMRS Level 2 have an Addiction Medicine Chief; the others have a physician Medical Director who is not an administrative Chief).

Regional Mental Health and Addiction Medicine Administration

RMHA includes the Chair of Chiefs of Psychiatry and Addiction Medicine, Associate Chairs, Regional Directors for Strategy and Programs, as well as Inpatient Psychiatry, Continuing Care, IUS, and Quality. The Chair of Chiefs of Psychiatry has also held the role of the Regional Director of Mental Health and Addiction Medicine services, and along with the Regional Behavioral Health Director, Inpatient Psychiatry, Continuing Care, Integrated Urgent Services, and Addiction Medicine, works closely with behavioral health and medical care specialists in developing criteria and guidelines for resource management and medical necessity for Inpatient/IUS services.

IV. COMMITTEES WITH ACCOUNTABILITY

Committees that perform critical functions in KPNC have been described in the Northern California Program Description. Committees with major accountabilities in Behavioral Health are described below.

Committee Name	Function	Frequency of Meetings	Membership	Makes Recommendations to
Chiefs of Psychiatry and Addiction Medicine	Policy decisions, approval of new programs, and oversight of operations and quality for outpatient and inpatient	10 times per year	All Psychiatric Chiefs, Addiction Medicine Chiefs, Sub-regional Inpatient Psychiatric Chiefs, various regional leads	Regional Senior Leadership, Operations Management Group
Operational Alignment Team	Provides strategic leadership in change management and performance improvement Liaison group between the Chiefs and Directors Group, Peer groups and	Monthly	Chair of Chiefs of Psychiatry, Psychiatry Chiefs representatives, Directors, Leads for Adult, Child, Triage managers, Intensive Outpatient Program managers/peer	Regional Senior Leadership

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Committee Name	Function	Frequency of Meetings	Membership	Makes Recommendations to
	Regional Mental Health Administration in order to achieve engagement, support, and alignment across all the Peer groups to enable and support the work		groups, Addiction Medicine, Regional Director of Inpatient Services, Regional Director of BH Quality, Associate Chairs.	
Behavioral Health Quality Oversight Committee (BHQOC)	Evaluates the quality of behavioral health care and services provided to KPNC members and supports continuous quality improvement of BH programs.	4times per year	Behavioral health physicians and non-physicians and regional quality leaders. Representation from Integrated Urgent Services, Addiction Medicine and Psychiatry, Regional Health Plan Quality, KFH Patient Care Services, TPMG Risk Management, and KFH Area Quality Leaders	Chiefs of Psychiatry, Regional Mental Health Administration, and the Regional Quality Oversight Committee.
Integrated Urgent Services (IUS) Committee	Oversees and monitors IUS quality and utilization programs as well as the Psychiatry After hours Call Center.	Monthly	Sub-Regional Inpatient Chiefs, Health Plan Continuum Administrators, Regional UM Staff	Sub-Regional IUS Committees/BHQOC
Sub-Regional IUS Committees	Similar Tasks as Regional IUS on the local level	Varies-- monthly or bimonthly	Chiefs of Psychiatry within the sub-region, Local Continuum of Care representation, IUS Chief	Local Chiefs, Local UM, IUS Committee

Chiefs of Psychiatry and Addiction Medicine

The Chiefs of Psychiatry and Addiction Medicine as a group are responsible for strategic direction, policy decisions, approval of new programs, and oversight of quality and utilization for outpatient and inpatient services. The Chiefs of Psychiatry and Addiction Medicine group is made up of all Psychiatry Chiefs, Chiefs of Addiction Medicine, and the Sub-Regional Inpatient Psychiatry Chiefs. The Chiefs of Psychiatry and Addiction Medicine elect the Chair of the Chiefs of Psychiatry. This person may also serve as the Regional Director of Mental Health Services, a position that is appointed by the Executive Director and Associate Executive Director of the Medical Group.

Operational Alignment Team

The OAT Group is led by the Director of Regional Mental Health and Addiction Medicine Services of Northern California. This group is charged with leading the change effort toward becoming a service-line of continuous learning and for driving the key Performance Improvement initiatives chosen by the Chiefs and Directors groups. The group makes recommendations to Chiefs of Psychiatry and Addiction Medicine around processes

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for driving change and identifies “bright spots” and other learning opportunities for sharing and spreading with the Chiefs and other operational leadership groups. This group is also a key advisory group to the Director of Regional Mental Health and Addiction Medicine regarding issues related to leadership, change management and strategic alignment.

Integrated Urgent Services Committee (IUS)

The Integrated Urgent Services Committee oversees and monitors IUS quality and utilization programs, the Psychiatry Afterhours Call Center, and the daytime Behavioral Health Phone Line. The chair of the IUS Committee serves on the Regional Resource Management Committee (RRMC). The RRMC oversees utilization management and serves as a link between behavioral health quality and utilization programs.

Behavioral Health Quality Oversight Committee (BHQOC)

The Behavioral Health Quality Oversight Committee (BHQOC), Kaiser Permanente Northern California (KPNC), is a subcommittee of the Quality Oversight Committee. Its function is to oversee and monitor the performance of Behavioral Health (BH) care inpatient and outpatient initiatives, priorities, and programs within KPNC and promote excellence of quality in all aspects of BH care. Membership includes representatives from The Permanente Medical Group (TPMG), Kaiser Foundation Health Plan (KFHP) and Kaiser Foundation Hospitals (KFH).

The functions and responsibilities of BHQOC include:

- Provide quality oversight and recommendations on BH program.
- Provide regulatory and accreditation guidance and oversight for BH care as required by regulatory and accrediting agencies.
- Review, approve, promote, and monitor performance on BH quality improvement initiatives/activities (e.g., HEDIS).
- Report on trends related to complaints, grievances, and appeals to collaboratively address quality issues that arise.
- Oversee and monitor progress of technological investment in outcomes measurement strategy (e.g., Tridium to EPIC initiative, online tools, etc.).
- Review trends related to BH patient safety events and identify systems-level opportunities for improvement.
- Oversee external BH provider network, including issues related to expansion, contracting, access, and quality.
- Evaluates the quality of clinical care and service across all settings for the full spectrum of BH services provided.
- Makes recommendations to relevant leadership and stakeholder groups for actions to improve BH clinical quality and service quality.
- Reviews HEDIS and other quality metrics relevant to the provision of BH services.
- Identifies opportunities for improvement and establishes priorities among them.
- Reviews and approves, from a quality assurance perspective, the implementation of new BH policies and procedures across all departments where BH services are provided.
- Escalates matters where serious quality concerns arise directly to relevant leadership and stakeholder groups.
- Documents meeting activities, distributes meeting materials and follows standard agenda formats and templates for reporting.

V. LINKAGES

Regional Mental Health Technology Committee

This committee is responsible for overseeing technology issues as they pertain to Mental Health and Addiction Medicine Services. There is a particular focus on issues pertaining to the electronic medical record (e.g.,

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access to mental health and addiction medicine information for non-MH/AMRS providers, templates for MH/AMRS providers, extraction of information from the record, etc.). There is also a focus on new technologies and their potential to improve delivery of MH and AMRS care to members.

Mental Health Department Directors

The Mental Health Department Directors, as a group, are responsible for the implementation of the strategic direction, the policy decisions, and program development for outpatient mental health services. The Mental Department Directors work in partnership with the Chiefs of Psychiatry and have administrative oversight of department operations.

Child and Adolescent Psychiatry Leadership Group

The Child and Adolescent Psychiatry Leadership Group is composed of Child Psychiatrists, Directors, and Managers. They are responsible for policy recommendations, development of new programs, and oversight of quality improvement and utilization management for all child and adolescent behavioral health services.

Adult Services Managers

The Adult Services Managers, as a group, are responsible for policy recommendations, development of new programs, and oversight of quality improvement and utilization management for all adult behavioral health services.

Addiction Medicine and Recovery Services (AMRS) Program Directors

The AMRS Program Directors as a group are responsible for policy recommendations, development of new programs, and oversight of operations and quality improvement for all Addiction Medicine and Recovery Services.

Addiction Medicine and Recovery Services (AMRS) Leadership Group

The AMRS Leadership Group is a regional group of Addiction Medicine Chiefs and Medical Directors collaborating with Addiction Medicine Program Directors who provide ongoing oversight of AMRS operations and quality of care with the intention of identifying strategic priorities, developing regional processes for driving change and fostering leadership in AMRS. The group is co-led by the Chair of the Chiefs of Addiction Medicine and the Chair of the Program Directors of Addiction Medicine and Recovery Services. This group makes recommendations to the Chair of Chiefs of Addiction Medicine and ensures alignment with other behavioral health leadership groups.

Feedback Informed Care Champions

The FIC Champions group is led by the Associate Director of Outcomes and Technology, meets on a quarterly basis, and is comprised of front-line clinical staff appointed and supported by their department Chief. The groups are charged with implementing improvement in clinical care at the patient-care level.

Regional Pharmacy and Therapeutic Committee (P&T)

The KPNC P&T Committee is responsible for developing and revising the KPNC Drug Formulary. The P&T Committee makes recommendations to KPNC regional and local leadership relating to pharmacy policy. The Chiefs of Psychiatry provide expert opinion to the Regional P&T Committee on a variety of pharmaceutical issues including decisions on formulary additions and deletions.

Regional Resource Management

Regional Resource Management and Behavioral Health have established effective linkage through the participation of the Regional Behavioral Health Director, Inpatient Psychiatry, Continuing Care, and Integrated Urgent Services and Addiction Medicine Regional Chair on the Resource Management Committee and the Resource Management Compliance Committee.

Medical Center Quality Committees

Local medical centers convene behavioral health quality committees which include representation/participation from behavioral health clinicians practicing in various medical center settings. The representative provides linkage between Psychiatry/Addiction Medicine and other departments that have behavioral health practitioners. The leaders also represent their departments on the Psychiatry and Addiction Medicine Quality Committee.

Inter-regional New Technology Committee

The INTC identifies and evaluates evolving medical technologies. A BH practitioner is a liaison to the New Technology Committee. In that role, the BH representative receives communications from and provides expert input on new technologies and how they relate to behavioral health. This representative provides linkage with the Chiefs of Psychiatry.

VI. QUALITY

The Behavioral Health quality program includes components related to quality, service, and care delivery. The behavioral health quality programs are linked to the KPNC quality program's goals and objectives.

Quality Goals

- Assess performance and make recommendations to the Chiefs of Psychiatry on quality and performance improvement.
- Promote consistent, high quality, evidence-based and member-centered care for our members and propose future quality initiatives and improvement activities.
- Disseminate and implement suicide prevention practices across the region.
- Coordinate with the Practitioner Performance Review & Oversight Committee to ensure quality of provider-delivered care.
- Promote improved functioning of facility behavioral health quality committees and their participation in facility quality activities.
- Promote cross-department collaboration and coordination on quality initiatives.

VII. ACCESS

The predominant form of entry for behavioral health services for KPNC members is through "open" direct access. Members access behavioral health services by calling clinics directly and requesting an appointment with a BH practitioner. TPMG practitioners outside of Behavioral Health may also refer a member for behavioral health services. Behavioral health services are managed by service type, described below. Standards for access are established and tracked. KPNC access standards adhere to the standards set by the California Department of Managed Health Care. On-call behavioral health practitioners are available 24 hours a day to assist members who require emergency services in the clinics, hospital, or emergency departments. The Medical center Chiefs of Psychiatry monitor and ensure the availability of practitioners for on-call services on an ongoing basis. Access standards to behavioral health are monitored by the Chiefs of Psychiatry on a regular basis under the strategic direction of the Regional Mental Health Associate Chair for Access and Operations and the regional Access Team. They are also monitored by the QOC and the BHQOC.

VIII. Resource Management

Designated Physician

The Associate Executive Director (TPMG) is responsible for TPMG Resource Management. The Director of MH and AMRS Services is the designated senior practitioner in the behavioral health aspects of resource management. He/She is assisted by the Regional Director for Inpatient Services and the Regional Director for Outpatient Services.

Behavioral Health/Resource Management Guidelines

KPNC primarily uses generally accepted standards of mental health and substance use disorder care. When conducting utilization review, determinations are made consistent with guidelines and recommendations of professional organizations and/or non-profit health care provider professional associations to guide qualified physician(s) or licensed practitioners in making a final decision regarding medical necessity. The final decision regarding the Member's treatment plan rests with the TPMG responsible practitioner. Resource Management/Continuing Care staff are available to support practitioners in the management of member's health care needs throughout the care continuum and provide a variety of services, such as discharge planning, utilization review, and care management.

KP clinicians utilize current literature and individual clinical expertise in making care decisions. TPMG Consulting Services publishes guidelines for the treatment of Depression and ADHD.

Coverage Decisions

Benefit coverage determinations are based on the Evidence of Coverage language approved by the California Department of Managed Health Care. A process for both member and practitioner appeals are available through the Regional Member Relations Department.

KPNC does not encourage decisions that result in under-utilization nor does KPNC reward practitioners or UM staff based on utilization.

Appropriate Professionals

The final decision regarding the member's treatment plan rests with the appropriate Behavioral Health Practitioner. Any denial based on medical appropriateness is reviewed by an appropriate Behavioral Health professional. Inter-rater Reliability (IRR) of Behavioral Health decisions is monitored as part of the regional IRR process on an annual basis.

Triage and Referral

Psychiatry After Hours Call Center has written Triage and Referral protocols. The Call Center protocols are reviewed and approved by the IUS Committee and the Subregional Chiefs and Directors of Inpatient Psychiatry on an annual basis. Call Centers are under the direction of a physician or licensed psychologist.

Only appropriate professionals are involved with Triage and Referral decisions:

- Clinical staff includes Psychologist, Marriage and Family Therapist, LCSW, and RN.
- Supervise clinical decisions for triage and referral staff: MD or Psychologist.
- Oversee triage and referral decisions: MD or Psychologist.

Monitoring Over and Under Utilization

Monitoring of Over and Under Utilization to ensure consistency and quality of care is accomplished by extensive data and information reviews. Additionally, outpatient utilization is monitored on a quarterly basis in a variety of ways. In particular, mental health visits and staffing ratios are reviewed to identify utilization and productivity trends.

Behavioral Health data is included in the Resource Stewardship Analytical Bulletin. This information is reported and distributed widely throughout the region at the regional and local levels. This information is analyzed and used to identify opportunities to improve care.

IX. SATISFACTION

KPNC measures member and practitioner satisfaction with Behavioral Health. Surveys include both quality and utilization topics. Surveys are at least annual. Results and actions for performance improvement are discussed on the regional and local levels. Surveys include the following:

- Behavioral Health Inpatient Satisfaction Survey
- Member Patient Satisfaction Survey
- Practitioner Satisfaction Survey

X. EVALUATION/REVIEW/APPROVAL OF THE BH PROGRAM

The Behavioral Health Program Description will be reviewed and approved annually. Approval is through the members of the following committees: Chiefs of Psychiatry and Addiction Medicine, Resource Management Committee, and the Quality Oversight Committee.

KAISER FOUNDATION HEALTH PLAN
NORTHERN CALIFORNIA, INC.

EQUITY, INCLUSION, & DIVERSITY PROGRAM DESCRIPTION 2024

REGIONAL EQUITY, INCLUSION & DIVERSITY DEPARTMENT

Reviewed by: Tera Eng
Senior Director, Equity, Inclusion & Diversity

Date: January 1, 2024



Overview – Kaiser Permanente-Organizational Commitment to Equity, Inclusion and Diversity

Throughout Kaiser Permanente's 75-year history, we have consistently taken a stand for equity, inclusion, and diversity, which are inextricably linked to our mission and part of everything we do. We know that having a diverse and inclusive workforce makes Kaiser Permanente a better place to receive health care, a better partner in the communities we serve, and a better place to work.

- We celebrate that our organization continues to reflect the diversity of the communities we serve, with race, ethnicity, age, gender, religion, individuals with disabilities, sexual orientation, military experience, and so many other diversity dimensions working together for a shared mission.
- We believe in equity, inclusion, and diversity in all aspects of our mission – in our exam rooms, our ORs, our Emergency Departments, our hospitals, our partnerships, among our staff, on our streets, and in our communities.

Overview – Kaiser Permanente Northern California

Kaiser Permanente Northern California (KPNCAL) is an integrated Health System composed of three legal entities: Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser foundation Hospital (KFH) and The Permanente Medical Group, P.C. (TPMG). The Program serves over 4.5 million Northern California Health Plan members/patients. KPNCAL is comprised of 14 Medical Service Areas and 23 Facilities

The KPNCAL Equity, Inclusion and Diversity (EID) Program includes various components outlined in the EID Department Program Description and serves KPNCAL's Health Plan and Hospitals (KFHP/H). It is closely aligned with the Regional Language Access and ADA/Civil Rights Programs within HP/H and partners closely with TPMG's EID team. KPNCAL partners with all KFHP/H business functions to embed EID thinking into priority areas from Care Experience to Quality, Patient Care Services, Community Health, Human Resources, and more.

The purpose of the KPNCAL EID Department Program Description is to inform both internal and external audiences how KPNCAL is organized to support the Program's commitment to Equity, Inclusion, & Diversity as KPNCAL provides outstanding care to our member population.

Equity, Inclusion, and Diversity Structure and Scope

EID's desire to provide high quality culturally responsive and inclusive care is supported by an expansive infrastructure which is key to its successful efforts to fully integrate health care equity into the fabric of the organization, and is led by the National Equity, Inclusion, and Diversity Department, KPNCAL Regional Equity, Inclusion, and Diversity Department, the Business Resource Groups (BRG – previously known as Employee Resource Groups), the unofficial Local Equity, Inclusion, and Diversity Committees and numerous Regional stakeholders. KPNCAL's EID Department officially reports up to the National Equity, Inclusion, and Diversity Department at the Kaiser Permanente Program. The KPNCAL EID Strategy is aligned with the program at-large, but is rooted in NCAL needs and serves the NCAL market within HP/H.

The organization's view of diversity is all-inclusive, to include race, ethnicity, gender, sexual orientation, gender identity, age, literacy, education, cultural heritage, functional ability, cognitive

ability, and other aspects that make each of us unique, being sensitive and considerate to the needs of all people including seniors and persons with disabilities. The Program takes full advantage of the strengths inherent in these differences in its members, patients, communities, workforce, and leadership, aiming to deliver on the basic KP value that all individuals are to be treated with sensitivity, dignity, and respect.

To help ensure health care equity, KPNCAL and its Equity, Inclusion, and Diversity infrastructure produces and maintains numerous programs, diversity related policies, and cultural awareness trainings for our HP/H staff to ensure the delivery of culturally responsive and inclusive care that meet the needs of our diverse membership. Annually, KPNCAL, coordinated by the Equity, Inclusion, and Diversity department performs assessments of the membership race, ethnicity, and language. Based on the analysis of annual data the Equity, Inclusion, and Diversity Department, in conjunction with local EID leaders, seeks to promote the following objectives:

- Provide culturally responsive and inclusive care and service to eliminate disparities and demonstrate equity
- Optimize and as needed review workforce diversity and culturally responsive and inclusive care at every level and create inclusive environments
- Provide the most compelling value for our diverse populations
- Build diverse and thriving communities

National Equity, Inclusion and Diversity Department

EID Vision – Equity and Inclusion for All

Within Kaiser Permanente's 2025 five overarching goals, is Quality and Equitable outcomes. The enterprise-wide foundational commitment of Equity leads to the Equity Execution plan with Commitments. The Equity Execution Plan (EEP) is a multi-year plan using an enterprise strategy execution framework. The EEP includes goals and measures in the following areas: Workforce equity, Health equity, Community: Systemic Racism, Economic Impact.

Finally, within the EID function, cross cutting areas to support the KP EEP includes: 1) Inclusion, Belonging and Empowerment for all People; 2) Fairness and Equity in All Systems; 3) Community and Societal Impact, and 4) EID Excellence and Infrastructure.

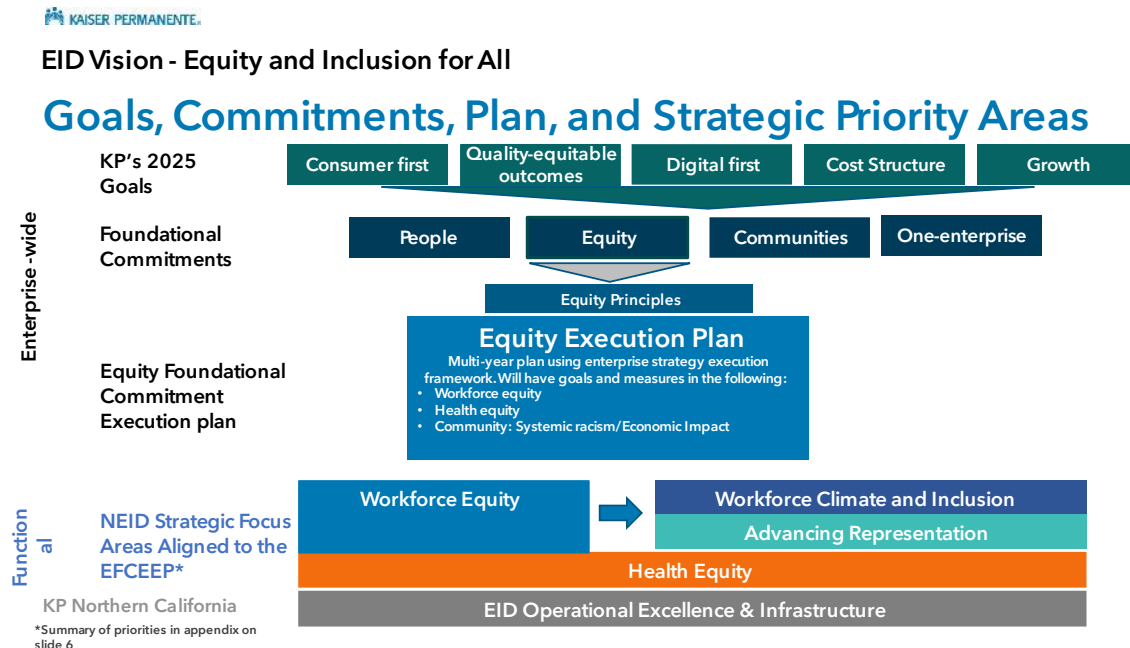
KP Equity Principles

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

Kaiser Permanente's Equity principles

Equity is the ideal of fairness and justice. These principles guide our practices and behaviors, reflecting our mission and vision.

 Inclusion	 Accountability	 Advocacy
I foster inclusive environments where everyone feels safe sharing ideas, concerns, and aspects of their identity without fear.	I am accountable for my individual action or inaction that leads to others being harmed.	I advocate for equity and inclusion for all people and amplify the voices of the most impacted and unheard.
Principles in Action		
• I encourage and celebrate self-expression and model authenticity that builds trust, safety, and a sense of belonging for all. • I respect the basic human right to fair and dignified treatment free of bias, racism, and oppression. • I act with personal integrity, transparency, and understanding.	• I am accountable for acting with integrity and respect. • I seek to demonstrate a commitment to learn, understand, and disrupt the influence of bias, stereotypes, and racism, in my thoughts, actions, and words. • I name and speak out on actions and processes that produce unfair, unjust, and preventable outcomes.	• I take personal accountability and act for fairness, justice, and inclusion for all. • I boldly commit to support everyone's equal right to belong and reach their full potential at Kaiser Permanente. • I actively use my voice, resources, and influence to support equity for all people.



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Our Kaiser Permanente EID Strategy

The equity execution plan is organized around three refined pillars of work to underpin the equity foundational commitments. The pillars describe KP's desired future state for systemic change and serve as a guide to the frame the work. We recognize it will likely take change in the 3-year horizon to achieve these ambitions, and we will continue to adapt and learn as we go.

1) Workforce

All people of KP have the equal opportunity to reach their full potential benefiting from an inclusive, psychologically safe workplace.

Goal - Achieve diversity at every level with a fully engaged and high performing workforce in equitable and inclusive environments.

Key focus areas for workplace:

- Workforce Equity - we build sustainable, effective practices throughout the employee lifecycle to achieve the best workforce performance and equity at all levels.
- Inclusive Environments - we enable a high-performing, inclusive culture that drives collaboration, engagement, belonging, and continuous learning.

2) Health Equity

We aspire to achieve equity in health outcomes and experience through the elimination of systemic barriers, such as racism and other forms of oppression in health care.

Goal – Achieve equitable health outcomes by providing inclusive care and eliminating avoidable and unjust disparities.

Key focus areas for care delivery:

- Health Equity - we institutionalize practices that allow us to continuously identify and eliminate inequities that prevent the best possible health outcomes for all populations.
- Inclusive Care - through continuous learning and skill development, we advance scalable cultural competence, agility, empathy, respect, and humility as key attributes to working within equitable systems.

3) Community

We aspire to engage, influence, and invest in community capacity to address the impacts of systemic barriers to health and economic opportunity.

Goal – Enhance health equity in the community and Kaiser Permanente's measurable impact on economic and social inclusion. (This includes collaboration with National Supplier Diversity.)

Key focus areas for community:

- Total Health - we are committed to helping people be healthier in all aspects of their lives and to building stronger, healthier communities.
- Economic and Social Inclusion - we ensure that the money we spend helps create jobs and increases the economic and social vitality of our communities.

COMPLIANCE AND REGULATION: Ensure that KP's strategic EID vision and operational excellence meets and/or exceeds regulatory and compliance requirements. (This includes collaboration with National Ethics and Compliance.)

KPNCAL Regional Equity, Inclusion, and Diversity Department

The KPNCAL Regional EID Department Program resides within the governing entity of Kaiser Foundation Health Plan, with strategies and services that are aligned with the National EID strategy. The Regional EID Department supports the infrastructure responsible for driving the region's strategic EID initiatives. This infrastructure includes the KPNCAL EID Leadership Forum and Community of Practice. Through the Regional EID Leadership Forum and Community of Practice, the EID Department provides guidance to local diversity programs ensuring the alignment with the National EID. Furthermore, the Regional EID Department partners closely with the Regional Language Access Program and ADA/Civil Rights program as needed to meet Culturally and Linguistically Appropriate Services (CLAS).

Regional EID also supports and aligns with the KFHP Human Resources (HR) strategy and the Labor Management Partnership's priorities and other business goals that support the delivery of high-quality health care for our members. Furthermore, the KPNCAL strategy supports the retention, development, and utilization of the highest caliber diverse workforce (employees, leaders, and physicians) in the industry. The purpose of KPNCAL EID Program is to:

- Partner as needed with the Regional Language Access Program and ADA/Civil Rights programs to provide leadership for culture and linguistic services in support of CLAS Standards of NCQA and Office of Minority Health to improve business results.
- Develop, recommend, and implement the regional diversity strategy in alignment with the organizational goals to leverage workforce diversity, including the review/recommendation of policy decisions.
- Enhance the cultural competence of support staff, clinical staff and practitioners through education, training, and a variety of resources and materials to support the delivery of culturally and linguistically responsive/appropriate care for members/patients.
- Develop, train, educate, promote, and ensure EID training and education is embedded throughout the program's initiatives and standard operating procedures and practices.
- Collaborate with the HR Department to recruit, retain, and enhance the diversity, cultural competence, skill, and performance of our workforce.
- Partner as needed with the Regional Language Access Program and ADA/Civil Rights program to build capacity to offer culturally and linguistically appropriate services and communicate information of such services to members/patients.
- In partnership with compliance and local leadership, promote EID training
- Develop, monitor, and communicate diversity metrics.
- Maintain department website updates.
- Facilitate membership growth through effective market segmentation that targets specific populations.
- Facilitate the development of partnerships to engage community/membership.
- Embed EID thinking into organizational priorities to design for equity.

Regional Equity, Inclusion, and Diversity Department Program Goals and Objectives

Goals

- Partner with Regulatory Quality teams to support accreditation efforts such as NCQA Health Equity Accreditation, TJC Health Equity requirements, AHA's Health Equity Transformation Assessment, Health Equity Index survey, Leapfrog Survey's health equity section, etc.
- Partner with Regional Language Access Program and ADA/Civil Rights program as needed to provide an inclusive experience
- Maintain and improve quality of care and service provided to members through an infrastructure that supports care delivery by embedding equity into prioritized areas of work as defined by leadership
- Identify areas to improve processes, patterns and outcomes of care, service and access through systems, reports, education, training etc. and
- Ensure the implementation and oversight of metrics and communicate the status of such to the appropriate leadership bodies.

Objectives

- Collect, measure, and analyze program performance information accurately and efficiently to identify opportunities for improvement. (In collaboration with medical centers, establish standards and performance expectations when appropriate, indicators, data collection and reporting).
- Report and communicate collected information results to medical centers, appropriate individuals/groups enabling practice changes, and improvement in quality of care and service.
- Demonstrate value through data performance collection and information reporting as required.
- Provide consultation and advice to improve Equity, Inclusion and Diversity activities in the region
- As needed, promote involvement of members of culturally diverse populations in identifying and prioritizing opportunities for improvement through patient advisory councils

KPNCAL Equity, Inclusion and Diversity Leadership Forum & Community of Practice

The KPNCAL Equity, Inclusion and Diversity Leadership Forum provides unofficial oversight of EID work provided within the region. This group is composed of local EID representatives from Kaiser Foundation Health Plan and Hospital (KFHP/H) that meet monthly. The KPNCAL Equity, Inclusion and Diversity Leadership Forum and Community of Practice is a second body consisting of regional and local EID representatives from across various business functions within KFHP/H that meets on a quarterly basis to review EID work and disseminate in their respective areas.

KPNCAL EID Leadership Forum & Community of Practice functions include:

- Review and recommend EID considerations across the region
- Identify EID priorities within unofficial local EID committees and/or regional business functions
- Develop and facilitate linkage to EID considerations in their areas to meet the needs of our membership/patients and communities
- Unofficially advise/recommend to the sponsor annual goals, strategy development and tactics to EID practices
- Unofficially identify gaps/challenges and monitor progress of EID practices in their respective areas
- Share and disseminate information to local and regional groups.

KPNCAL Equity, Inclusion, and Diversity Sponsor Meetings

The KPNCAL Equity, Inclusion, and Diversity Sponsor meetings provide oversight on priorities and direction of the regional EID department. Sponsors include NEID leadership and KPNCAL Executive leadership.

KPNCAL EID Sponsor Meeting functions include:

- Provide status updates on progress of set goals and key milestones in EID goals.
- Review and approve overall strategy and direction of department.
- Monitor progress of goals to ensure timeline is met and gaps are identified and resolved.
- Establish and make recommendation on gaps or opportunities identified.

Performance Goals – Priority Setting, Performance Improvement and Accountabilities

The performance goals, objectives and priorities are determined by the KPNCAL Equity, Inclusion and Diversity Department and reviewed with the Executive Sponsor. Goals are set by identifying metrics, establishing targets, getting targets approved, finalizing goals and weights for staff, and finally cascading goals as relevant. Additionally, goals are finetuned based on other business function priority areas and opportunities to embed equity thinking into key performance indicators. Annually, status and updates are documented in the Equity, Inclusion, and Diversity Work Plan. The KP NCAL HP/H Leadership team has oversight of the Equity, Inclusion, and Diversity goals for the year.

Equity Priorities

Equity commitments — a closer look

Kaiser Permanente's equity commitments include actions around health equity, community health, economic opportunity, and workforce equity. The following equity commitments are established by the National Equity, Inclusion, and Diversity department and are adopted by the regions, including the Northern California region.

Advance health equity

Commitment: We will improve care experience and health outcomes by eliminating racism and other forms of bias or oppression in health care.

Our total health approach to advance health equity includes culturally responsive and inclusive care, addressing social needs, social justice, and dismantling racism. These priorities guide our investments as an organization. Additionally, we are integrating equity into our care quality efforts. And while our boards of directors have prioritized health equity for years, we are now ensuring that all performance data and measures will be viewed through an equity lens. Examples of our health equity work include:

- Maintaining the Health Equity Advisory Council that will advance our long-standing commitment to providing high-quality, equitable, and culturally and linguistically responsive care
- Continuing to partner with the Community Health department to explore opportunities to address the social drivers of health that have led to poorer health outcomes for our most vulnerable populations

Address racism and intergenerational trauma

Commitment: We will increase knowledge of the health impacts of racism and create systems of care and support that mitigate the impact of intergenerational trauma.

We will leverage our platform and influence to support grassroots efforts to end systematic racism and break the cycles of related stress and trauma that limit achievement of total health. We will provide \$25 million in grant funding to non-profit organizations that are led or governed by people from underrepresented communities working to:

- Dismantle discriminatory institutional practices, structures, and public policies through leader development, community power-building, organizing, and advocacy
- Promote healing from chronic stress, trauma, and grief that stems from systemic racism and social injustice

Provide economic opportunity

Commitment: We will create economic opportunity for Black-owned businesses and other businesses owned by marginalized groups.

Economic opportunity is foundational to healthy communities; it supports housing stability and food security, as well as physical, mental, and social health. We know that support for under-resourced business owners of color can change the trajectory for individuals, families, and entire communities.

Kaiser Permanente invests in programs that create equitable economic opportunity for underrepresented communities and work to dismantle racist systems that create barriers to success. We promote these shifts to help close the racial wealth gap. Accordingly, we will use our purchasing power to build healthy, equitable, and sustainable economies:

- We will provide support to more than 2,000 businesses owned by people from underrepresented communities.
- We are committed members of the Billion Dollar Roundtable and related supplier diversity efforts to spend \$2 billion per year on individuals of color-, women-, LGBTQ+, veterans-, veterans with disabilities-, and individuals-with-disabilities-owned enterprises.
- We provide good jobs to individuals facing barriers to employment through high impact hiring efforts.

Advance workforce equity

Commitment: We will build an inclusive, psychologically safe workplace, where everyone has an equal opportunity to reach their full potential.

Our workplace commitments are centered on our employees and physicians. This work will help us build a highly inclusive, engaged, and psychologically safe workplace so that our people can

contribute at their highest level to support Kaiser Permanente's mission. Examples of this work include:

- Further remove bias and racial inequities from the employee and physician experience through our new [Belong@KP](#) program
- Implementation of equitable and inclusive practices across the employee life cycle with the intention of identifying, recruiting, developing, mentoring, assessing, and retaining diverse talent
- Address the need for healing and recovery from historical and societal racial and oppression-related stress and trauma through listening sessions aimed at collecting information for action.

Belong@KP

As part of Kaiser Permanente's equity commitments, we are introducing [Belong@KP](#), an enterprise-wide program to foster inclusion and social justice into everything we do.

- Through [Belong@KP](#), we will lay the foundation of an inclusive environment by learning how to think and behave more inclusively.
- These inclusive behaviors will be core to the culture we need to support healing and unity and successfully achieve our mission, creating an improved career experience where everyone feels they matter, they are valued, and are treated fairly.
- In an inclusive, psychologically safe, engaging work environment, our people can contribute at their highest levels, better enabling KP to provide equitable and culturally responsive care and pursue social justice for our members, patients, communities, and each other.

What is [Belong@KP](#)?

- [Belong@KP](#) is an action-focused awareness and behavior change program designed to help the people of KP learn and demonstrate inclusive behaviors and combat racism and social injustice, so we all feel we matter, we are valued, treated fairly, and share a sense of belonging. This program will help our people recognize biases in their thinking and actions and give them tools to think and act more inclusively.
- Additionally, we will embed inclusive practices into how we identify, recruit, develop, mentor, assess, and retain diverse talent.

[Belong@KP](#) is built on anti-bias and anti-racism core principles that guide the learning journey. We partnered with experts from the NeuroLeadership Institute to develop custom learning experiences.

- The 3 anti-bias modules were developed in partnership with the NeuroLeadership Institute.
 - **Break Bias** is about learning to notice and address unconscious bias as it arises.

- **Cultivate Belonging** is about fostering an environment of psychological safety and authenticity to make sure everyone reaches their full potential.
- **Respect Every Voice** is about asking, listening, valuing, and helping other people speak up.

What is the difference between Belong@KP and ILEaD?

- Belong@KP and ILEaD (Inclusively Leading through Equity and Diversity) are complementary programs developed to help the people of Kaiser Permanente act more inclusively.
- ILEaD is built upon Kaiser Permanente's 7 attributes of leading inclusively: self-aware, fair, courageous, adaptable, curious, collaborative, and humble.
- Belong@KP is focused on fostering inclusion and social justice in everything we do, centered on principles and habits that are specific to disrupting bias and dismantling racism.

Belong@KP and our equity commitments

- Kaiser Permanente aims to promote fair and inclusive behaviors and systems within our organization to achieve workforce equity and inclusion, advance health equity for our members and communities, and leverage our voice, resources, and influence to create equity and inclusion for all underrepresented and historically marginalized groups.
- By achieving greater workforce inclusion and equity through Belong@KP, we will more effectively leverage the power of our diversity, enabling our entire workforce to give their best in support of our mission and our other equity initiatives.

How does Belong@KP support KP's equity, inclusion, and diversity journey?

Belong@KP is the next step on that journey, aiming to create a more inclusive and equitable workplace. In transforming our work environment, we will better leverage the power of our diversity for the benefit of our workforce, our members, and our communities.

Health Equity

Kaiser Permanente is committed to eliminating disparities and inequities in health care quality and access, in addition to leading the industry in developing and implementing innovative approaches to improve health equity. Our total health approach to advance health equity includes culturally responsive care, addressing social needs, social justice, and dismantling racism. These priorities guide our investments as an organization. Additionally, we are integrating equity into our care quality efforts. And while our board of directors has prioritized health equity for years, we are now ensuring that all performance data and measures will be viewed through an equity lens. Examples of this work include:

- Continue addressing the social drivers of health that have led to poorer health outcomes for our most vulnerable populations
- Partner with the NCAL Maternal and Child Health team to promote equity for our birthing families and newborns. This includes building off of the Senate Bill 464 initiatives to expand ongoing opportunities to learn and practice unconscious bias techniques in healthcare.
- Consult with Quality leaders to embed equity into quality consulting lifecycle and take an equity centered design lens to performance improvement
- Partner with regional stakeholders to combat systemic racism and break the cycles of stress and trauma that lead to poor health outcomes.

Racism and intergenerational trauma

We will leverage our platform and influence to support grassroots efforts to end systematic racism and break the cycles of related stress and trauma that limit achievement of total health. We will provide \$25 million in grant funding to non-profit organizations that are led or governed by people from underrepresented communities working to:

- Dismantle discriminatory institutional practices, structures, and public policies through leader development, community power-building, organizing, and advocacy
- Promote healing from chronic stress, trauma, and grief that stems from systemic racism and social injustice

Equity-Centered Design

Kaiser Permanente is committed to dismantling inequity by design in our organization. The KPNCAL EID department has taken on the task of launching, consulting, and supporting equity-centered design initiatives. Equity-Centered Design (ECD) is a holistic approach that helps you apply an equity lens in your work. In NCAL, EID is partnering with the NCAL EID Leads, Quality Improvement (Clinical Innovation Consultancy), Regional Portfolio Management Offices, Consumer Experience, and other prioritized groups.

Aspiring Equity-Centered Design Practices

These five practices outline what KP values and recommends for re-designing a future in which equity and inclusion are woven into the fabric of our organization.

1. Start with yourself – practice self-reflection.
2. Center on historically excluded communities to lead and co-design.
3. Make the invisible, visible - share knowledge and build on what already exists.
4. Implement in small increments; adapt and adjust before leading large scale change.
5. Re-design at all levels within the KP ecosystem (e.g., fish, lake, groundwater).

[Equity-Centered Design Website](#)

Economic Opportunity

Economic opportunity is foundational to healthy communities; it supports housing stability and food security, as well as physical, mental, and social health. We know that support for

under-resourced business owners of color can change the trajectory for individuals, families, and entire communities.

National Equity, Inclusion, and Diversity (NEID) Kaiser Permanente invests in programs that create equitable economic opportunity for underrepresented communities and work to dismantle racist systems that create barriers to success. We promote these shifts to help close the racial wealth gap. Accordingly, we will use our purchasing power to build healthy, equitable, and sustainable economies:

- We will provide support to more than 2,000 businesses owned by people from underrepresented communities.
- We are committed members of the Billion Dollar Roundtable and related supplier diversity efforts to spend \$2 billion per year on individuals of color-, women-, LGBTQ+, veterans-, veterans with disabilities-, and individuals-with-disabilities-owned enterprises.
- We provide good jobs to individuals facing barriers to employment through high impact hiring efforts.

Health Disparities

Note: the following are priorities set by the National Equity, Inclusion, and Diversity department. The health disparities priorities outlined below are within the scope of The Permanente Medical Group and not the KPNCAL Equity, Inclusion, and Diversity team which has oversight within the Health Plan and Hospitals.

At Kaiser Permanente, we are committed to reducing and eliminating disparities in health care quality and access and leading the industry in developing and implementing innovative approaches to improve health equity. Our membership comprises of nearly 40% of members from historically underrepresented groups, linguistic diversity exceeding 130 languages, and a total workforce composition that reflects and frequently exceeds the diversity of the communities we serve. We are ideally positioned to lead the nation's efforts in providing culturally responsive care to reduce, and ultimately, mitigate health disparities.

- Kaiser Permanente has used quality of care data broken down by race, gender, and ethnicity for more than 10 years as a guide to drive health care innovation and priorities.
- When our data indicates a disparity in care, we create a comprehensive plan to address and reduce that disparity.
- Among the areas we have closed the gap in screening and control rates (*Data source: Equitable Care Health Outcome Report Q1 2023*):

Breast cancer screening • National 90th percentile: 78.5% • KP Black/African American: 85.2% • KP Asian/Pacific Islander: 84.6% • KP Hispanic/Latinx: 85.4% • KP Multiracial: 84.0% • KP White: 82.3%	Colorectal cancer screening • National 90th percentile: 76.2% • KP Black/African American: 74.2% • KP Asian/Pacific Islander: 76.2% • KP Hispanic/Latinx: 70.5% • KP Multiracial: 73.3% • KP White: 76.6%	Blood pressure control: • National 90th percentile: 73.3% • KP Black/African American: 74.4% • KP Asian/Pacific Islander: 79.1% • KP Hispanic/Latinx: 77.2% • KP Multiracial: 75.2% • KP White: 77.3%

[\[ECHO Reports\]](#) (requires permission to access)]

Health Equity Advisory Council:

- As shared by Greg Adams, chairman and CEO of Kaiser Foundation Health Plan, Inc. and Hospitals, Kaiser Permanente created the Health Equity Advisory Council (HEAC) to build on our work to identify and mitigate health care disparities and inequities and reinvigorate our long-standing commitment to providing high-quality care that is culturally and linguistically responsive and equitable.
- HEAC will advance KP's health equity commitments and specifically the elimination of inequities, which are multi-dimensional and include but are not limited to access, affordability, housing, mental wellness, racism, bias, and oppression through education, leadership, subject matter expertise, and resources. HEAC will be organizational stewards and bold disrupters for sustainable and equitable change by challenging the current structures and operations to identify and eliminate any that might enable or perpetuate racism and/or inequities.

Improvement Goals

We will set a limited number of improvement targets and track progress toward those targets through an equity lens.



Cancer Care

- We will reduce colorectal cancer mortality by 50% over the next 10 years and eliminate differences between race/ethnicity groups (3-year pro-rated goal)



Mental Health & Wellness

- Within the next three years, double the percentage of individuals with depression who show evidence of response (based on PHQ-9) after diagnosis, and maintain or achieve equity between race/ethnicity categories



Cardiovascular Health

- At the end of 3 years, the incidence of stroke and heart attack are unchanged or better than 2021.
- Kaiser Permanente will achieve heart attack and stroke rates for each racial and ethnic group that are not higher than the enterprise rate in 2021.



Maternal Health

- Vision Zero: We will equitably eliminate preventable maternal deaths associated with obstetrical hemorrhage and hypertensive disorders in the next 5 years

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Outcome Measures

We will monitor trends in these outcome measures and identify the areas that offer opportunities for improvement



Cancer Care

- Incidence of colon, breast, lung, and cervical cancer
- Stage of cancer at diagnosis for colon, breast, lung, cervical, and prostate cancer
- 5-year survival for colon, breast, lung, cervical, and prostate cancer
- Care experience: Cancer CAHPS (Consumer Assessment of Healthcare Providers and Systems)



Cardiovascular Health

- Annual incidence of acute myocardial infarction, stroke, heart failure, end stage renal disease (ESRD)
- 30-day mortality following acute myocardial infarction, stroke, heart failure
- 5-year survival for people with a new diagnosis of ESRD



Mental Health & Wellness

- Response to treatments for depression (Patient Health Questionnaire-9) in all settings
- Incidence of suicide



Maternal Health

- PC-02: Rate of low-risk cesarean births
- Overall Maternal Mortality
- Number of preventable maternal deaths associated with obstetrical hemorrhage and hypertensive disorders

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Community Engagement - Business Resource Groups (BRGs) and Community Advisories

KP has established mechanisms to receive feedback from the diverse communities served through the Business Resource Groups, community advisors, and the Medicaid Consumer Advisory Board. Representation includes individuals/members from racial/ethnic and linguistic groups that constitute 5% of eligible individuals within our KPNCAL population.

KP is committed to diversity management and inclusion as a core organizational value and business strategy and provides opportunities for staff to voluntarily participate in BRGs. The national policy and KPNCAL operation guidelines establish requirements to assist BRGs in aligning their goals, objectives, and activities consistent with KP's mission, Equity, Inclusion and Diversity strategy, business strategy, and demonstrate appropriate fiscal management and oversight compliant with KP's Code of Conduct, (Principles of Responsibility), National, Regional, and Local policies and procedures, and Federal, State legislation which includes tax requirements. The leadership body for all the BRGs operating in KPNCAL is the EID Steering Committee. The Diversity Steering Committee includes members from such areas as: Regional EID Department, Human Resources, Compliance, MAPMG, and Quality, with the aim to serve as an advisory forum providing guidance and oversight to assist the BRGs in meeting the overall mission, goals, objectives and compliance requirements.

The Regional EID Department provides day-to-day operational guidance and direction to the BRG Leads to assist the groups in meeting operational requirements (i.e., formation/renewal process, annual budget/activity request process, funding, disbursements and tracking, activity reporting, website maintenance, communication assistance), respond to compliance questions,

and facilitate BRG Lead meetings/networking on a quarterly basis, education and training along with consulting in issues-resolutions. In addition, EID engages staff and members of the BRGs in dialogues to provide feedback about meeting the needs of the diverse populations we serve. Annually, the BRG Leads are encouraged to review demographic and equitable care data to help identify opportunities to improve offerings.

KP recognizes that where we live and how we live has a big impact on our health and well-being. Our work is driven by our mission: to provide high-quality, affordable health care services and to improve the health of our members and our communities. It's also driven by our heritage of prevention and health promotion, and by our conviction that good health is a fundamental right. Our Community Health strategy recognizes that health requires more than health care and that better health outcomes begin where we live, learn, work, and play. With this mind, the Community Health team actively participates on and collaborates with community advisors to help improve the health of the communities we serve. The EID team partners with the Community Health department to support equity needs in the community from a consulting role. This can include sharing equity data, supporting patient and community voice initiatives, and consulting on equity centered design in their priorities.

The KP Medicaid Program has also established a Community Advisory Council (CAC) for the line of business. The EID team consults with the Medicaid program to support equitable, linguistically and culturally aligned, and socially conscious approaches to the CAC. In doing so, EID is part of a larger initiative to elevate the voices and needs of our members and communities.

KAISER PERMANENTE NORTHERN CALIFORNIA

Culturally and Linguistically Appropriate Services (CLAS) Program Description

REGIONAL LANGUAGE ACCESS PROGRAM DEPARTMENT



Overview – Kaiser Permanente Northern California (KPNC)

Kaiser Permanente Northern California (KPNC) is an integrated Medical Care Program composed of three closely aligned organizations: Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Foundation Hospitals (KFH) and The Permanente Medical Group (TPMG). The Program serves over 4 million Northern California Health Plan members. Throughout this document, these entities are collectively referred to as “the Program.”

Components of the Program also include a Quality Program augmented by the Labor Management Partnership (LMP). KPNC has partnered with AFL-CIO employee unions to establish LMP. This partnership is used as a forum to maintain the positive labor-management relations upon which the organization was built, and to leverage the important contributions of labor to the provision of quality health care.

The purpose of this document is to inform both internal and external audiences how KPNC's Language Access Program Department is organized to support the Program's commitment to Culturally and Linguistically Appropriate Services. This document is reviewed and updated annually to ensure accurate representation of the program's organizational chart and all required elements.

KPNC Structure and Scope

There are three major levels of authority, accountability, and responsibility for the delivery of equity and diversity services: National, Regional, and Medical Center.

The organization's view of diversity is all-inclusive—more than race, ethnicity and gender, diversity includes age, education, personal lifestyle, cultural heritage, functional ability, and other aspects that make each of us different, and diversity is also sensitive to the needs of all people including seniors and persons with disabilities. The organization's diversity focus is to take full advantage of the strengths inherent in these differences in its members and workforce.

Kaiser Permanente's Commitment to Equity, Inclusion & Diversity

This affirms Kaiser Permanente focus on equity, inclusion and diversity as a core organizational value and key business strategy and integrates its diversity and inclusion strategy into core regional business initiatives and plans. Fairness and equity are defining characteristics of the KP work environment. Discrimination and harassment are not tolerated or condoned in accordance with the Equal Employment Opportunity and Affirmative Action policies.

Kaiser Permanente is committed to equity, inclusion and diversity 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 and improves the total health and is designed to ensure that all Medically necessary covered services are available and accessible to all member regardless of race, ethnicity, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, gender expression, socioeconomic status, health status or disability of its members and the communities it serves.

Regional Language Access Program Department

The Kaiser Permanente Northern California Language Access Program Department partners closely with National, Regional and Medical center leaders and stakeholders to support the delivery of high quality, equitable health care and equitable access to health plan services across the Northern California Region. The Program supports the organizational objectives of:

- Providing the best care for everyone
- Optimizing the diversity of our staff and providers
- Providing the most compelling value for a diverse population

The Department's Strategic Plan affirms continued commitment to culturally responsive care and service consistent with the Culturally & Linguistically Appropriate Services (CLAS) standards.

The purpose of the Regional Language Access Program Department is:

- To support the delivery of culturally responsive care and equitable service to our members/patients.
- To set language access and cultural & linguistic goals and priorities to support strategic goal achievement.
- To build the capacity to offer culturally and linguistically appropriate services within our staff and providers.
- Provide oversight and quality monitoring of interpreter services, which include Professional Healthcare Interpreters, Qualified Bilingual Status Employees, and contracted interpreter services.
- Provide oversight and quality monitoring of translation services provided by contracted translation agencies and professional editors/reviewers.
- Provide cultural & linguistic training to staff and providers to ensure enhanced awareness of cultural competency imperatives and beliefs and practices. In partnership with regional leadership, ensure regulatory compliance with ongoing culturally and linguistic training for staff and providers.
- Support and implement language assistance programs and policies. Perform compliance monitoring to assess measure, analyze and evaluate systematically the quality of culturally & linguistically appropriate services provided to members.
- Provide consultation and advice to improve facilitation of language access and equitable and equal access services in the region.
- Develop, monitor, and communicate stratified Language Access and Equity performance metrics.
- Ensure that KPNC meets or exceeds Federal, State, accreditation, and contractual cultural and linguistic requirements. Represent KPNC in external and internal cultural & linguistic regulatory audits and surveys.

Regional Language Access Program Department Structure, Performance Goals and Accountabilities

The Regional Language Access Program department resides within the governing entity of Kaiser Foundation Health Plan (KFHP), with strategies and services that are aligned with the National Equity, Inclusion & Diversity strategy, the KP Promise, Mission, and Values. The Regional Language Access Program department also supports and aligns with the Human Resources (HR) strategy, the Labor Management Partnership's priorities and other business goals that are necessary to achieve the highest quality health care outcomes for our members and patients. The Sr Manager, Program Management has oversight and accountability for the Program's cultural & linguistic services, performance goals, strategy, and solutions. There are 4 staff members (Project Manager & Consultants) who report to the Sr Manager, Program Management and are dedicated to support cultural & linguistics projects & initiatives.

The Language Access Program department's performance goals, objectives, and priorities are approved by KPNC's Human Resources SVP and Human Resources Senior Director and are also part of KFHP Northern California's cultural and linguistic diversity Quality Program workplan.

Goals

- Provide a comprehensive linguistics program.
- Maintain and improve quality of care and service provided to members.
- Support and implement language assistance programs.
- Minimize risk and liability.
- Assess, measure, analyze and evaluate systematically the quality of language assistance services provided to members.
- Ensure policies and procedures meet corporate and regulatory standards and are implemented and maintained effectively.
- Identify areas to improve processes, patterns and outcomes of care, service and access through systems, reports, education, training etc.
- Assure compliance with internal and external accrediting and regulatory standards; and
- Ensure the implementation and oversights of metrics and communicate the status of such to the appropriate leadership bodies.

Objectives

- Collect, measure, and analyze program performance information accurately and efficiently to identify opportunities for improvement. (In collaboration with medical centers language and diversity leads, establish standards and performance expectations when appropriate, indicators, data collection and reporting).
- Report and communicate collected information results to medical centers, appropriate individuals/groups enabling practice changes and improvement in quality of care and service.
- Demonstrate value through data performance collection and information reporting as required.
- Provide consultation and advice to improve equity related activities in the region.
- Comply with regulatory and accreditation requirements.
- Support medical center improvement efforts. Set activity priorities to support strategic goal achievement.

The Regional Language Access Program department supports the infrastructure responsible for driving the region's strategic diversity and equity initiatives. This infrastructure includes the Outpatient Interpreter Services Coordination leaders, Inpatient Interpreter Services Leaders, and peer groups involved with quality oversight, compliance, and member concerns in the Kaiser Permanente Northern California medical centers. The Language Access Program department also works with Health Plan Regulatory Services, Medi-Cal State Regulatory and Operations team, Kaiser Foundation Hospitals (KFH), Permanente Medical Group (PMG), Human Resources and KP HealthConnect to facilitate organizational compliance in the areas of cultural and linguistic services and the appropriate collection of patient demographics, race, and language preference data. The Regional Language Access Program department annually reports the results of its program activities to the Northern California Quality Oversight Committee (QOC).

Additionally, the Regional Language Access Program department (a) shares quarterly Translation and Interpreter Services Demand and Spend data with regional and medical center leadership to inform strategic deployment of internal and external interpreter and translation services resources to provide the most efficient, highest quality care and service to our members. (b) qualifies external language services resources and agencies for provision of Translation and Interpreter Services who play a critical role in supporting the organization's ability to provide timely, qualified language assistance to our patients and their families who are limited English speaking (b) uses results from annual Member and Staff satisfaction surveys, cultural & linguistic member grievances and from external contracted Language Services agencies quality oversight audits for investigating adequate language assistance access for enrollees and any other administrative issues; and implements regional initiatives and establishes best practices based on this feedback.

Kaiser Permanente is committed to providing language assistance services to enhance the quality of care for our Limited English Proficient (LEP) members. Regional Language Access Program department conducts ongoing compliance monitoring of the Language Assistance Program which includes the Department of Managed Health Care (DMHC) Language Assistance program (LAP) regulations. The Language Access Program department is responsible for updating the policies on Translation Services and Qualified Interpreter Services to ensure overall compliance with all federal and state laws. The Regional Language Access program Department consults with Health Plan Regulatory Services (HPRS) and collaborates with the Southern California Region to develop and maintain the Statewide oversight process documents to ensure compliance with the DMHC regulations. This includes the following.

- Qualified Interpreter Services for Limited English Proficient Persons Policy
- Qualified Translation Process for Member Informing Materials Policy
- Population Demographic Profile/Enrollee Assessment Data Sources and Methodology
- Staff Training
- Provider Contracting and Compliance
- Compliance Monitoring of Language Assistance Components
- Language Assistance Program Implementation and Monitoring Guide

Cultural & Linguistic Tools & Resources

The Regional Language Access Program department maintains internal websites to assist and inform Health Plan and Care delivery departments about cultural and linguistic tools & resources, workflows and procedures, trainings, best

practices, and regulatory requirements to ensure provision of effective communication practices and equal access to all members.

- [Language Access Program Department Website](#)
- [Language Access -Translation Services Website](#)
- [Language Assistance Policies and Procedures](#)

Medical Centers

Each medical center leadership team is responsible for delivering culturally responsive care and adhering to regulatory standards. There is a physician and an administrative lead on each team. Both advocate for their respective medical center. In addition, each medical center has a local Diversity council or committee or individuals accountable for overseeing and managing local diversity programs. This forum allows for alignment of the Diversity and Equity initiatives and goals among the region and medical center.

The leadership teams are responsible for:

- establishing a committee structure that provides oversight and review,
- holding medical center, KFHP, KFH and TPMG physicians, managers, and staff responsible for specific functions of monitoring and resolution of member complaints and grievances, assessment of member satisfaction and regulatory and accreditation compliance.
- establishing Medical Center Diversity goals based on regional goals and
- directing action as necessary to improve care and service.

The medical centers establish their own programs, goals & priorities, resources, systems and are most responsive to the particular health care issue of the populations served by their medical center.

Northern California Language Assistance Program

The Regional Language Access Program department provides a Comprehensive Language Assistance Program (LAP) for the Northern California Region to ensure meaningful access to language assistance at all points of contact for Kaiser Permanente's diverse consumers. The LAP uses various linguistic resources to meet the needs of KPNC's Limited English Proficient (LEP) patients and members who are deaf or hard of hearing. Each local area has the ability to use the various components of the LAP to meet the needs of their local areas.

The main components to the LAP are:

- Contracted Language Vendors for Interpretation and Translation Services - KP contracts with external language services vendors to provide interpretation services over-the-phone, in-person and through video.
- Translation Services infrastructure (Quality Tools and Qualified Resources)
- Qualified Bilingual Status/Staff (QBS) - The QBS program is administered by the Kaiser Permanente Northern California (KPNC) Labor Management Partnership (LMP) and provides a means to qualify (i.e., prove competency) of bilingual staff that use their linguistic skills to provide language assistance services to Kaiser Permanente members/patients. Participants of the QBS program are deemed qualified through testing and training. Employees may volunteer to participate in the QBS program. In addition, certain jobs are identified as "bilingual- required" to help ensure that the staffing mix reflects the linguistic needs of the membership/communities served. Employees who fill bilingual-required positions are automatic participants of the QBS program.

Reporting

The Regional Language Access Program Department monitors the overall language assistance program for KPNC and reports the following for the region and by service area:

- Utilization for contracted language assistance vendors
- Spend for contracted language assistance vendors, QBS and Dedicated Interpreters
- Documentation of the use/refusal of language assistance services by members/patients
- Quality Performance Indicators
- Complaints & Grievances
- Member/Patient and Staff/Provider satisfaction

Monitoring

The Regional Language Access Program Department employs a comprehensive monitoring approach to ensure the language services vendors are compliant with organizational expectations for quality language assistance and can demonstrate performance according to quality indicators. The monitoring approach includes but is not limited to quarterly monitoring/reporting of performance indicators as well as an annual review of interpreter files.

To assess and monitor member/patient satisfaction with language assistance services, KPNC surveys members that have self-identified as requiring language assistance services. KPNC surveys staff and providers annually to assess satisfaction with language assistance services. In addition to the member satisfaction surveys, Regional Language Access department regularly reviews Member Services complaints regarding language assistance.

Translation Services

KPNC follows the Quality Translation Process for Member Informing Materials Policy which addresses standards for provisions of accurate, consistent, quality written translations of member/patient informing materials. The Regional Language Access Department

Key areas outlined in the policy include, but not limited to:

- Vital Documents – written materials that are essential for understanding health plan benefits or accessing covered health care services in threshold languages ensuring quality, accuracy, timeliness; provisions are outlined for both standard vital documents (do not contain member/patient specific information) and non-standard vital documents (contains member/patient specific information) and requirements for Taglines or Notice of Language Assistance notices in threshold languages.
- Qualified Translation Professionals – contract with external preferred translation vendors through a formal Request for Proposal (RFP) process. The vendor contracts include quality control processes and their assessment of the use of competent translators.
- Member Requests – Health Plan honors all member requests for translation regardless of document type or language.
- Alternative Format Materials – materials are provided to meet member/patient needs for effective communication in accordance with ADA requirements and KP's Equal Access Policy.
- Compliance Monitoring – outlines responsibilities of Health Plan departments along with monitoring departments for ongoing support, education, and training.
- Designation of Threshold Languages – non-English language that has been identified as an individual's preferred language based on proportional values of an identified population (patients, members, county) as defined in a statute and/or regulatory requirement (i.e., Commercial, Medi-Cal).

The Translation Services Program provides a centralized infrastructure with dedicated Translation Project Manager and quality tools such as: Glossary of Terms, Language Style Guides, Language Translation Memory, Editor/Reviewer Checklist, and an internal review process to evaluate the quality of vendor translations which consists of receiving the translation copy with the English source copy and scoring on the Linguistic Evaluation Form.

Providing timely translations results from the comprehensive infrastructure, education, and training, monitoring and oversight (i.e., workflow tools and processes) such as: online submission to the translation vendor(s), quotes provided within 24 hours, utilization of translation memory for efficiency and cost saving, negotiated rapid turnaround for various documents within 28-72 hours.

Translation Quick Tips and contact reference sheets are distributed throughout the medical centers and posted on the KPNC Translation Services website to ensure that departments/requestors know who to contact to get their documents translated. Sight Translation instructions are also available to assist member/patient immediate needs, along with pre-translated materials through the clinical library. Members may request written translation of non-standard vital Health Plan documents in their preferred language and the translation is provided within 21 calendar days as stated in the Policy.

Additionally, translated documents are accessible to staff via the Clinical Library for member educational material.

Instructions for requesting documentation translation is posted on the KPNC Translation Services website at <http://kp.org/translationservices>.

Training and Education

The Regional Language Access Program Department develops, coordinates, communicates and implements Cultural & Linguistic training and educational courses, tools and resources through KP Learn web based training, in-person training, along with monthly Quick Tips, email blasts, flyers, video-based training, huddle cards, and through the Language Access website, to improve member/patient/staff interactions, to ensure the provision of culturally and linguistically appropriate services, reduce health care disparities and improve health care outcomes, foster work force respect and communication, as well as to meet compliance and regulatory requirements.

To ensure that all staff and providers are aware of Cultural & Linguistic (C&L) standards, KP staff and providers are trained on how to interact with seniors and persons with disabilities, how to access and assist Limited English Proficient (LEP) members needing language interpretation (including Sign Language interpretation services), and other C&L topics to ensure that culturally appropriate services are rendered. This occurs through New Employee Orientation, in-service staff meetings, and ongoing through KP Learn regulatory and compliance trainings, Community of Practice meetings.

Partnerships are developed with, but not limited to, Learning and Development, Local Education and Training, Front Line Leaders (Receptionist/Service Reps), Department Administrators, Managers, KP HealthConnect, Human Resources, Labor Management Partnership and the medical center Language & Diversity Leads/Champions to ensure the appropriate training, job aids, scripting, understanding, monitoring and documentation tools are in place. Training is developed to meet the local areas present and future needs to ensure a culturally and linguistically competent workforce and facility.

Member Demographic Data Collection/Needs Assessments

To understand the needs of Kaiser Permanente Northern California (KPNC) members, a wide variety of data sources are used. In order to effectively address diverse member needs, including addressing health-related disparities and providing quality linguistic services, KPNC leverages the efficiency and advantages offered by KP HealthConnect, our electronic medical record system, to centralize the collection of demographic data, which includes race, ethnicity, language preferences (spoken, written and interpreter need) of our members. KPNC has been collecting language preference data for over 15 years and race and ethnicity data in the inpatient setting for almost 20 years. In 2011, KPNC implemented the collection of race and ethnicity data in the ambulatory setting. KPNC uses algorithms to map member data to National Committee for Quality Assurance (NCQA) Race/Ethnicity data categories. The result of the mapping is placed into the KP's Geographically Enriched Member Sociodemographics (GEMS) datamart. The GEMS data mart supports various analytic needs by providing curated and generates demographic, geographic, and socioeconomic data about members, patients, and the populations served by KP.

Kaiser Permanente Northern California (KPNC) collects self-reported race and ethnicity information from members and patients into KP HealthConnect (KPHC) during appointment registration or appointment check-in which avoids any concerns about this data being used in underwriting. Although Kaiser Permanente is required to ask for this information, patients are not required to provide it. Responses of "other", "unknown", or "declines to state" are all acceptable. The information is entered under the Reg screen in the Demographics field in KPHC.

Language preferences and interpreter need of patients/members may change over time or depending on the situation. Therefore, it is critical to confirm and update language preferences of patients/members, particularly those who have a non-English preference on record in KPHC. Opportunities to collect and verify language preference include Member enrollment, registration or check in for appointments, ED visits or inpatient stays, making an appointment through the Appointment and Advice Call Center, making a request through the Member Services Call Center. Language Preference (Spoken, Written and Interpreter Need) information is entered in the Patient Demographics screen in KPHC. Additionally, an Interpreter Services Questionnaire (ISQ)/Interpreter Needed, MA Rooming Tool and Interpreter Need

Flag has been developed in KP HealthConnect (KPHC) to track the offer, request, and refusal of interpreter services in the member/patient's KPHC chart. The Interpreter flag serves as an alert to staff to offer language assistance for each visit, the ISQ and MA Rooming Tool are utilized to document the encounter (use and refusal of interpreter services). Membership Demographic data is posted monthly and available through the Regional Language Access Program website to track completion of member's language preference information. Additionally, reports documenting member's use and refusal of Interpreter Services are generated quarterly to monitor KPNC's consistent use and documentation of qualified interpreter services with members.

Additionally, KPNC uses a variety of indirect methods to assess the needs of its members' anticipated language needs, including looking at the race, ethnicity, and language profile of the community we serve. Every three years, KPNC conducts an assessment utilizing state-level census and/or community data, member data to assess the cultural and linguistic needs of the members/communities we serve.

KPNC conducts a spoken language assessment of the communities we serve, utilizing the American Community Survey (ACS) Data, acquired through Integrated Public Use Microdata Series (IPUMS-USA), when made available publicly. IPUMS is not a collection of compiled statistics; it is composed of microdata, where each record is a person, with all characteristics numerically coded (Refer to <https://usa.ipums.org/usa-action/faq#ques0>). The assessment is for trending and data analysis purposes to assist in planning for and improving our language services capabilities in our service areas. Both membership and community language data are reviewed because changing demographics may be more apparent at the community level than at the membership level.

Northern California Population Needs Assessment (PNA)

Regional Language Access Program department in partnership with Health Education and Medi-Cal and State Programs conduct a Health Education and Cultural & Linguistic Population Needs Assessment (PNA) to identify the health education, cultural & linguistic needs of KPNC members, and utilize the findings for continuous development and improvement of health education programs and cultural and linguistic services.

Multiple data sources, methodologies, techniques, and tools are used to conduct the PNA. The PNA is updated annually to assess the needs of the community we serve. The PNA Summary Report is submitted to the DHCS at the completion of each PNA. The Summary Report includes objectives; methodology; data sources; survey instruments; findings and conclusions; program and policy implications; and references.

Supplier Diversity

KP believes in providing diverse businesses the most practical opportunity to be included in our contracting and subcontracting activities. KP is active member of local, regional and national organizations, chartered to advance business opportunities, support and advocate for the growth and welfare of minority, women, LGBTQ+, veteran and disabled-owned business enterprises, and connect them to corporate members and their buyers. Through KP Supplier Diversity initiative KP is maintaining our focus on long term mission to contribute to health outcomes by increasing the vitality of our community by spurring innovation, increasing competition, and supporting economic development through small business and job creation. The Regional Language Access program department partners with KP Sourcing and Supplier Diversity to qualify and contract with diverse suppliers for provision of qualified language assistance services.

Medi-Cal Community Advisory Committee (CAC)

The purpose of the Medi-Cal CAC is to maintain community partnerships with consumers, community advocates, and Traditional and Safety net providers. The CAC helps direct and advise health plans regarding policy decisions related to educational, operational, and cultural competency issues affecting groups who speak a primary language other than English. The Sacramento County Community Advisory Committee (CAC) is a collaborative committee that is run by the Sacramento Geographic Managed Care (GMC) Medi-Cal Managed Care Plans (MCPs). The CAC meeting facilitation is rotated annually between MCPs. Each MCP has a staff representative assigned to the CAC. The Kaiser Permanente Northern California's (KPNC) Cultural & Linguistics (C&L) liaison works directly with the KP staff

representative assigned to the CAC to ensure that information related to KPNC's Cultural & Linguistic (C&L) program and services is shared with the Sacramento County CAC for review and feedback.

Patient Advisory Council (PAC)

KP is dedicated to providing culturally and linguistically responsive care, creating health equity and improving the care experience for everyone by eliminating all forms of oppression in health care. As such, KP is committed to maintain Patient Advisory Councils as a forum where leaders, project leads, and members of various committees can present ideas and initiatives to obtain the member perspective and actively engage in discussions to improve collaboration and understanding between health care practitioners and KP members. KPNC region maintains Patient Advisory Councils (PAC) and Patient Partners with a range of focus (hospital; patient safety, primary care, patient safety, mental health, cancer care, transgender, pediatric, NICU, teen, senior, family medicine) and languages (Chinese, English, Spanish, Tagalog). Across our PACs, we have individuals representing the racial/ethnic and linguistic groups that constitute at least 5 percent of individuals. KPNC local medical center PACs governing body is the local medical center Quality Committee. PACs provide an annual report to their local governing body and regional Person & Family Centered Care/Patient Advisory Council (PFCC/PAC) lead. PACs provides a summary of performance and effectiveness evaluation and impact and outcome measures. PACs share the top three (3) to five (5) key activities and accomplishments related to quality of service, safety, and care experience. The regional PFCC/PAC lead reports to the Regional Risk Management and Patient Safety Committee (RRMPSC) governing body. The regional PFCC/PAC Lead provides bi-annual reports to RRMPSC governing body. Our patient partners are embedded into our quality and/or safety committee to meet Leapfrog requirements.

Regulatory Compliance and Quality

Northern California Quality Oversight Committee (QOC)

The purpose of the Kaiser Permanente Northern California (KPNC) Quality Oversight Committee (QOC) is to evaluate the quality of care and services provided to Kaiser Permanente members and patients in Northern California in all settings. The QOC sponsors are NCAL KFHP/H President and Executive Director and CEO of the Permanente Medical Group. QOC membership includes representatives from KFHP, KFHP, and TPMG and a quorum is a simple majority of the members. The Regional Language Access program department reports annually the results from the Language Assistance compliance monitoring of Health Plan Departments and the overall Language Access program activities to the Northern California Quality Oversight Committee (QOC). Additionally, the Regional Language Access Program department reports the annual cultural & linguistic complaints and grievances to the Member Concerns Committee, which is a subcommittee of the QOC. The reports on language assistance and cultural & linguistics to QOC continues to serve as demonstration of QOC oversight of the Language Assistance Program, which is required under state law.

Accreditation, Regulation and Licensing (AR&L)

The AR&L Leader liaisons with external regulatory and accrediting agencies provide consultation regarding regulatory compliance, assist in compliance issue resolution, and partner in preparation for The Joint Commission and other surveys. In 2010, the Language Access Program Department partnered with Regional AR&L team to develop an oversight process for external contracted language services agencies, in support of Medicare and Joint Commission requirements. In addition, the unit supports regulatory compliance with building requirements in hospital builds/re-builds.

Health Plan Regulatory Services (HPRS)

The Vice President (VP) of HPRS is a member of QOC with oversight for:

- Implementation of state contracts, HP benefits/policy, training, and education.
- Regulatory submission/response for service delivery, network, and expansion changes.
- Audit response to Department of Managed Health Care and State programs.
- Member relations including regulatory/audit responses, external review, re-considerations, grievance processes/disposition, training, and education.

Medi-Cal and State Programs

Medi-Cal and State Programs provides operational and regulatory guidance to various stakeholders involved with our Medi-Cal managed care members. The department ensures that as new regulations are released, they are implemented. In addition, the department also works with Medi-Cal plan partners to execute contracts and oversee the Vaccines for Children Program and Medical Financial Assistance.

Civil Rights Compliance

The Regional Civil Rights and Americans Disabilities Act (ADA) Program in the Regional Compliance Office reports to the VP Regional Compliance. The department manages the ACA's Section 1557 compliance infrastructure and risk profile and conducts a broader review of member complaints and grievances including complaints in the areas of discrimination and cultural & linguistics. The Regional Language Access Program Department partners closely with the Regional Civil Rights and ADA Program to support regulatory compliance with ADA and Cultural and Linguistics requirements.

Member Rights

KP is committed to ensuring a safe, secure, and respectful environment for everyone – including our members, patients, visitors, clinicians, providers, health care teams, and employees. Member Rights & Responsibilities are published on kp.org member and gives the members information about member services, specialty referrals, privacy and confidentiality, and the dispute-resolution process. Members have a right to 24/7 free of cost qualified language assistance services. As such language assistance and nondiscrimination notices are posted on kp.org and at the medical centers to inform members about their right to use of interpreter services. Member benefits are described in detail within the Evidence of Coverage (EOC) and more about KPNC's interpreter services is described in the Member Resource Guide, which is provided to all new members.

All medically necessary covered services are available to all members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability. All covered services are provided in a culturally and linguistically appropriate manner.

Care Experience

Member and Patient Satisfaction Monitoring and Reporting

The Regional Language Access Program department partners with the Regional Civil Rights and Americans Disabilities Act (ADA) Program in the Compliance offices and with Member Services to systematically assesses and monitor members' satisfaction through analysis of member initiated cultural and linguistic complaints or grievances. Member Complaint Analysis is performed through ongoing monitoring and evaluation of member complaints, grievances to assess member satisfaction, identify trends, and recommend corrective actions when indicated. Member Complaints are addressed to responsible medical center departments for resolution and also forwarded to local Interpreter and Diversity leaders for immediate attention. In addition, summarized findings, identified trends and recommended corrective actions, if applicable, are reported annually to Member Concerns Committee (MCC).

NCAL Continuum of Care Skilled Nursing Facility/Long Term Care Quality Oversight Model Program Description

Continuum of Care
Skilled Nursing Facility/Long Term Care Quality Oversight Model Program Description

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Skilled Nursing Facility/Long Term Care Quality Oversight Model Program Description

Overview

This playbook is Phase I approach intended to address the gaps and current needs of Continuum and provide guidance in addressing SNF quality oversight and Regional LTC Coordination.

The future needs and strategy around SNF Quality Oversight and and Regional LTC Coordination will include roles and responsibilities of coordinators, site visit frequency, and other operational requirements.

Purpose: To provide guidance on quality oversight in contracted skilled nursing facility and establish a consistent communication and follow-up.

Quality Oversight Governance Structure

The Regional Credentials and Privileges Committee (RCPC) will serve as part of quality oversight governance in the reviewing, investigation and remediation of escalations, sentinel/critical events and quality issues for the KP NCAL region. As an extension of the current scope of the RCPC, SNF quality oversight will ensure that broader regulatory requirements are met. Leveraging this governing body will provide a more robust framework for ensuring quality care for SNF patients at SNF partner facilities. Using the policies and procedures outlined in this document will ensure continued compliance and a more active role by the RCPC in quality oversight activities.

Current Activities for SNF Quality Oversight

- On-site rounding in contracted facilities (SNF RN coordinators and physicians; continuum leadership)
- Local KP/SNF Joint Quality Committee Meeting (local Continuum leadership and SNF)
- Regional KP/ Strategic Joint Quality Committee Meeting (Regional Continuum leadership and SNF strategic partners)
- Annual Quality Visit as needed (local continuum)
- Off-cycle visit as indicated (local continuum)
- Regulatory Visit/s from California Department of Public Health (CDPH) (unusual occurrence, complaint visit, recertification visit)
- Credentialing/ Recredentialing Visit (local continuum as required by Regional Credentials and Privileges Committee (RCPC) for credentialing requirements)

Types Of Quality Events and Reporting Timeline to KP Continuum

Examples but not limited to the following:

Sentinel Event/s and/or Unusual Occurrence/s:

Unusual event that threatens the welfare, health, and safety of clients (Code of Regs 76551)

- Patient Related Harm: falls with injuries, assault, abuse, medication error
- Epidemic outbreaks, poisoning, major accidents, death from unnatural causes, fire, flood, power outages and temperature issues affecting patient care
- Falls with major injuries with rehospitalization
- Acquired stage 2 or above pressure injury
- Allegations of assaults/abuse
- Any acquired communicable/reportable disease
- Medication errors that lead to change in conditions from the current health status
- Any unexpected changes in conditions that changes the current health status
- Any disasters that require relocations of patients
- Any unexpected deaths

Quality Event/s

- Any CDPH site visit/s for cause/complaint following a reported complaint
- Survey by regulatory agency (CDPH; Life Safety survey)
- Quality of care concerns members and providers.

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Administrative Event/s

- Staffing/personnel changes affecting admission and quality of care

Type/s of Event	SNF Timeline of Reporting Requirement to KP Continuum	Timeline of Submission Summary of Follow-up/Investigation	
		Facility Requirements	KP Requirements
Sentinel Event/Unusual Occurrence	Within 24 hours	Facility to provide summary of investigation within 5 business days	- Continuum will review and follow-up within 5 business days. Follow notification process local and regional. - Some sentinel events may require a KP follow-up and decision within 24 hours, based on severity. Examples and not limited to the following are: - Epidemic outbreaks - Any disasters that require relocation of patients - Any unexpected deaths
Quality Event	2 business days	Facility to provide summary of investigation within 7 business days	Continuum will review and follow-up within 7 business days
Administrative Event	2 business days	Facility to communicate with local service area of potential access issues for admission related to staffing changes.	Continuum local service area will inform region of facility staffing status related to SNF referrals/ admission.

Quality Monitoring Post Event

- Contracted facility is required to have a quality improvement program and implement an on-going quality assurance plan
- The facility Quality Assurance plan is reviewed during Joint Quality Committee (JQC) meetings both local and regional.
- For any quality event/s as outlined above, contracted facility must notify KP Continuum and provide a summary of follow-up and plan of correction as applicable.
- Local KP Continuum is responsible for tracking and following up of any quality event/s.** Depending on the type of quality event, address the issue with facility leadership first, ask for their summary and action plan, and date of full compliance to the issue.
- During the JQC meeting, contracted facility will include information pertaining to any quality issues/ trends and quality indicators with action plan. The local KP Continuum will review any trends and areas of concern. Off cycle unannounced site visits may be conducted at any time to validate facility adherence and follow-up to quality assurance plan.

Safety and Risk Mitigation

- Kaiser Permanente will contract and credential facilities with **3 – 5 CMS Star Quality Rating**.
 - Intent to contract with facilities below a 3 CMS Star Quality Metrics (QM) rating must be discussed and approved by the VP (Vice President) and Executive Director of the Continuum.
- Any significant drop-in Centers for Medicare & Medicaid Services (CMS) Quality Rating and/or a Special Focus Facility (SFF) identified in CMS, Harm tag (G tag or higher)/substandard deficiency (F tag or higher) during annual recertification survey or complaint survey (e.g., FRIs – facility reported incidents)

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will be assessed by local and regional continuum for quality-of-care monitoring and consideration of either holding or limiting skilled admission.

- Facilities with 1-2 CMS Star Quality Ratings and/or a Special Focus Facility
 - Increase rounding frequencies
 - Member interviews around care experience during rounding
 - Review any publicly reported CMS designations for this facility
 - During KP/SNF Joint Operations Committee meeting, facility to include QA plan to address poor quality CMS Star rating
 - Local and Regional continuum to decide whether to hold or restrict admission by acuity
- Medical Services Contracting (MSC) provides a list of facilities flagged by the CDPH and the CMS as out of compliance or rescinded. A DOPNA is “Denial of Payment for New Admissions” and is an enforcement that is applied by CMS when a Skilled Nursing Facility (SNF) is found to be non-compliant with participation requirements for the Medicare and Medicaid program. CMS may issue a DOPNA for all new admissions if a SNF is found to have deficiencies. MSC receives the notice of past or pending DOPNA action so it is possible that a facility may or may have not received the notice in real time. As soon as Continuum is made aware of the DOPNA list:

HOLD new referrals **and:**

- Schedule a conference call immediately to include local and regional Continuum leadership and affected facility. If facility reports full compliance or rescission, a written confirmation from CDPH indicating facility is in full compliance with participation for CMS requirements must be submitted via email to local Continuum. Upon receipt of the full compliance letter from CMS, local and regional continuum will update all stakeholders for resuming admission.
- Facility on confirmed DOPNA list will automatically be on hold for admission immediately. A site visit by the local Continuum must be conducted within 2 weeks and be submitted to RCPC for formal CAP.
- Quality monitoring of members who are still in the facility prior to DOPNA include:
 - Increase rounding frequencies
 - Member interviews around care experience during rounding
 - Members will be informed of the DOPNA facility status with the option to be transferred out of the facility. If the member and/or responsible party opts to transfer to another facility, KP RN coordinator will coordinate and assist in SNF referral.

Cause for Contract Termination

Contracted facility may be at risk for termination if there is no evidence of sustained improvement in quality of care while on CAP. Local service area should engage with regional leadership and Medical Services Contracting in advance of the recommendation to terminate contract to ensure review and communication are in place.

Credentialing/Recredentialing Site Visits

As outlined in *Recredentialing and Privileging Policies and Procedures (RCPC) Policy and Procedure No:8* on Site Visits for Organizational Providers, the Continuum Administrators (CA(s)/designee or the appropriate health plan representative will oversee the site visit process and the approval of site visit tools. The structured on-site review process employs a survey tool tailored to the organizational provider (OP) type. The surveyors evaluate the following, as applicable:

- Written policies and procedures
- HIPAA-protected health information/confidentiality policies and practices
- Medical records of KFHP members
- Patient care practices
- Continuity of care
- Patient safety

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- Environment including physical appearance and cleanliness
- Infection control
- Quality improvement program, including a review of organization's process for credentialing its practitioners
- Utilization management program
- Patient and family education
- Staff training and competency
- Disabled accessibility
- Treatment areas
- Progress on KFHP Corrective Action Plan (CAP), if applicable
- Indicators specific to type of OP
- Recent regulatory agency survey reports/citations and related corrective action responses.

Site Visits Between Recredentialing Cycles

As outlined in RCPC Policy #7 *Credentialing and Recredentialing of Organizational Providers (OPs)*, site visits may be initiated at any time for any reason by the local service or at the request of RCPC in accordance with Policy #8 *Site Visits for OP*. Site visit results will be reported to RCPC when performed at their request or performed in response to an incident involving a member or patient.

Site visits must be conducted following any quality-of-care issue that poses significant risk to Kaiser.

Corrective Action Plan (CAP)

A Corrective Action Plan (CAP) may be implemented when the local Continuum service area determines that issues of quality occur that could adversely impact patient care or service. The local Continuum may take preliminary corrective measures while awaiting review and approval of a formal, written CAP by the RCPC.

The steps of a CAP will include, but are not limited to:

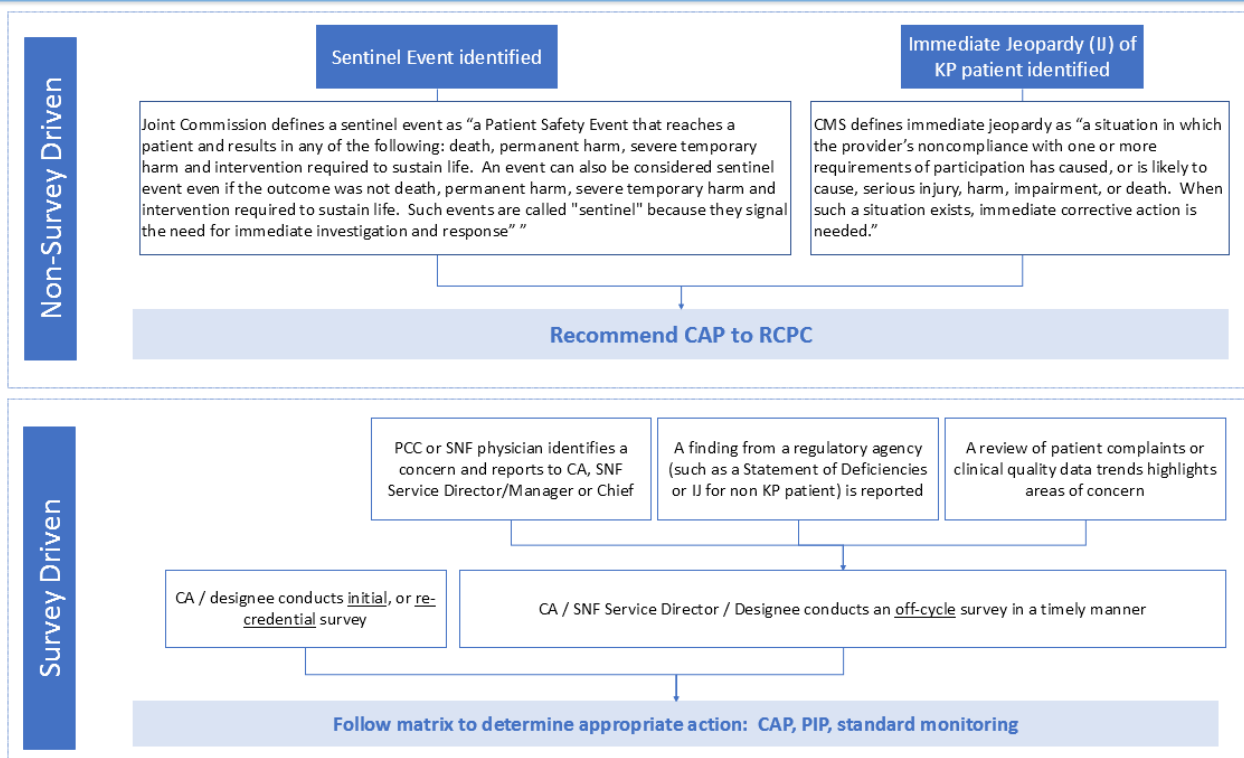
- A request for a written plan of correction and a timeline for its implementation to be submitted by the facility.
- A follow-up unannounced visit at approximately 30 calendar days after the CAP effective date to ensure that significant action has been taken and progress made on the CAP; **and**
- A formal, announced site visit at approximately 60 calendar days after the CAP effective date to evaluate the effectiveness of the implementation of the CAP; **and**
- A follow-up announced site visit no sooner than 180 calendar days after the CAP effective date to ensure remedies from the CAP have been sustained.

At the end of the corrective action period, the CA/designee or appropriate health plan representative determines if the OP has satisfactorily completed the CAP or if the OP needs to participate in an extended CAP cycle. The CA/designee or appropriate health plan representative may recommend that the CAP be extended. Additional site surveys will be conducted at 30, 60 and 180 calendar day intervals during the extended CAP period and the status of the extended CAP will be reported to RCPC accordingly. Once an extended CAP is completed to the CA/designee's satisfaction, a report will be submitted to the RCPC. RCPC may approve lifting a CAP any time after the initial 180 calendar day CAP cycle but before the end of an extended 180-day CAP cycle.

CAPs may include referral suspension, referral restriction by acuity, or referral restriction by average daily census (ADC), each of which requires approval of the RCPC to remove. Additionally, RCPC may instruct that any existing census of KFHP members be moved to an appropriate, alternate provider or location. This action must be followed by a report to the RCPC at its next regularly scheduled meeting.

Continuum of Care Skilled Nursing Facility/Long Term Care Quality Oversight Model Program Description

Triggers for Performance Improvement Plan (PIP) and Corrective Action Plan (CAP)



Continuum of Care Skilled Nursing Facility/Long Term Care Quality Oversight Model Program Description

After Survey Decision Matrix for PIPs and CAPs

	Trigger	If YES, then	If NO, then	Notes / Definitions
1	Did the survey result in a failing score?	<u>Must</u> recommend a CAP to RCPC	Q2	• Passing survey score is $\geq 80\%$
2	Is there a cumulative trigger?	Implement a PIP or after considering all factors, CAP is more appropriate, Recommend a CAP to RCPC	Q3	Local area should recommend a CAP vs a PIP if • SNF has not been responsive in the past • SNF has multiple PIPs in a short period of time (< 2 years) • SNF has not demonstrated sustained improvement • Excessive length of time to resolve identified issues (>6 mos) • Multiple system issues (which may be minor when considered individually), are pervasive in the SNF
3	Were issues <u>directly</u> affecting patient care identified?	Implement a PIP or after considering all factors, CAP is more appropriate, Recommend a CAP to RCPC	Q4	• A PIP may be appropriate if the following occurred: <u>Single</u> instance of missed medication or treatment administration, <u>single</u> instance of staff noted to enter room with call light on and turn call light off without addressing patient need, <u>single</u> staff member fails to wear appropriate PPE, etc. • A CAP may be more appropriate if there were multiple observations of above examples.
4	Were issues identified that require a return survey to verify resolution?	Implement a PIP or after considering all factors, CAP is more appropriate, Recommend a CAP to RCPC	Q5	• If issues are identified and the resolution can only be demonstrated with a return visit to the SNF, at minimum, a PIP must be implemented. • If an issue is identified that can be resolved remotely (e.g., faxing of a document), then a PIP or CAP isn't required.
5	Were issues <u>indirectly</u> affecting Patient Care identified?	Implement a PIP	Normal monitoring	• Issues could include record keeping including employee files, environmental issue (missing ceiling tile, chipped/missing floor tiles, etc.), unclear grievance process, plan of care not updated, etc.

SNF Closures

There are four triggers which would lead to a hold or restriction of admissions to a SNF facility.

1. Receive closure notice from regulatory agency (outbreak, DOPNA, other)
2. Local & Regional Continuum leadership jointly decide to hold or restrict admissions based on quality of care concern after a site visit
3. Local and Regional Continuum leadership jointly decide to hold or restrict admissions after facility CMS Star rating drops below a 3 and/or facility is selected as Special Focus Facility (SFF) status
4. RCPC approves CAP recommendation from Local Continuum leadership

Notification Requirements

- If a closure is recommended due to a quality of care concern or CMS Star quality rating drop, the local Continuum leadership sends an email, followed by a phone call to regional Continuum leadership to reach a joint and final decision.
- If a SNF facility is contracted and has census of greater than 5 patients, the SNF Director/ Manager provides a contingency plan to manage hospital throughput during closure/restriction.
- The SNF Director/Manager also notifies the restricted/closed SNF facility of the restriction and, if relevant, the SNF facility(s) included in contingency plan of potential increased admission volume.
- The SNF Director/Manager updates the NCAL SNF Facility Capabilities SharePoint site to note the facility is closed. The contingency plan should also be included in the Comments section of Closure tab. If the "potential open date" shifts during closure, this should be updated.
- If a closure is initiated by an SNF facility (due to staffing shortages or other issues), the SNF Director or Manager should request the facility to send an email to document closure.

Accountability to lift the Hold/Admission Restriction

- Trigger 1 - regulatory agency decision
- Trigger 2 and 3 - Local and Regional Continuum leadership joint decision
- Trigger 4 - RCPC decision

Continuum of Care

Skilled Nursing Facility/Long Term Care Quality Oversight Model Program Description

Joint Quality Committee (JQC) Meetings

Agenda and Elements Discussed at local and regional JQC meetings

- Local and regional Continuum will ensure regular JQC meetings quarterly at a minimum. The agenda will include quality oversight but is not limited to the following:
 - Facility Updates (staffing and operational updates)
 - KP updates
 - Regulatory updates
 - Recent state survey results and action plan
 - Grievances and complaints
 - Unusual occurrence
 - Quality
 - Quality Assurance and Performance Improvement (QAPI) Program
 - Quality Score card review (readmission Data, utilization Dashboard, infection control, etc.)
 - Quality Events
 - Any CDPH site visit/s for cause/complaint following a reported complaint
 - Survey by regulatory agency (CDPH; Life Safety survey)
 - Quality of care concerns from members and providers

Continuum of Care
Skilled Nursing Facility/Long Term Care Quality Oversight Model Program Description

Sample Agenda (Joint Quality Committee) Meeting

KP and SNF Joint Quality Committee Meeting

Meeting Details	
Date:	Time: Location:
Meeting Objective:	
Purpose: Collaboration to improve quality, access, and efficiency. ❖ Spread quality initiatives ❖ Develop consistent work flows across the region ❖ Improve referral and placement efficiency ❖ Develop programs to meet the needs of our members and the community	
Agenda	
1	Welcome / Introductions / Updates • SNF Partner Updates ◦ Staffing ◦ Operational updates • Kaiser Permanente Updates • Regulatory Updates
2	Quality • Facility Quality Assurance and Performance Initiative (QUAPI) • Quality Score Card Review • Quality Events ◦ Any CDPH site visits for cause/ complaint following a reported complaint ◦ Survey by regulatory agency (CDPH, Life Safety Survey) ◦ Quality of care concerns from members and providers ◦
3	Access and Service • Referrals and Placement • Specialty services and programs: Wound Care, Bariatric, Sub acute access.
4	Next Steps/Action Items/ Next Meeting
Notes:	

Continuum of Care

Skilled Nursing Facility/Long Term Care Quality Oversight Model Program Description

Tracking of Quality Events (Performance Improvement Plan, Star Rating, Special Focus Facility)

Monitoring quality of care is central to KP care delivery. SNF Quality data will be updated by local Continuum and will be maintained in database that will be tracked by regional Continuum and follow the activities as required in the [Current Activities for SNF Quality Oversight](#) section of this document.

Elements of QAPI Program

Medi-Cal Managed Care Plans are required to establish a method for Skilled Nursing Facility Long-Term Care services Quality Assurance Performance Improvement (QAPI) program oversight.^{1,3} According to DHCS, LTC includes skilled nursing facilities, subacute facilities, and pediatric subacute facilities.

Local service areas are responsible for ensuring that the SNF QAPI program meets specific standards and requirements, guaranteeing the quality and safety of care for members and taking action if needed. The following information as a guideline for local service areas to adhere to the CalAIM requirements in implementing the SNF QAPI program.

The quality oversight and coordination activities described below applies to the following care settings:

Long-Term Care (LTC), Subacute care, Long-Term Services and Supports Quality & Appropriateness (LTSS) and Intermediate Care Facility for Developmentally Disabled (ICF/DD).

Quality Assurance & Improvement Findings

Summary

Collect quality assurance and improvement findings from CDPH to include, but not be limited to, survey deficiency results, site visit findings, and complaint findings. There will be a designated performance measurement lead and a backup contact who will participate in DHCS activities and perform data reporting, tracking, process improvement and audit activities.²

Responsible Party: Regional LTC Manager

Responsibilities

- Fulfill the responsibilities of the Performance Measurement Lead as described in [APL 19-017](#)
- Serve as lead and have backup contact
- Attend technical conference calls
- Collect and report rates for MCAS (Managed Care Accountability Set) measures
- Monitor MCAS measures to ensure they meet or exceed MPLs (Minimum Performance Level)
- Develop and implement PDSA cycles for MCAS measures not meeting MPL

Quality data and improvement processes

Responsible Party: Regional LTC Coordinator RN

Process

- Tracking and monitoring of quality assurance data, improvement findings, infection control, adverse, critical/sentinel events, and complaint data.
- Tracking utilization and health outcomes.
- Reporting, investigations and actions for Quality events will be in accordance with the policy for reporting Quality events outlined in this document under the [Types Of Quality Events and Reporting Timeline to KP Continuum](#).
- Post-event quality monitoring activities may follow (e.g., facility to provide a summary of follow-up and plan of correction)

Continuum of Care

Skilled Nursing Facility/Long Term Care Quality Oversight Model Program Description

- Local KP Continuum is responsible for tracking and following up on any Quality or Readmission Events (for cause/complaint, survey, quality of care, as defined by Quality events on [pg. 3](#) of this document).

Efforts to Prevent, Detect, & Remediate Critical Incidents

Summary

Incorporate DHCS and CDPH efforts to prevent, detect, and remediate identified critical incidents

Responsible Party: Regional LTC Coordinator RN working with Contracted Partners

Process

- The facility must identify high-risk patients upon assessment using risk tool(s) for eg.) fall risk, chronic conditions, functional limitations, and ensure there are safeguards in place to prevent critical incidents.
- The facility must report a "Sentinel Event/s and/or Unusual Occurrence/s:" within 24 hours in accordance with [Types Of Quality Events and Reporting Timeline to KP Continuum](#).
- The facility must provide a summary of the investigation within 5 business days
- Continuum will review and follow up within 1 to 5 business days based on the [severity level guidance](#).
- Post-event quality monitoring activities may follow (e.g., facility to provide a summary of follow-up and plan of correction)
- Collection of critical events, trending and remediation or action plans. Reporting to centralized regional repository for further analysis, trending and follow-up.

CMS Identified Elements of SNF'S QAPI

Summary

Incorporate contracted SNFs' QAPI programs, which must include five key elements identified by CMS. The CMS QAPI 5 Elements provide a framework for all **LTC, Subacute SNF and ICF/DD** facilities to utilize to ensure they maintain compliance with the various aspects of a well-developed QAPI program.

Responsible Party: Regional LTC Coordinator RN

Process

SNF Partners will be required to upload evidence of required documents with the **Regional LTC Coordinator RN** to a centralized repository made available by the MCP to ensure compliance with DHCS QAPI requirements for validation. Missing items or information not meeting the standard of care for documentation will be communicated back to the Contracted Partner for further clarification or submission. Each service area will validate the documentation prior to a site visit.

Audit frequency and size:

The MCP operationalizes the requirements of quality oversight through a randomized audit of 10% of all LTC contracted buildings per quarter to validate the 5 Elements of QAPI are met. Audits will be conducted by the Regional LTC Coordinator RN and entered in the **LTC Quality Platform**.

Audit criteria from Contracted Partner for validation:

- Check for Element 1: Design and Scope and look for:**
 - SNF QAPI Policy & Procedures
 - QAPI program documentation
 - Ongoing Process Improvement (PI) projects

Continuum of Care

Skilled Nursing Facility/Long Term Care Quality Oversight Model Program Description

- Evidence of communication with residents and their families in their care (may be validated onsite)
- Inclusive of all systems of care including:
 - Management practices
 - Clinical care
 - Quality of life
 - Resident choice (may be validated onsite)
- **Check for Element 2: Governance and Leadership** and look for:
 - Evidence of governing body activities e.g.) quarterly or annual meetings.
 - Facility-wide training (may be validated on-site)
 - A list of the members of the governing body responsible for oversight.
 - Evidence of expectation setting around the following:
 - Safety
 - Quality
 - Rights
 - Choice
 - Resident-centered rights and choice (may be validated onsite)
 - Staff accountability – evidence of corrective action for a critical event or incident
 - **Onsite validation:** Evidence of an atmosphere where staff is comfortable identifying & reporting quality problems as well as opportunities for improvement.
- **Check for Element 3: Feedback, Data Systems & Monitoring** and look for:
 - Monitor Data collection and analysis
 - Infection Control
 - Adverse Events - investigated with Action Plan
 - Complaints
- **Check for Element 4: Performance Improvement Projects** and look for:
 - Monitor that facility conducts PIPs timely
 - Ensure identification of problems and interventions for improvement.
- **Check for Element 5: Systematic Analysis and Action** and look for:
 - Policies and procedures promote use of Root Cause Analysis
 - Systemic Actions that look across systems to prevent future events and promote sustained improvement.
 - Quality improvement projects
 - Staff education and training
 - Focus on continual improvement

Continuum of Care
Skilled Nursing Facility/Long Term Care Quality Oversight Model Program Description

Recommended frequency of element criteria evaluation:

Element		Annual	Quarterly
Element 1	SNF QAPI Policy & Procedures	✓	
	QAPI program documentation	✓	
	Ongoing Process Improvement (PI) projects		✓
	Evidence of communication with residents and their families in their care		✓
Element 2	Evidence of governing body activities e.g.) quarterly or annual meetings.	✓	
	A list of the members of the governing body responsible for oversight.	✓	
	Facility-wide training	✓	
	Setting expectations: • Safety • Quality • Rights • Choice		✓
Element 3	Monitor data collection:		✓
	• Infection Control		✓
	• Adverse Events		✓
	• Complaints		✓
	Adverse events have been investigated appropriately with Action Plans		✓
Element 4	Monitor that facility conducts PIPs timely		✓
	Identification of problems & interventions for improvement.		✓
Element 5	Policies & procedures demonstrate use of Root Cause Analysis	✓	
	Quality improvement projects		✓
	Staff education and training	✓	
	Focus on continual improvement		✓

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Skilled Nursing Facility/Long Term Care Quality Oversight Model Program Description

The following is an example of a tracking tool service area leaders can use to ensure the CMS 5 Elements of QAPI are being met by SNF Partners.

CMS 5 Elements		Recommended Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Element 1	SNF QAPI Policy & Procedures	Annually												
	QAPI program documentation	Annually												
	Ongoing Process Improvement (PI) projects	Quarterly												
	Evidence of communication with residents and their families in their care	Quarterly												
Element 2	Evidence of governing body activities e.g.) quarterly or annual meetings.	Annually												
	A list of the members of the governing body responsible for oversight.	Annually												
	Facility-wide training	Annually												
	Setting expectations: • Safety • Quality • Rights • Choice	Quarterly												
Element 3	Monitor data collection:													
	• Infection Control	Quarterly												
	• Adverse Events	Quarterly												
	• Complaints	Quarterly												
Element 4	Adverse events have been investigated appropriately with Action Plans	Quarterly												
	Monitor that facility conducts PIPs timely	Quarterly												
	Identification of problems & interventions for improvement.	Quarterly												
Element 5	Policies and procedures demonstrate use of Root Cause Analysis	Annually												
	Quality improvement projects	Quarterly												
	Staff education and training	Annually												
	Focus on continual improvement	Quarterly												

Continuum of Care

Skilled Nursing Facility/Long Term Care Quality Oversight Model Program Description

Annual QAPI Reporting

Responsible Party: Regional LTC Manager

Summary

The **Regional LTC Manager** will submit QAPI program reports in accordance with CalAIM requirements by using the following process:

1. KP will collect data from Contracted Partners on the outcomes and trending data for its QAPI program. This data will include information on the following:
 - The number and type of QAPI activities that were conducted quarterly
 - The results of the quarterly QAPI activities
 - Any trends that have been observed in the QAPI data
2. KP will format the data in a way that is compliant with the DHCS requirements.
3. KP will submit the QAPI data to DHCS. This submission will be made in a way that is compliant with the DHCS requirements. This submission will include the following:
 - The data will be secure and confidential upon submission
 - The data will be timely according DHCS requirements

KP will submit the QAPI data to DHCS annually. In accordance with DHCS's requirement from KP. Reporting Summary below describes reporting requirements along with source information.

Required Reporting Summary

LTC		ICF/DD	
Report	WQIP	Report	Oversight & Compliance
Frequency	Qtrly & Annual	Frequency	Qtrly & Annual
Elements	1. Number of Out-patient ED Visits per 1,000 Long Stay Resident Days 2. Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization 3. Potentially Preventable 30-day Post-Discharge Readmission	Elements	1. Enforcement Actions 2. Citations 3. Penalties
Data Source	DHCS	Data Source	CDPH
Distribution contacts	Kellee Vargas, Leo Gallo	Distribution contacts	Kellee Vargas, Malou Catuira
	NCALKPLTCQuality@kp.org		NCAL ICFDD Quality (pending creation)



LTC Quality Oversight
Reporting Requirements

1. Managed Care Plans (MCPs) will be held to quality and enforcement standards in [APL 22-015](#).
2. MCPs to comply with Quality Improvement System requirements in [APL 19-017](#).
3. CMS QAPI Five Elements - <https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/qapifiveelements.pdf>
4. CalAIM Enhanced Care Management (ECM) Policy Guide. <https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf>

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Skilled Nursing Facility/Long Term Care Quality Oversight Model Program Description

SNF/LTC CONTRACT OVERSIGHT – Annual Review of all SNF/LTC Facilities-Roles & Responsibilities					
SERVICE AREA SNF DIRECTOR/MANAGER/DE PT	Conduct quarterly JQC Meetings	Follow-up with quality issues and monitor performance	Complete site visits (recredentialing and quality visits)	Escalate SNF quality concerns/updates as needed	
SNF REGIONAL DIRECTOR/DEPT	Conduct monthly Meetings with LTC Directors	Conduct quarterly JQC Meetings with Tier 1 SNF partners	Provide oversight to manage and evaluate quality metrics for SNF/LTC annual workplan, quarterly updates, AFL updates, and new regulatory interpretations	Maintain database of SNF quality oversight (Star Rating, PIP, CAP)	Monthly collaboration with MSC for Contract Oversight
REGIONAL COMPLIANCE AND RISK MGMT	Provide Consultation for Risk Management/Media Risks/Safety				
REGIONAL CONTRACTING (ND&A)	Provide Monthly List of New/Terminated Contracts				
LEGAL GUIDANCE	Provide Consultative Guidance on Legal Issues				

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Skilled Nursing Facility/Long Term Care Quality Oversight Model Program Description

Assessment Factors Used to Determine the Seriousness of Deficiencies Matrix

	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J PoC Required 	K PoC Required 	L PoC Required 
Actual harm that is not immediate	G PoC Required	H PoC Required 	I PoC Required 
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D PoC Required	E PoC Required	F PoC Required 
No actual harm with potential for minimal harm	A No PoC Required  No remedies Commitment to Correct Not on CMS-2567	B PoC Required 	C PoC Required 

Guidance on Severity Levels

- **Level 1** - No actual harm with potential for minimal harm: A deficiency that has the potential for causing no more than a minor negative impact on the resident(s).
- **Level 2** - No actual harm with a potential for more than minimal harm that is not immediate jeopardy: Noncompliance with the Requirements for Participation that results in the potential for no more than minimal physical, mental, and/or psychosocial harm to the resident and/or that result in minimal discomfort to the residents of the facility but has the potential to result in more than minimal harm that is not immediate jeopardy.
- **Level 3** - Actual harm that is not Immediate Jeopardy: Noncompliance with the Requirements for Participation that results in actual harm to residents that is not immediate jeopardy.
- **Level 4** - Immediate Jeopardy to resident health or safety: Noncompliance with the Requirements for Participation that results in Immediate Jeopardy to resident health or safety in which immediate corrective action is necessary because the provider's noncompliance with one or more of those requirements has caused, or is likely to cause, severe injury, harm, impairment, or death to a resident receiving care in a facility.

Guidance on Scope Levels

- **Scope is isolated** when one or a limited number of residents are affected and/or one or a limited number of staff are involved, and/or the situation has occurred only occasionally or in a limited number of locations.
- **Scope is a pattern** when more than a limited number of residents are affected, and/or more than a limited number of staff are involved, and/or the situation has occurred in several locations, and/or the same resident(s) have been affected by repeated occurrences of the same deficient practice. The effect of the deficient practice is not found to be pervasive throughout the facility.
- **Scope is widespread** when the problems causing the deficiencies are pervasive in the facility and/or represent systemic failure that affected or has the potential to affect a substantial portion or all the facility's residents. Widespread scope refers to the entire facility population, not a subset of residents or one unit of a facility. In addition, widespread scope may be identified if a systemic failure in the facility (e.g., failure to maintain food at safe temperatures) would affect many residents and is, therefore, pervasive in the facility.

Continuum of Care
Skilled Nursing Facility/Long Term Care Quality Oversight Model Program Description

APPENDIX	
RCPC Policy and Procedure	 7 Credentialing Organizational Prov  8 Site Visits for Organizational Prov
Sample JQC Agenda	 Sample KP JQC Agenda v1.docx
SNF Site Visit tool	 SNF Site Survey Tool Skilled and Cu:
Five Star Users' Guide	 Five Star Users' Guide October 2022 https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcompliance/downloads/usersguide.pdf

Continuum of Care
Skilled Nursing Facility/Long Term Care Quality Oversight Model Program Description

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TPMG Equity, Inclusion, and Diversity Program Description 2024

Kaiser Permanente Northern California (KPNCAL) is an integrated Health System composed of three legal entities: Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser foundation Hospital (KFH) and The Permanente Medical Group, P.C. (TPMG). The Program serves over 4.5 million Northern California Health Plan members/patients. KPNCAL is comprised of 15 Medical Service Areas and multiple offices. The purpose of the TPMG Equity, Inclusion & Diversity (EID) Department Program Description is to inform both internal and external audiences how TPMG is organized to support the Program's commitment to Equity, Inclusion, & Diversity while providing quality, equitable, and culturally responsive care to our patients and communities.

The TPMG EID Program's scope is rooted in providing high quality culturally responsive and inclusive to meet the needs of our patients and communities in the NCAL market. The TPMG EID Program embraces Kaiser Permanente's view of diversity is all-inclusive, to include race, ethnicity, gender, sexual orientation, gender identity, age, literacy, education, cultural heritage, functional ability, cognitive ability, and other aspects that make each of us unique, being sensitive and considerate to the needs of all people including seniors and persons with disabilities. The program takes full advantage of the strengths inherent in these differences in its members, patients, communities, workforce, and leadership, aiming to deliver on the basic KP value that all individuals are to be treated with sensitivity, dignity, and respect.

The TPMG EID Program's strategy is supported by three pillars—Patients, People, and Community. It is through these pillars that we anchor our strategic priorities and build our programming across the TPMG enterprise.

- Our strategic EID priorities are to advance health equity, care experience, language access, and compliance/regulatory requirements in the patient pillar.
- In the people pillar, the EID priorities are to cultivate a Climate of inclusion and belonging, bolster workforce diversity, and broaden education and development initiatives in the EID space.
- In the community pillar, the EID priorities are to strengthen community engagement and advance the pipeline of diverse physicians and staff.

The TPMG EID Program's objective is to deliver personalized and equitable care and cultivate an inclusive environment that respects the diverse needs and perspectives of our people, patients, and communities. The key responsibilities of the program are to:

- Educate leaders, physicians, and staff throughout TPMG to embrace & embody the values of diversity, inclusion & health equity
- Partner and consult with departments and leaders throughout TPMG to develop, pilot, and implement innovative care delivery & inclusion strategies
- Develop & implement strategies to diversify TPMG leadership, physicians, and staff to foster a workplace honoring diversity, equity, and inclusion
- Implement systems to identify & monitor health disparities and create system level programs & interventions to drive health equity in care delivery
- Develop inclusive care delivery models & processes that provide personalized care experiences for all our diverse patient populations based on their unique preferences
- Promote & build awareness of TPMG diversity, equity, and inclusion initiatives and the impact of our work on our patients, people, customers, and the communities we serve

- To support this work, we have an executive sponsorship steering committee, Regional service line leaders, a medical center leadership group, and local medical center committees

TPMG EID Program's governance structure consists of an executive sponsor team, medical center leaders and teams, and regional service line teams. This structure is in alignment with The Federation EID team and KFHP/HP NCAL Regional EID Department, as well as the KP National EID Office, Business Resource Groups and other committees and stakeholders.

The TPMG EID Program works collaboratively with all TPMG functional and operational leaders to embed EID thinking into priority areas. There is TPMG EID alignment with other programs including Quality, Human Resources, Physician Education & Development, Health Engagement and Consulting, Risk & Patient Safety, Physician Recruitment & Retention, and many other programs in NCAL. There is active EID strategy deployment across several specialties and primary care departments. Additionally, TPMG EID Program partners with KPNCAL's Health Plan and Hospitals (KFHP/H) and the Regional Language Access and ADA/Civil Rights Programs within KFHP/H.

The TPMG EID leaders meet to review and recommend EID priorities across the region and develop and facilitate linkages in their areas to meet the needs of our membership/patients and communities. They then facilitate strategy development and tactics for EID practices, identify gaps/challenges and monitor progress of EID practices in their respective areas, and share and disseminate information to local and regional groups.

There are an abundance initiatives and programs that are sponsored regionally and at local medical centers that support this strategic framework. Our physicians and staff have a wealth of opportunities to enhance their learning and development around bias, racism, cultural awareness, and sensitivity through a host of local and regional educational offerings. These offerings include, but are not limited to, *Belong @KP*. *Belong@KP* is an action-focused awareness and behavior change program designed to help learn and demonstrate inclusive behaviors and combat racism and social injustice. This program helps our people recognize biases in their thinking and actions and give them tools to think and act more inclusively. *Belong@KP* is built on anti-bias and anti-racism core principles that guide the learning journey. In addition to these learning opportunities, we embed EID principles into our Annual Compliance trainings for physicians in TPMG as well as all Continuous Medical Education (CME) activities across every medical center in NCAL.



Kaiser Foundation Health Plan, Inc.

Northern California Region

**2024 Utilization Management (UM)/Resource Management
Program Description**

KFHP Northern California Region
2024 Utilization Management (UM)/ Resource Management (RM)
Program Description

SIGNATURE PAGE



04/18/2024

Robin Betts

Date

Vice President, Quality, Clinical Effectiveness & Regulatory Services
Co-Chair Quality Oversight Committee



04/18/2024

Yi-Fen (Irene) Chen, MD

Date

Associate Executive Director for Quality
Co-Chair Quality Oversight Committee

**KFHP Northern California Region 2024 Utilization Management/Resource
Management Program Description**

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INTRODUCTION

The Kaiser Foundation Health Plan's Utilization Management/ Resource Management ("UM/ RM") Program is organized and written so that staff members and others can understand the program's structure, scope, processes and information sources used in UM and RM.

Utilization Management Program

Utilization review is a process that determines whether a health care service recommended by your treating provider is medically necessary. If it is medically necessary, the service will be authorized, and the member will receive the services in a clinically appropriate place consistent with the terms of the member's health coverage. Utilization Management (UM) activities and functions include the prospective, retrospective, or concurrent review of health care service requests submitted by providers and the decisions to approve, modify, delay, or deny the request based in whole or in part on medical necessity. Kaiser's utilization review program is subject to direct regulation under the Knox-Keene Act and must adhere to managed care accreditation standards.¹

Kaiser Foundation Health Plan (KFHP) in partnership with TPMG and KFHP has a UM program focused primarily on prospective review of requests for out-of-plan and in-plan referrals for a variety of outpatient ambulatory services. A full list of services that require prior authorization in Northern California may be found on the RM-UM Wiki Site, Clinical Library, and/or kp.org Webpage.

Resource Management Program

Resource Management (RM) is the collective set of actions Kaiser Permanente undertakes to assure the affordability and quality of health care services delivered to Kaiser Permanente members. The activities that comprise RM is different than the utilization management activity described above. RM is the activity concerned with the prudent and clinically appropriate allocation of resources in the provision of health care services. i.e., hospitals, prescription drugs, diagnostic imaging services. KFHP has a comprehensive program of RM that supports the delivery of affordable quality health care services.

RM is an essential component of providing appropriate and affordable health care to members as part of Kaiser Foundation Health Plan, Inc. (KFHP) quality improvement program. TPMG physicians and other health care professionals provide the majority of care to KFHP members. The Health Plan and Hospital non-physician RM staff are available to support the clinical staff as they manage member health care needs throughout the care continuum by providing a variety of services, including discharge planning and care management. Together, KPNC provides and coordinates high quality and affordable care for Health Plan members through effective medical and resource management.

KPNC PRINCIPLES AND PRACTICE

Kaiser Permanente practitioners and health care professionals make decisions about a member's care based on clinical needs in association with appropriate treatments and services and existence of coverage. Kaiser Permanente does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization. The health plan does not use incentives to encourage barriers to care and service. This does not preclude the use of appropriate incentives for fostering efficient, appropriate care.² In order to maintain and improve the health of Kaiser Members, including California's Exchange Marketplace ("Covered California"), all practitioners and health professionals must be diligent in identifying any potential under-utilization of care or service.

ORGANIZATION OVERVIEW

¹ Section 1367.01 of the Knox-Keene Act

² 2019 NCQA UM Standard 4, Element G

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Kaiser Permanente Northern California (KPNC) is an integrated health care delivery system composed of three closely aligned organizations. These organizations are Kaiser Foundation Health Plan, Inc. (“KFHP”), Kaiser Foundation Hospitals (“KFH”), and The Permanente Medical Group (“TPMG”). Kaiser Foundation Health Plan, Inc. (“KFHP”), is a nonprofit, public benefit California Corporation that contracts with individuals and groups to provide or arrange comprehensive prepaid health care benefits. KFHP is a federally qualified health maintenance organization, and a California-licensed Knox-Keene health care service plan.

KFHP contracts with Kaiser Foundations Hospitals (“KFH”), a nonprofit, public benefit corporation that owns and operates community hospitals, to provide or arrange hospital services for health plan members. KFHP contracts with TPMG, a multi-specialty physician corporation, to provide or arrange medical and other health care services for KFHP members.

The KPNC UM Program is developed by KFHP, in cooperation with KFH and TPMG. KFHP retains accountability for all utilization management/resource management activities and must ensure that members receive appropriate access to care and service in compliance with regulatory and accreditation standards. The Health Plan’s Quality Oversight Committee (QOC) and Health Plan UM Department provide oversight of UM/RM activities performed through the TPMG and KFH in partnership with the NCAL Health Plan Physician Advisor (HPPA) (“NCAL HPPA”).

BEHAVIORAL HEALTH/CHEMICAL DEPENDENCY

The Behavioral Health Care and Addiction Medicine Recovery Services are described in Attachment T: Behavioral Health Care Program Description. The program description specifies the triage and referral process for behavioral healthcare services, how the organization evaluates service sites and the levels of behavioral healthcare services. The program description includes how the NCAL Executive Director of Behavioral Health and the Regional Director for Inpatient Psychiatry and Continuing Care are involved in implementing and evaluating the behavioral healthcare aspects of the UM/RM program. In the areas of autism and transgender services, the NCAL Regional Health Plan Executive Director of Behavioral Health Transgender and Autism is also involved in implementing and evaluating the behavioral healthcare aspects of the UM/RM program.

KPNC offers a comprehensive and integrated Behavioral Health (BH) Care Delivery System. BH services available to members includes: outpatient, telehealth and inpatient psychiatric services, residential treatment and outpatient and inpatient chemical dependency/substance abuse services. Multiple approaches and levels of care are utilized to deliver medical necessary treatment appropriate to the member’s diagnosis, including but not limited to psychotherapy (individual and group), medication management, crisis intervention, residential services and case management. Inpatient Behavioral Health (BH) is provided via a KP Psychiatric Health Facility on the grounds of the Santa Clara Medical Center and via contracts with a network of non-Kaiser community hospitals.³

Behavioral Health Services are available to members in multiple ways throughout our system. Patients can consult with their primary care physicians who are trained to diagnose and treat some behavioral health conditions. Primary care physicians and other medical care physicians can easily refer a patient to their BH colleagues in each area. Patients can also self-refer to BH departments throughout the region. BH practitioners consult with medical care practitioners on an as-needed basis for patients with co-morbid conditions.

There is no prior authorization required for Behavioral Health Services including inpatient level of care for Mental Health/Substance Use Disorder (MH/SUD) conditions, Neuropsychological/Psychological testing, Transcranial Magnetic Stimulation (TMS), office based Opioid treatments, or initial referrals for Applied Behavioral Analysis (ABA). At such time continued treatment is evaluated for medical necessity review and authorization is required. There are case management services within both inpatient and outpatient programs. Inpatient case managers do concurrent review and assist the contracted facilities in discharge planning for individual patients. Outpatient case

³ 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)

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managers and intensive case managers are used when necessary to coordinate and facilitate the care of at-risk members and members with severe and persistent mental illnesses.

Kaiser Health Plan provides coverage for the diagnosis and treatment of mental health and substance use disorders that fall under any diagnostic categories included in the most recent edition of the International classification of Diseases or Diagnostic and Statistical Manual of Mental Disorders.⁴ The long-term therapy exclusion and visit/day limits have been eliminated for specified psychiatric conditions. Kaiser Permanente does not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the same classification.

KPNC uses generally accepted standards of mental health and substance use disorder care. When conducting utilization review, determinations are made consistent with guidelines and recommendations of professional organizations and/or non-profit health care provider professional associations to guide qualified physician(s) or licensed practitioners in making a final decision regarding medical necessity. The final decision regarding the Member's treatment plan rests with the TPMG responsible practitioner. Resource Management/Continuing Care staff are available to support practitioners in the management of member's health care needs throughout the care continuum and provide a variety of services, such as discharge planning, utilization review, and care management. SB 855 was signed into law in September 2020 and requires commercial health plans in California, for contracts issued, amended, or renewed on or after January 1, 2021, to cover medically necessary treatment for specified mental health conditions and substance use disorders under the same terms and conditions applied to other medical conditions. As such, SB 855 redefined the description for medically necessary mental health conditions and substance use disorders. Health plans must use the most recent criteria developed by a nonprofit professional association for the relevant clinical specialty when conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders. Physicians and health care professionals determine whether a service or treatment is medically necessary by using the following criteria to assist them in their clinical decision-making process:

<i>Clinical Specialty</i>	<i>Nonprofit Professional Association Criteria/Guidelines</i>
Substance use disorders	ASAM (American Society of Addiction Medicine)
Adult Mental Health	LOCUS (Level of Care Utilization System), as developed by the AACP (American Association of Community Psychiatrists)
Child and adolescent mental health	CALOCUS-CASII (Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument) ECSII (Early Childhood Service Intensity Instrument), both developed by the AACAP (American Academy of Child and Adolescent Psychiatry)
Autism Spectrum Disorder	National Standards Project 2 Guidelines, as developed by the National Autism Center
Transgender	World Professional Association for Transgender Health (WPATH) Standards of Care

GOALS AND OBJECTIVES

The UM/RM Program has identified the following goals and objectives:

Goal: Ensure effective utilization review oversight and compliance with state and federal statutes and regulations and accreditation standards.

Objectives:

⁴ As indicated in footnote 3 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.

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- Continually improve utilization review processes by monitoring and identifying services subject to utilization review and develop and/or revise utilization management criteria to support medical necessity decision making consistent with professional standards of care.
- Monitor and evaluate the utilization of outside services, including specialty referrals and services not available in plan.
- Actively seek opportunities to improve member and practitioner satisfaction with the Utilization Management Program.
- Ensure that the UM Program components support the delivery of medically necessary care to our members in accordance with their benefits and consistent with state and/or federal benefit mandates (e.g., reconstructive surgery and mental health parity).
- Ensure members and practitioners receive written communications that provides for transparency on the basis and explanation of medical necessity decisions and that comply with all statutory and accreditation standards.
- Measure, monitor, evaluate and take action as needed to ensure compliance with member/provider disclosure requirements on an ongoing basis.

Goal: Ensure Effective Resource Management Objectives:

- Achieve consistency in program-wide resource management policies, guidelines, and practices.
- Effectively evaluate and appropriately incorporate and utilize new technologies in patient care.
- Effectively oversee resource management activities at all levels of the organization and provide Regional oversight by the Resource Management Committee (“RMC”), with regular reports to the Plan’s QOC.
- Tailor resource management reports to the needs of individual Medical Centers. Provide data support and analysis to local Medical Centers for developing meaningful work plans to monitor progression of resource management activities such as Bed Management, Repatriation, and Capacity Planning.
- Establish and monitor improvement plans that result from focused evaluation and consultation activities.
- Monitor appropriate utilization of resources via demonstration of healthcare quality outcome.

KFHP/ TPMG/ KFHP LEADERSHIP STRUCTURE and AUTHORITY for UTILIZATION AND RESOURCE MANAGEMENT

UTILIZATION MANAGEMENT

Regional Health Plan President and the UM Health Plan Physician Advisor (HPPA)

The NCAL HPPA is accountable to the NCAL Regional Health Plan President for assisting the health plan in fulfilling its UM Program oversight obligations. The NCAL HPPA is responsible to ensure that the process by which the plan conducts formal UM activities comply with statutory requirements.⁵ The NCAL HPPA is holding an unrestricted license to practice medicine in California. The NCAL HPPA role includes:

- Actively participates in the Regional UM Committees in exercising oversight of the UM function as defined in Health and Safety Code §1367.01, CMS, ACA and NCQA.
- Actively participates in the annual review and approval of UM policies and procedures, UM provider surveys, and member and provider communications related to UM.
- Reviews and approves annually on behalf of KFHP the criteria and/or guidelines used for services that KFHP acknowledges fall within the scope of UM as defined in Health and Safety Code §1367.01, CMS, ACA and NCQA. Such review must demonstrate and document that KFHP’s UM clinical criteria and guidelines are consistent with sound clinical principles and professionally recognized standards of care. As required, conducts review and oversight of any delegated UM activities or materials.
- Conducts reviews, as appropriate, for any internal UM activities (e.g., reconstructive and plastic services).

⁵ Section 1367.01(c) of the Knox-Keene Act

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- Works with appropriate KFHP departments to ensure that assessments are performed in relevant areas/functions to ensure that TPMG follows statutory timelines and content requirements for its communications regarding determinations to approve, modify, delay or deny health care services requested by providers.
- Works with appropriate KFHP and TPMG departments/designees to perform assessments when there is relevant information (such as complaints or grievances) that may suggest a UM component or activity with respect to specific areas or services, outside of those already designated as UM, where the treating practitioner must request authorization from another party before the requested service is rendered. If such instances are identified, the NCAL HPPA must bring it to the attention of KFHP and TPMG for discussion and action.
- Reviews appeals from selected UM denials, Independent Medical Review (IMR) cases related to medical necessity denials and other cases as warranted (e.g. reconstructive surgery) prior to their submission to DMHC, as well as after the IMR decision is rendered. Lessons learned are shared with the KFHP and TPMG.
- Provides an annual report of activities/findings to QOC, which will then be included in that Committee's reports to the KFHP Board of Directors.
- Serves as the physician advisor to the Coverage Decision Support Unit (CDSU) to give clinical guidance to the Unit and interface with TPMG in issues related to coverage decisions based on medical necessity.

Medical Director for Accreditation, Regulatory, and Utilization Management Compliance

The TPMG Medical Director for Accreditation, Regulatory, and Utilization Management Compliance partners with the NCAL HPPA, and other Medical Directors to evaluate, maintain and improve the compliance of the UM Program in accordance with state and federal regulations and accreditation standards. This position is also the Medical Director for Medi-Cal (Medicaid) and State Programs.

Assistant Physicians-In-Chief (APIC) for Outside Services/Referrals

The Assistant Physicians-In-Chief (APIC) for Outside Services/Referrals reports to the Physician in Chief (PIC) at the local facility and has oversight responsibilities for the utilization review of out-of-plan referrals. A referral for out-of-plan services will be approved by the APIC after it is determined that the services are medically necessary based on established UM criteria and not available or accessible within KFHP. The Permanente Medical Group appoints an APIC who serves in each of the NCAL service areas.

Executive Director, NCAL Quality and Regulatory Services

The Executive Director, NCAL Quality and Regulatory Services directs the operations that support the UM/RM Program in Northern California. This position partners with the NCAL HPPA, the Medical Director for Accreditory, Regulatory, and Health Plan Utilization Management, Executive Director of Behavioral Health Services and other Regional Leaders, collaboratively, they develop the vision, strategy, infrastructure, and relationships required for a successful UM/RM Program. The position also coordinates selected Regional UM activities, such as the Program Description, Annual UM/RM Program Evaluation and Regional UM Policies and Procedures.

NCAL Regional Managing Director of Health Plan Utilization Management

The Regional Managing Director directs the Regional Health Plan Utilization Management Department and provides leadership and oversight of Health Plan compliance with county, state and federal regulatory and accreditation requirements for utilization review performed at local facilities in NCAL. Working closely with the NCAL HPPA and the Medical Director for Accreditory, Regulatory, and Utilization Management, the Managing Director advises internal and external stakeholders on specific compliance and governance issues to ensure the Health Plan meets contractual requirements and organizational objectives.

The NCAL Regional Health Plan Utilization Management Department staff consists of Registered Nurses and Project Managers who provide support, consultation, and expertise to KFHP and TPMG regarding appropriate utilization/resource management and compliance with internal and external regulatory and accreditation agency requirements. Staff also represents UM in a broad spectrum of health plan initiatives.

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RESOURCE MANAGEMENT

The Regional Health Plan President and Associate Executive Medical Director of TPMG

The Regional Health Plan President and Associate Executive Medical Director of TPMG hold the RM Program accountable for developing appropriate performance targets, in collaboration with the Area Medical Centers on Utilization Management (UM). They receive and review regular, written regional quality and utilization reports, and make inquiries and take action as appropriate.

The Health Plan's Regional Vice President, Continuing Care Operations

The Regional Vice President, Continuing Care Operations, directs and coordinates all services within the health care delivery continuum including Home Health, Hospice, SNF, DME, Ambulance, Eldercare Services, Claims and Referrals. The goal is to ensure effective coordination between a member's plan of care and the delivery systems. The Regional Executive Director establishes long range goals for continuing care operations and monitors performance and standards of practice.

NCAL Executive Director of Behavioral Health

The Executive Director provides health plan oversight and direction to Behavioral Health (adult and children) services for the following programs: Autism Spectrum Disorder (ASD)/Developmental Delays, Transgender Services. This position partners with the Regional Director of Inpatient Psychiatry and Continuing Care Directs to manage quality and resource/utilization of services delivered by KP and non-KP mental health providers in both hospital and hospital alternative settings. The Executive Director also acts as the Health Plan's leader and partners with the Executive TPMG functional leaders to ensure that behavioral health services consistently meet regulatory and accreditation standards. The Executive Director leads the development and oversight of the contracts for external providers utilized by KP to provide services at all levels of behavioral health, including provisions for Applied Behavioral Analysis (ABA) for autism spectrum disorders, crisis residential and residential programs for BH patients, and transgender surgical services

Regional Director of Inpatient Psychiatry and Continuing Care

The Regional Director of Inpatient Psychiatry and Continuing Care manages quality and resource management services delivered by KP and non-KP mental health providers in both hospital and hospital alternative settings. The Regional Director collaborates with Psychiatry Chiefs and Continuum Administrators in three service areas to plan programs and funding. The Regional Director provides leadership and direction for psychiatric resource management, influences without authority to encourage appropriate utilization. The Regional Director maintains active relationships with management and clinical leadership at contract sites and represents three service areas on regional mental health committees, acts as the liaison from Mental Health to KFHP. Other responsibilities include: setting behavioral healthcare UM or RM policies, reviewing UM behavioral healthcare cases and participating on the RMC.

UTILIZATION AND RESOURCE MANAGEMENT COMMITTEE STRUCTURE

Quality Oversight Committee ("QOC")

The responsibility for assessing and monitoring the quality of care and treatment and services provided to members is delegated by Kaiser's Board of Directors (BOD) to Northern California's Quality Oversight Committee (QOC). The UM/RM Program is approved and monitored by the QOC and its subcommittees and reported to the BOD. The QOC has oversight of the UM Program and regulatory requirements by product line i.e., Commercial, Marketplace, Medicare, Medi-Cal, Self-funding.

Resource Management Committee ("RMC") The Northern California Regional RMC serves as a sub-committee of the Quality Oversight Committee (QOC). The RMC identifies and promotes utilization strategies and activities, oversees Health Plan Resource Management through its regulatory and accreditation work, monitors utilization across the health care continuum, consults with Area Medical Centers on Utilization Management (UM) issues and facilitates performance improvement. The RMC functions include:

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- Engaging in the coordination and prioritization of RM and UM activities.
- Oversight of the RM activities throughout the facilities within NCAL.
- Ensuring UM compliance with regulatory and accreditation requirements.
- Encouraging RM/UM considerations in other activities throughout the organization.

The RMC partners with members of key departments across the health plan and medical group to accomplish its functions.

SCOPE – UTILIZATION MANAGEMENT FUNCTIONS

A Health Plan or any entity with which it contracts for services that include utilization review or utilization management functions that prospectively, retrospectively or concurrently reviews and approves, modifies, delays or denies, based in whole or in part on medical necessity, requests by providers shall comply with Section 1367.01 of the Knox-Keene Act. Whether UM review and decisions are made by TPMG physicians or as a joint process between TPMG physicians and KFHP or delegated to a contracted entity, medical necessity decisions are subject to Health Plan oversight and notification requirements in the Knox-Keene Act [§1367.01(h)], CMS, ACA, DHCS, and NCQA.

The UM Program plans, monitors, guides and oversees a variety of UM functions including, prior authorization of selected services. Treating physicians, Health Plan UM Department staff, DME Physician Champions, TPMG Assistant Physician in Chiefs (APICs) and the NCAL Pediatric Developmental Disabilities Office (PDDO) are responsible to oversee utilization review for out-of-plan care and requests for external specialty referrals, DME referrals, home health care and hospice.

If a treating physician requests an out-of-plan referral to a specialist, or any service on the prior authorization list, the requesting physician enters the request through the appropriate system and TPMG physicians confirm whether comparable services and/or specialty care are available in plan and to determine medical necessity for requested services. Only the delineated TPMG APIC, DME Physician Champion and PDDO Physician Reviewers can deny a provider request for health care services on the basis that it is not medically necessary. If the request is denied, modified or delayed, the member and provider receive a written communication of the decision.

REVIEW OF OUT-OF-PLAN SERVICES: HOSPITALIZATION, EMERGENCY CARE AND PRIOR AUTHORIZATION OF SELECT SERVICES

A. Out-of-Plan Hospitalizations and Outside Services Case Management

Northern California Outside Utilization Resource Services (NCAL OURS) is a Region-wide program, which concurrently reviews and authorizes the care and treatment for members receiving out-of-plan hospital services. The program determines if the members are clinically suitable for:

- Continued stay in non-KFHP hospitals
- Transfer to KFHP or contracted hospitals
- Discharge with KP follow up

Prior authorization is not required for out-of-plan Hospitalizations due to an emergency medical condition, Outside Services Case Managers work with physicians to concurrently evaluate the medical necessity of the out-of-plan care. Local KFHP/HP staffs facilitate transfer and coordinate the continuing care needed by members who are determined to be clinically stable for transfer to a KFHP or contracting hospital.

- B. 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 TPMG specialist. Furthermore, specialists within the TPMGs 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 TPMG 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-TPMG 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.

C. Emergency Services and Emergency Prospective Review (EPRP) Program

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KFHP covers out-of-plan emergency services that are necessary to screen and stabilize the member. Prior Authorization is not required for emergency admissions. Emergency services are at no cost to Medi-Cal members. EPRP is a program staffed by Board Certified TPMG emergency physicians that provide non-plan emergency physicians access to members' clinical information and to discuss, plan, and authorize post-stabilization care. It is designed to be first notification of non-plan emergency care by non-plan clinicians. EPRP is linked to the member services call center to facilitate emergency notification.

The TPMG physician and affiliated providers discuss and arrange post-stabilization care which may include: Discharge, transfer to a KFHP contracted hospital or tertiary facility, or admission to the non-KFHP hospital. In the event of a transfer to a KP or contracted hospital, EPRP arranges the transfer with the accepting facility, and accepting physician, and orders appropriate transportation.

If a member is deemed unstable and requires admission, NCAL OURS is notified and provides ongoing oversight of the stay until such time as the member can be safely transferred to a Plan facility or is discharged to a lower level of care.

Non-plan emergency claims are reviewed retrospectively by the Claims Clinical Review Department staff which considers whether the member reasonably believed they had an emergency medical condition requiring care at the Emergency department. All potential claim denials are reviewed with final decision made by a physician.

D. Prior-Authorization of Select Health Care Services

Prior-Authorization is a utilization management (UM) process that determines whether a provider requested health care service that is medically necessary, in advance of services, is rendered. The determination of whether a service is medically necessary is based on medical necessity UM criteria and the review of clinical information from various sources. (Refer to Section: Development of UM Criteria for UM Decisions) The KPNC UM Program requires prior authorization for the following health care services that may be found in the : [NCAL UM Criteria and Prior Authorization List](#) located on the Clinical Library and/or kp.org Webpage.

Clinical information is collected and evaluated from various sources including KP HealthConnect, member or authorized representative, treating practitioners, or specialists:

- 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 Rehab evaluations.
- Operative, pathological reports, photographs
- UM medical necessity criteria related to the request and information regarding benefits

The UM review considers individual patient needs and the characteristics of the local delivery system. Based on patient circumstances, applicable UM criteria may need to 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
- Co-morbidities
- Complications
- Home environment, as appropriate
- Progress toward accomplishing treatment goals
- Family support
- Psychosocial situation and needs

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- Benefit structure including coverage for skilled nursing facilities, sub-acute care facilities or home care when needed
- Delivery system capabilities and limitations such as availability of skilled nursing facilities, sub-acute care facilities or home care in the service area to support the patient after discharge
- Local hospitals' ability to provide all recommended services within the estimated length of stay

SCOPE –RESOURCE MANAGEMENT FUNCTIONS

PHYSICIAN LEADERSHIP AND OVERSIGHT FOR RESOURCE MANAGEMENT

Regional Director of Hospital Operations. TPMG

The TPMG Director of Hospital Operations partners with the KFHP senior leadership in overseeing the clinical care provided to Kaiser members at the hospitals through its clinical staff and facilities.

Chair of the Resource Management Chiefs

The Chair of the TPMG Resource Management Chiefs is the physician expert, consultant, and advisor for the RM Program administered within KFHP facilities. This position partners with the TPMG Regional Director of Hospital Operations and the Regional Executive Director of Resource Management to provide leadership to the RM Chiefs and Coordination of Care Service Directors (COCSD) at the Medical Centers in Northern California. The Chair of the RM Chiefs serves as a member of the RMC.

Local Medical Center Resource Management Activities, Committees and Departments

The KPNC RM Program identifies effective methods deployed locally to improve resource allocation and resource management performance within the Medical Centers. Local and Regional resource management strategies are reviewed annually and ad hoc. RM performance data and information are available to regional and medical center leaders through the Decision Support department. Reports by Decision Support allow medical centers to identify drivers of positive and negative variations in the use of services in relation to targets and key data metrics.

RM improvement opportunities are identified locally and regionally. Medical Center leaders, department managers, and physician leaders initiate improvement projects which support and align with the organizational strategic RM goals. Improvement activity outcomes are shared at the local and regional levels and report up to the RMC. Area medical centers, at the local level, and TPMG Resource Management Chiefs are responsible to administer a variety of RM functions such as inpatient admissions and concurrent care.

ADMISSIONS AND CONTINUED STAY REVIEW OF IN-PATIENT STAY

A. Admission Review

Prior and/or concurrent authorization is not required for services provided in KFHP acute medical care hospitals, KFHP acute psychiatric care hospitals, 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 Inpatient Quality Management model of care include:

- Timeliness of Care (Do It Today and Why Not Now)
- Real time Peer Review for appropriateness of care
- Real-time escalation
- Communication and Collaboration
- Long View of Care

The review relies on clinical guidelines appropriate for the care setting, including, but not limited to: InterQual, Medicare guidelines, KP standards including, specific unit admission /transfer guidelines, community standards, facility licensure restrictions and KFHP benefits and approved guidelines. Kaiser utilizes Integrated Urgent Services (IUS) as a resource along with criteria and guidelines set forth in the most recent version of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty including

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LOCUS/CALOCUS

The Admitting Physician and Patient Care Coordinator Case Manager (PCC-CM) consider the individual's unique case circumstances when applying clinical guidelines to a given patient. Case considerations such as: age, clinical history, complications, and failed outpatient management guide decision-making. KP Standards of Care including specific unit admission/transfer guidelines, community standards, licensure restrictions, are also considered in the review process by the RN Case Manager.

The RN Case Manager consults with the treating physician to ensure clinical documentation supports the correct patient classification, i.e., inpatient or observation unit. The severity of the signs and symptoms exhibited by the patient determine the need, timing and location of diagnostic procedures.

B. Continued Stay Review

Continued stay review is performed continuously during the stay to ensure progression and appropriateness of care at the selected level as well as on-going monitoring of the quality of care delivered. Reviews are conducted in conjunction with the treating physician's professional medical judgment and specific case considerations. If the treating physician determines that the member no longer needs acute inpatient level of care, for non-Medicare cases, the member will be verbally notified of the plan to discharge and provided with the number to Expedited Review Unit (ERU) if the member disagrees with the discharge. In Medicare cases, the member will be issued an Important Message, consistent with Medicare regulations, whether the member wishes to appeal or not.

C. Discharge Review

Discharge review may be conducted by the Hospital and Continuing Care staff to assess the patient's clinical stability for transition to the most appropriate post-acute level of care. Local service delivery availability for site and level of care options are evaluated in developing plans of care for individual members, and discussed and agreed upon with the treating physician. Discharge Planning is a part of the coordination of care process which is designed to provide continuity and prepare the patient for each phase of health care delivery when discharged home. Individual patient needs are assessed and determined through an interdisciplinary effort that includes the patient, physician and health care team.

MONITORING UNDER AND OVER-UTILIZATION AND APPROPRIATENESS of UTILIZATION

KFHP monitors the over- and under-utilization of services through a variety of activities and through numerous health plan venues across the continuum. KFHP systematically reviews this information in the Resource Management Committee which is a subcommittee of the NCAL Regional Quality Oversight Committee (QOC). The NCAL QOC reports to the Kaiser Foundation Health Plan Board of Directors.

Oversight of Over/Under and Appropriateness of Utilization:

Appropriate subject matter experts from selected clinical arenas will routinely present utilization reports to the RMC which will analyze Over/Under Utilization. The reports will include metric analysis and action items of potential over- and/or under-utilization of services to ensure professionally recognized standards of practice are maintained. The RMC will review over/under utilization using the lens below:

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

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

The reports will include the corresponding analysis and monitoring or process improvement actions,

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if indicated.

The RMC will meet regularly to review Over/Under Utilization in select clinical arenas

NCAL Quality Oversight Committee and Subcommittees:

The NCAL QOC and its subcommittees receive reports from both Medical Centers and Regional Departments/Programs that cover a wide range of regional or region-wide services that support the quality of care and services that Members receive. Viewed through the lens of appropriate utilization to achieve Healthcare Quality Outcomes, under/over utilization is built into many of the reports along with action plans for ensuring appropriate utilization if an element is not meeting appropriate utilization metrics. Examples include, but are not limited to:

NCAL Quality Oversight Committee:

- Annual Medical Center presentations that include annual utilization rate analysis and discussion about improvement strategies in underperforming areas. A medical center may be asked to report back to QOC on a more frequent basis than annually if necessary.
- Quarterly reports from the QOC subcommittees that include information on the information they are receiving in their committee meetings regarding appropriate utilization
- Review of HEDIS rates and action plans for improvement activities
- Direct reports and presentations from programs such as lab, pharmacy, home health/hospice, skilled nursing and other services.

Regional Resource Management Subcommittee: This committee receives reports on a monthly basis from multiple services and care venues who report in at least annually.

Overuse/Over-utilization Measures:

-
- Use of Imaging Studies for Low Back Pain
- Pharmacy Utilization report
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- IMAGAC Radiology Report for other imaging modalities
- Appropriate use of Antibiotics for Children with Upper Respiratory Infection

Underuse/Under-utilization Measures:

- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
- Alcohol and Drug Treatment (Initiation and Engagement)
- Follow-up care after Psychiatric Hospitalization (7 and 30 days)
- Metabolic Monitoring on Children on Antipsychotics

On a quarterly basis, this subcommittee reports to the Regional QOC regarding the information and activities that the committee reviewed in the previous quarter.

Other Committees Supporting Analysis of Over/Under and Appropriate Utilization:

A. Laboratory Services

The KPNC Laboratory Utilization Committee coordinates efforts among Medical Centers to develop and evaluate best practices in the use of laboratory tests. Determination of appropriate testing, patterns of test ordering by facility and practitioners, and other resource management information is collected, analyzed and reported to local and regional TPMG and KFHP leadership to support effective management of resources.

- This committee reports into the regional Resource Management Subcommittee for oversight of appropriate or over/under utilization.

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B. Radiology/Diagnostic Imaging Services

KPNC Radiology/Diagnostic Imaging Utilization Committee coordinates efforts among Medical Centers to develop and evaluate best practices in the use of diagnostic imaging procedures and exams. Determination of appropriate testing, patterns of test ordering by facility and practitioners, and other resource management information is collected, analyzed and reported to local and regional TPMG and KFHP leadership to support effective management of resources.

- This committee reports into the regional Resource Management Subcommittee for oversight of appropriate or over/under utilization.

C. Regional Pharmacy and Therapeutics Committee:

KPNC manages pharmacy utilization by way of the Prescription Drug Formulary including the provision of guidelines, and restrictions. The Regional Pharmacy & Therapeutics Committee approves and publishes the guidelines in the KPNC Drug Formulary.

- KPNC drug formulary guidelines and restrictions are used to help promote quality and appropriate prescribing by TPMG physicians.
- The formulary status of all pharmaceuticals, including interim additions, is provided on-line and available on the physician's computer.
- Monitoring activities are conducted by Regional and Medical Center P&T Committees evaluating the utilization and adherence to published guidelines.
- TPMG physicians may prescribe non-formulary drugs without prior authorization. When a physician determines in the course of evaluation and treatment, a non-formulary drug is medically necessary, the physician provides an exception code to enable dispensing.
- The regional P&T committee reports into the regional Resource Management Subcommittee for oversight of appropriate or over/under utilization.

OVERSIGHT OF AT-RISK POPULATIONS

A. End Stage Renal Disease (ESRD) Program

A Regional Renal Oversight Committee (RROC) monitors and evaluates the quality and appropriateness of care for patients diagnosed with kidney disease. The RROC is responsible for providing direction and oversight regarding the provision of renal services by contracted providers and internal End-stage Renal Disease (ESRD) services to include acute hemodialysis, peritoneal dialysis, vascular access services and post-transplant services.

The RROC identifies and pursues opportunities to improve care, and resolves identified problems in care and service. The Regional ESRD program develops, coordinates and manages the Administrative, Operational, Contractual and Clinical Quality Oversight activities of the Northern California ESRD member population. The Medical Director ESRD Contracted Services coordinates with the NCAL Vice President, Continuing Care Operations to ensure members receive appropriate care at non-KP facilities rendering care to KP members.

B. Medical Director of Medicare Advantage

The Medical Director of Medicare Advantage and Part D pharmacy plans is responsible to:

- Ensure clinical accuracy of coverage determinations involving medical necessity, for Medicare members.
- Provide oversight for Health Plan operations involving medical/utilization review for Medicare members.
- Provide oversight for Health Plan's benefit, formulary and claims management activities affecting Medicare members.
- Provide oversight for Health Plan's quality assurance activities affecting Medicare members.

TPMG Medical Directors active in these areas are accountable to the Medical Director of Medicare Advantage and Part D pharmacy plans for this work.

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Medical Director for Medicare Advantage, Cost and Prescription Drug Plans Escalation Process Issues of particular concern regarding Medicare beneficiaries are elevated to the Medical Director for Medicare Advantage, Cost and Part D Plans. The affected parties will engage the Medical Director in written or telephonic communication as expeditiously as required to resolve the issue or mitigate risk to KP Medicare beneficiary or to KP.

Issues for concern that may be suitable for escalation include, but are not limited to:

- Awareness of a situation or event that has potential for KFHP, Inc. operation-wide concern, e.g., one that may impact all Medicare Advantage Plans, Cost Plans, and Prescription Drug Plans.
- UM or quality related occurrence or event which has the potential to put the organization or member at risk.
- Opportunity to request consultative advice or opinion from Medical Director, such as review of a challenging case.
- Notification by Member Services to the Medical Director of a decision on appeal from an Administrative Law Judge (ALJ) or Medicare Appeals Council (MAC).

The details of the issue and outcome will be reflected in the appropriate Committee minutes.

C. Medi-Cal Specialized Services

KPNC provides services to Medi-Cal members through a direct contract with the State Department of Health Care Services (DHCS) and the Medical Director for Medi-Cal (Medicaid) State Programs. In order to comply with the contractual requirements associated with managing the special needs of this population, additional services/coordination may be provided both within KFHP and Out-of-Plan to ensure that the members receive the services required.

Linkage and/or monitoring of services may include, but are not limited to:

- 120-Day Initial Health Assessment
- Alcohol and Substance Abuse
- California Children's Service (CCS)
- Child Health Disability Prevention Program Activity (CHDP)
- Comprehensive Perinatal Service Program Activity (CPSP)
- Early Periodic Screening, Diagnostic and Treatment Program & Supplemental Services (EPSDT)
- Family Planning
- Hospice
- Mental Health
- Genetic Screening
- Sensitive Services/Minors
- Minor Consent
- Sterilization
- Tuberculosis (TB/DOT) Direct Observed Therapy
- Transplant Services
- Seniors and Persons with Disability (SPD) Waiver

DISCLOSURE OF THE UM PROGRAM

It is the responsibility of KPNC to ensure Plan compliance with statutory UM Program disclosure requirements in accordance with Section 1363.5(a) of the Knox-Keene Act. The disclosure to regulators and to network providers and affiliated providers references the process used to authorize, modify, or deny health care services under the benefits provided by the plan. In addition, KPNC includes on its Public Website, a detailed summary describing the process by which the plan reviews and authorizes or approves, modifies, or denies requests for health care services and an up-to-date listing of services that require prior authorization.⁶ Enrollees and members of the public may

⁶ Section 1368.016(a)(3)

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receive a copy of the UM Policies and Procedures upon verbal or written requests to the Member Services Call Center.

DEVELOPMENT OF UM CRITERIA FOR UM DECISIONS

The UM criteria used by KPNC UM/RM Program to conduct utilization review to determine whether to authorize, modify, or deny health care services are developed in accordance with Section 1363.5 and the Statewide P&P Health Plan Review of Utilization Management Process that includes Attachment 1: NCAL Workflow Process for UM Criteria.

- (1) Developed with involvement from actively practicing health care providers.
- (2) Consistent with sound clinical principles and processes.
- (3) Evaluated, and updated if necessary, at least annually.
- (4) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee in that specified case.
- (5) Be available to the public upon request.

UM criteria for a specific procedure or condition are available to providers and members at no cost , accompanied by the following notice:

"The materials provided to you are UM criteria 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."⁷

KPNC physicians and non-physician reviewers rely on medical necessity UM criteria used in the prospective, concurrent and retrospective review of health care services in conjunction with clinical judgment and case specific considerations. UM criteria are reviewed and approved annually by the RMC and presented to the QOC for approval by the NCAL HPPA. The UM Program revises and develops new UM criteria in accordance with Section 1363.5 via the Statewide UM Workflow Process for UM Criteria in the Health Plan Review of Utilization Management Process P&P.

The established Workflow Process ensures criteria development and review by the appropriate TPMG clinical body or clinical workgroup, comprised of representatives from relevant clinical specialties.

Qualified physicians are appropriately and extensively involved in the annual review and update process prior to approval by the RMC and QOC. All KPNC physicians and Affiliated Providers that provide services to KFHP members are provided on-line access to KPNC approved UM criteria.

RESOURCE MANAGEMENT: CLINICAL PRACTICE GUIDELINES

"Clinical Practice Guidelines" ("CPG") are developed to assist clinicians in evaluating and treating common medical and mental health problems encountered by patients. CPGs are developed by recognized expert clinicians in a particular field and use evidence-based methodology and the latest scientific literature to support the delivery of quality health care. Guidelines are updated every two years by the Guideline Development and Guideline Management Teams, and they are distributed electronically to KPNC physicians, physician assistants, nurse practitioners, and other health care professionals.

New guidelines are selected based on established criteria, which include number of patients affected by a condition, quality of care concerns, and clinical practice variation. CPGs are offered to clinicians as an aid to their clinical decision-making. Clinicians are not obligated to follow the CPG for a member's clinical circumstances may vary. However, CPGs provide a framework for evaluating and treating the patient in a manner consistent with the best quality outcome. The CPG is regarded as a significant reference tool for providers to achieve that desired end.

⁷ Section 1363.5(c)

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The use of a CPGs differs from utilization review. UM occurs when a qualified UM physician other than the treating clinician reviews the treating clinician's request against utilization review criteria and makes a determination to approve, deny, delay or modify the clinician's request based on medical necessity. UM criteria are consistent with professional standards of practice and developed according to whether a particular service requires prior authorization, concurrent review or retrospective review.

INTER-RATER RELIABILITY (IRR) TESTING PROCESS

Annually, KPNC evaluates the consistency upon which health care professionals involved in UM review apply the criteria in decision making. Areas of opportunity are analyzed and shared with health plan and medical center leadership for their consideration and implementation. This evaluation applies to all physicians and licensed staff who are involved in making UM decisions. The evaluation utilizes the following method on an annual basis: Regional Peer Groups (with input from physician/subject matter experts) develops case scenarios for review on an annual basis. Each reviewer, based on department, evaluates and completes the case scenarios. The scenarios for IRR are based on criteria our organization has adopted for decision making corrective action is taken to address sub-threshold scores. Findings are reported to the RMC.

UM DECISION TIMEFRAMES

Decisions to approve, modify, delay or deny a requested health care service based on medical necessity, are made in a timely fashion appropriate for the nature of the member's condition, not to exceed five (5) business days from the Plan's receipt of the information reasonably necessary and requested by the Plan to make a determination.

In the case of a retrospective review (post-service decisions), the decision is communicated to the individual who received services, or to the individual's designee, within 30 calendar days of the receipt of information that is reasonably necessary to make this determination and communicated to the provider in a manner that is consistent with current California law.

Decisions to approve, modify, delay or deny requests by providers for the provision of health care services to non-Medicare members must be completed within 5 business days after the date the health plan receives the request. The written communication to providers and members is done within two business days, and notification to the requesting provider(s) within 24 hours of the decision.

Decisions to approve, modify, delay or deny requests by providers for authorization of health care services on Medicare cases must be completed, along with notice to providers and members, no later than fourteen (14) calendar days after the date the health plan receives the request.

When the member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, decisions to approve, modify or deny requests by providers 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. For Medicare cases, if a provider believes that waiting for a standard determination could place the member's life, health, or ability to regain maximum function in serious jeopardy, the provider may request an expedited decision. The decision must be rendered no later than 72 hours after the designated health plan department receives the request.

MEMBER AND PRACTITIONER COMMUNICATION

Written Notice of Denial, Modification or Delay of Requested Health Care Services

When a physician requests a health care service on the member's behalf and the request has been reviewed, approved, modified or delayed as a result of UM review, the member and provider are provided a written communication that

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includes the following required elements:

- A clear and concise explanation of the reasons for the Plan's decision
- A description of the UM criteria used, and the clinical reasons for the decision regarding medical necessity.⁸
- Information as to how the member may file a grievance with the Plan and in case of Medi-Cal members, explain 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 includes the name and telephone number of the health care professional responsible for the decision. The telephone number is a direct number or an extension to allow the physician or health care provider easy access to the professional responsible for the UM decision. UM/RM staff and physicians are available during normal business hours to assist members and physicians with UM/RM concerns.

Coverage Decision Support Unit

The Coverage Decision and Support Unit (CDSU) is a centralized denial unit reporting to the Regional Health Plan Utilization Management Department. The CDSU was established in 2004 to ensure consistency, accuracy, timeliness and appropriateness of denial letters. CDSU is staffed with registered nurses and non-clinical staff who oversee the production and archiving of denial letters. In addition, CDSU nurses provide telephonic consultation to the APICs for Outside Services/Referrals, DME Physician Champions and other UM decision-makers and support staff regarding benefits interpretations, coverage decisions, and denial notification requirements.

Denial notices are issued in accordance with applicable regulations and accreditation standards set forth by CMS, DMHC, DHCS, DOL, DHS, and NCQA. The KFHP NCAL HPPA, Medical Director for Accreditory, Regulatory, and Utilization Management Compliance, Health Plan Compliance and the Medicare Compliance Department, as part of KFHP, provide direction and oversight of the process of issuing members written notification of non-coverage.

Visiting Member Quality Oversight Statement

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

PROGRAM RESOURCES

Evaluation of New Technology

KPNC maintains a rigorous process for evidenced based health care technology assessment. The Northern California TPMG New Medical Technology Department addresses technology inquiries from TPMG physicians and Health Plan administrators with synthesis of pertinent scientific evidence and TPMG clinical expert opinion on the effectiveness of different treatments and tests.

KPNC also participates in the Inter-regional New Technologies Committee for timely and objective evaluations of new technologies and application of existing technologies, including medical and behavioral health procedures to help practitioners program-wide make informed health care decisions.

⁸ Section 1367.01(h)(4)

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TPMG clinical chief groups collaboratively decide which new technologies to integrate into their practice. A Behavioral Health practitioner is a liaison to the New Technology Committee. In that role, the Behavioral Health (BH) representative receives communications from and provides expert input on new technologies and how they relate to behavioral health. This representative provides linkage with the Chiefs of Psychiatry. As necessary, the KPNC Benefits, Contracts and Policies Committee review decisions to identify any impact on Health Plan benefits.

Benefits Management

The following are used to assist KPNC in making consistent coverage decisions:

- Evidence of Coverage
- Benefits coverage experts in Health Plan Compliance Department and Member Services
- Consultation with the Legal Department, as appropriate, for guidance and assistance with the interpretation and implementation of State and Federal benefit coverage mandates, (e.g., reconstructive surgery, mental health parity).
- Computer systems include references related to KPNC benefit coverage, Federal, State, Covered California and Medicare requirements.

MEMBER AND PRACTITIONER SATISFACTION

Satisfaction surveys for both member and practitioner are routinely administered, reported and discussed within quality and utilization committees. Survey results are reviewed to identify patterns, trends, success of interventions, opportunities for performance and UM process improvements.

Member Satisfaction

Member satisfaction survey results are evaluated on a regional basis and distributed to service leaders at every level in the organization to inform local activities.

KPNC utilizes several survey tools to measure member satisfaction with UM/RM; quarterly and annually:

- Inpatient: HCAHPS + National Research Corporation questions
- Continuity of Care Surveys for:
 - Home Health CAHPS
 - Hospice CAHPS
 - Behavioral Health
- Outpatient and Ambulatory Surgery CAHPS
- Outpatient: Member Patient Satisfaction Survey (MPS) - includes Behavioral Health
- Consumer Assessment of Health Plans Survey (CAHPS)
- Member Experience Tracking Evaluation and Opinion Research (METEOR)
- Member complaints, grievances, and appeals data are reviewed within Quality and UM/RM Programs to improve services to members. In addition, appeals data are reviewed at the RMC to enhance the evaluation of member satisfaction and identify opportunities to improve understanding of member needs and expectations related to UM/RM activities.

Practitioner Satisfaction

The Physician Satisfaction Survey combines both quality (continuity of care) and UM/RM process measures. The survey is conducted annually with results reported at the local level and through RMC to the QOC. When local and regional evaluation of survey results identifies opportunities to improve physician satisfaction, activities to address the opportunities are included in UM/RM Program work plans. Physician satisfaction results are available to practitioners and providers at the Medical Centers and the Affiliated Provider Network through quality and utilization departments, committee meetings, websites, emails, and letters.

POLICIES

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Completion of Covered Services

KPNC, at the request of a member, will provide coverage to complete a course of treatment from a terminated provider or a nonparticipating provider in accordance with Section 1373.96 of the Knox – Keene Act, other applicable state law, as well as All Plan Letters (APLs) issued by DHCS. The completion of covered services is provided by a terminated provider who at the time of the contract's termination was treating the member, or by a nonparticipating provider treating a newly covered member for any of the following:

- Acute Condition
- Serious 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

The plan may require a non-participating provider whose services are continued for a newly covered enrollee to agree in writing to the same contractual terms and conditions that are imposed upon currently contracting providers.⁹

The UM and other departments such as Social Services and Member Services assist members in obtaining other care when KFHP coverage ends. The information provided to the member and/or representative supports the individual's ability to make an informed decision about care and coverage options. The Completion of Covered Services Policy and Procedure guides the process to ensure continuity of care in the event a member's coverage ends, however, the member requires continued care.

Transition of Care

Transition of Care may be needed when:

- Continued care is needed, e.g., continuation of care through the post-partum period for pregnant members in their second or third trimester and continued access to a provider for up to 90 days through an active treatment period for chronic and acute medical condition in commercial members,
- a member has been receiving care from a plan provider who has subsequently been terminated,
- the member's benefits have been exhausted, or have ended
- Medi-Cal members who have been mandatorily transitioned from Medi-Cal fee for service into Kaiser Permanente's managed Medi-Cal plan

Provisions offered for transitional care may include:

- Providing information about government programs including Covered California, community-based organizations and clinics, and MLTSS
- Providing information on conversion from group policies to individual coverage or private payment
- Referral to Social Services or Patient Business Services to explore options or arrange community-based care, as appropriate, to assist with the member's social and financial circumstances.
- Identifying level of care and local service delivery options

Member Appeals of a UM Decision and Independent Medical Review (IMR)

If a member, a member's authorized representative, or a provider on the member's behalf disagrees with a UM decision, the member/provider may appeal the denial through the Health Plan's Joint Regional Appeals Committee (JRAC). Practitioners may also request a discussion with the UM physician reviewer regarding the denial determinations based on medical appropriateness on behalf of their patients. Physicians are informed about this process at least annually, as well as with each specific denial notice.

Advisors to the JRAC include counsel from the KFHP and TPMG Legal Department and TPMG Medical-Legal

⁹ Section 1373.96(e)(1)

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Department, HPPA, TPMG physicians competent to evaluate the specific clinical issues presented in the request for review, appropriate staff from Health Plan Compliance the Health Plan (KFH/KFHP) and TPMG. The JRAC is chaired by the Director of Regional Member Case Resolution Center and is staffed by Regional Member Services Senior Case Managers/Consultants. Appeals are reviewed and resolved in accordance with applicable statutory and regulatory timeframes and notice requirements, including DMHC contact and IMR information.

Expedited Appeals

All members have the right to request an expedited (72-hour) appeal to evaluate a denial, modification or delay of provider requested health care services and supplies or a health plan decision to terminate health care services. An expedited (72-hour) appeal process is conducted if a member's life, health, or ability to regain maximum function could be jeopardized using the standard review process. Member Services manages the expedited UM appeals and the decisions are made by physicians at the Expedited Review Rounds Committee.

Independent Medical Review (IMR)

Effective 2001, pursuant to Section 1374.30 of the Knox-Keene Act, all Commercial, Covered California and Medi-Cal members have access to Independent Medical Review (IMR), to resolve a "disputed health care service."¹⁰ A "disputed health care service" means any health care service eligible for coverage and payment under a health care service plan contract that has been denied, modified, or delayed by a decision of the plan, or by one of its contracting providers, in whole or in part due to a finding that the service is not medically necessary. Upon completion of the either the grievance¹¹ or appeals process, resolution letters contain the IMR application and an addressed envelope to the DMHC to facilitate member requests for IMR.

Commercial, Covered California and Medi-Cal members may request IMR for cases involving medical necessity, experimental/investigational treatment, or non-plan emergency room service denials. The DMHC administers the IMR program in California and the IMR decision is binding upon the health plan.

Medicare member grievances are processed according to the requirements established by the Center for Medicare & Medicaid Services (CMS) which includes submission to MAXIMUS Federal Services, Inc. for independent review.

UM review for out-of-plan requests for experimental or investigational treatment

Refer to RM-UM P&P 17.0 UM Denial of Practitioner Requested Services to the Wiki Site Link: [RM/UM Policies & Procedures](#)

Use of Board Certified Consultants/ Experts to assist in making Medical Necessity Determinations

Refer to RM-UM P&P 9.0 Appropriate Professionals: Use of Board Certified Physicians to the Wiki Site Link: [RM/UM Policies & Procedures](#)

DELEGATION OVERSIGHT

KFHP has the discretion to delegate and responsibility to oversee UM/RM functions performed by either TPMG or KFH in support of KFHP's UM/RM goals and objectives. KFHP, through the Quality Assurance Program Agreement (QAPA) delineates the respective roles, responsibilities and oversight among KFHP, TPMG, and KFH that support the KPNC UM/RM Program.

Delegation of UM/RM to Contracted Affiliated Providers

When UM/RM activities are delegated to contracted affiliated providers, KFHP through the RMC retains responsibility and oversight of the delegated functions. The delegation is subject to an executed delegation agreement

¹⁰ Section 1374.30(b)

¹¹ Section 1368

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in which UM/RM activities are clearly defined, including:

- Reporting requirements for the delegated entity;
- Reporting requirements for KPNC to the delegated entity;
- Evaluation process of the delegated entity's responsibilities;
- Approval of the delegated entity's UM/RM program and processes;
- Mechanisms for evaluating the delegated entity's program reports, and
- KPNC revocation and termination rights.

For new delegated entities, KPNC performs a pre-delegation assessment to ensure the ability of the delegated entity to perform the UM/RM functions. Based on the pre-delegation assessment and demonstrated ability to perform certain UM/RM functions, the RMC approves and recommends delegation of UM/RM activities.

The final decision to delegate UM/RM activities and to approve the delegated entity's UM/RM Program is made by the QOC. The final letter of agreement that includes the delegation matrix and the delegation agreement will stipulate specific UM/RM functions as delegated or retained by Kaiser Permanente. Based on a careful evaluation, KP delegates certain UM/RM functions to American Specialty Health Plans (ASHP) for chiropractic care and acupuncture services. KP delegates to MedImpact and OptumRx for certain pharmaceutical management responsibilities for Commercial and Covered California Kaiser members using external pharmacies.

Delta Dental Delegation Agreement

Kaiser entered into a contract with Delta Dental to provide Pediatric dental care required as part of essential health care benefits under the Affordable Care Act. UM is delegated to Delta Dental for all dental and specialty dental care including Medicare members.

On an annual basis, KPNC performs a comprehensive assessment of the delegated activities including an audit (if not NCQA certified) of the delegated entity. This audit includes an evaluation of the UM/RM Program, policies and procedures, and evaluation of denial and approval file compliance. In addition, KPNC performs an ongoing evaluation of semi-annual reports submitted by the delegated entity, an ongoing evaluation of denial files, and approval of the delegated entity's policies and procedures, and other ongoing monitoring, as needed. The results of the annual evaluation and assessment summaries of semi-annual activities are presented to the RMC/designee for review and approval. Resource Management will provide ASHP and other delegates with member experience and clinical performance data during the annual evaluation process or upon request.

Should there be any concerns regarding failure of a delegated entity to carry out delegated activities, the RMC and QOC will determine corrective action plans up to and including revocation of the delegated activities. All submitted corrective action plans are evaluated and followed until KPNC assures full correction action implementation.

CONFIDENTIALITY

Health Insurance Portability and Accountability Act (HIPAA)

KPNC strives to comply with all applicable HIPAA requirements and maintains policies relating to HIPAA compliance. All HIPAA related policies are accessible to all employees for review on the KPNC Intranet compliance site. Ongoing mandatory educational training are 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.

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PROGRAM EVALUATION

UM/RM Program documents include the Program Description, Annual Work Plan, and Annual Program Evaluation. The evaluation must address the adequacy of resources, committee structure, practitioner participation and leadership involvement in the UM program and determines whether to restructure or change the UM program for the subsequent year based on its finding. The UM/RM Program documents, policies and procedures are reviewed by the RMC annually and revised as needed. (Refer to the UM Annual Program Evaluation document.)



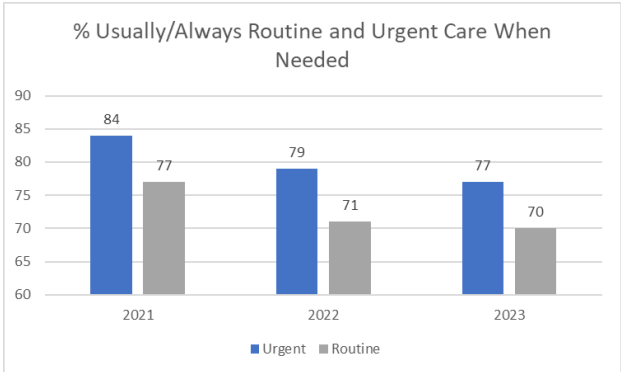
**Kaiser Foundation Health Plan, Inc.
Northern California Region**

2023 Quality Program Evaluation

Quality Oversight Committee Approval Date: April 16, 2024

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Accessibility of Services (NET 2)			
Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
Primary & Specialty Care Access			
Access to Routine and Urgent Care <u>Routine & Regular Appointments</u> CAHPS Goal: 77% of members will report either usually or always (u/a) getting a routine appointment when needed	- Monitor CAHPS results and report findings to the Member Concerns Committee (MCC) - Monitor and report access to appointment complaint findings to the MCC. - Obtain action plans from facilities not meeting regional goal through local evaluations and work plans.	TPMG AED Annual: October 2023	 Results: KPNC member satisfaction scores related to routine and urgent access to care decreased in 2022 and did not meet the established target. Additionally, member satisfaction with routine access decreased by one percentage point in 2023. Satisfaction with urgent access decreased by two percentage points in 2023. Analysis: Appointment access data is monitored on an ongoing basis by the Access Committee and KPNC has maintained access to routine and urgent appointments, as measured by percent initiated to seen and average days wait, in primary care. While the decline compared to 2022 was not significant, the declines for access measures were steeper compared to pre-pandemic (2019). Barriers: The recovery from the pandemic is still impacting members' perception of their ability to get

Accessibility of Services (NET 2)			
Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
			care and results should be considered in that context. This may be still impacting preferences in appointment timing and modality. Next Steps: Continue to monitor CAHPS/METEOR survey results and report findings to the MCC. Continue to monitor and report access to appointment complaint findings to the MCC. Continue focus on improving access to primary care.
Access to Urgent Care <u>Urgent Care Appointments</u> CAHPS Goal: 84.29% of members will report either usually or always (u/a) getting urgent care as soon as needed	- Monitor CAHPS results and report findings to the Member Concerns Committee (MCC) - Monitor and report access to appointment complaint findings to the MCC. - Obtain action plans from facilities not meeting regional goal through local evaluations and work plans.	TPMG AED Annual: October 2023	See Above for urgent care analysis.
Access to After-Hours Care <u>After Hours Call Center (AACC)</u> <u>Annual Report</u> - Average Speed of Answer (ASA) is within 60 seconds - Less than 3% of calls will be abandoned	- Monitor and report after- hours access to care complaint findings to the MCC. - Monitor and report after-hours access metrics, and report to AOC. - Obtain action plans from facilities not meeting regional goal through local evaluations and work plans.	TPMG AED Annual: October 2023	*Refer to 2023 AACC Report Section*
BH Telephone Access <u>Psychiatry After Hours Call Center (PACC) Telephone Service Report</u> 85% or more of calls will be answered within 30 seconds	- Monitor PACC telephone service and report to IUS and BHQOC. - Within existing space constraints, actively recruit PACC staff to meet increasing call volume demands.	Regional Director of Inpatient Psychiatry and Continuing Care Quarterly:	2023 Psychiatric After Hours Call Center Telephone Access

Accessibility of Services (NET 2)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps																														
Less than 5% of calls will be abandoned	Provide PACC call abandonment trends to Chiefs of Psychiatry.	Jan 2023 April 2023 July 2023 October 2023	<table><tr><th colspan="5">Calls Answered within 30 seconds</th></tr><tr><th></th><th>Q1 2023</th><th>Q2 2023</th><th>Q3 2023</th><th>Q4 2023</th></tr><tr><td>Target 85%</td><td>87.7%</td><td>90.1%</td><td>92.0%</td><td>94.2%</td></tr></table> <table><tr><th colspan="5">Abandonment Rate</th></tr><tr><th></th><th>Q1 2023</th><th>Q2 2023</th><th>Q3 2023</th><th>Q4 2023</th></tr><tr><td>Target <5%</td><td>3.9%</td><td>3.1%</td><td>2.9%</td><td>2.5%</td></tr></table> Results: The PACC met both targets in all quarters. Barriers: None Next Steps: Continue to monitor performance and identify opportunities to improve.	Calls Answered within 30 seconds						Q1 2023	Q2 2023	Q3 2023	Q4 2023	Target 85%	87.7%	90.1%	92.0%	94.2%	Abandonment Rate						Q1 2023	Q2 2023	Q3 2023	Q4 2023	Target <5%	3.9%	3.1%	2.9%	2.5%
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Access to Care for Life-Threatening and Non-Life-Threatening Emergencies <u>Psychiatry After Hours Call Center (PACC) ED Referral and Emergent BH Drop In Clinic Audit Reports</u> <u>Goal:</u> - Behavioral health access to care for non-life-threatening emergencies is within 6 hours - PAAC is appropriately referring members to the closest ED for life threatening and non-life-threatening emergency situations	Monitor access to BH clinicians for life threatening and non-life-threatening emergencies	Chair, Chiefs of Psychiatry Annual: October 2023	<table><tr><th></th><th>2022</th><th>2023</th></tr><tr><td># Referred & Seen in KPHC ED</td><td>284</td><td>218</td></tr><tr><td>% Seen in <6 hours from PACC all</td><td>97%</td><td>97%</td></tr><tr><td>% Seen within 6 hours of ED arrival</td><td>100%</td><td>100%</td></tr></table> Results: A total of 271 calls received at the Psychiatric After-Hours Call Center (PACC) from 7/1/2022 to 6/30/2023 were referred to the emergency department. Of the 271, 218 members showed up at a KPNC emergency department. Of these 218		2022	2023	# Referred & Seen in KPHC ED	284	218	% Seen in <6 hours from PACC all	97%	97%	% Seen within 6 hours of ED arrival	100%	100%																		
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Accessibility of Services (NET 2)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps																																																									
			members, 97% were seen within 6 hours of their PACC call, and 100% of members were seen by a provider within 6 hours of arriving at the ED. This is consistent with 2022 performance, which is on a steady incline. Barriers: None Next Steps: Continue to monitor.																																																									
Access to Routine and Urgent Care Visits <u>Access standards:</u> - Urgent Mental Health Visits within 48 hours - Nonurgent Mental Health visits within 10 business days - Urgent Chemical Dependency visits within 48 hours - Nonurgent Chemical Dependency visits within 10 business days.	- Monitor quarterly results to determine if distribution to Non-Urgent Physician Services persists after the global public health emergency - As needed, recruit and hire BH clinicians. - Facility specific access action plans to be submitted and monitored by Chair of the Chiefs of Psychiatry when targets not met.	Chair, Chiefs of Psychiatry Quarterly: Jan 2023 April 2023 July 2023 Oct 2023	NCQA MH TAR Report <table><tr><td></td><td>BH Urgent</td><td colspan="2">BH Routine</td></tr><tr><td></td><td>All</td><td>MD</td><td>Non-MD</td></tr><tr><td></td><td>% w/in 48 hrs</td><td>% w/in 10 bus. days</td><td>% w/in 10 bus. days</td></tr><tr><td>Goal</td><td>80%</td><td>80%</td><td>80%</td></tr><tr><td>Q1</td><td>96%</td><td>73%</td><td>96%</td></tr><tr><td>Q2</td><td>98%</td><td>70%</td><td>96%</td></tr><tr><td>Q3</td><td>97%</td><td>71%</td><td>99%</td></tr><tr><td>Q4</td><td>97%</td><td>72%</td><td>99%</td></tr></table> <table><tr><td></td><td colspan="2">BH Urgent</td><td colspan="2">BH Routine</td></tr><tr><td></td><td>MD</td><td>Non-MD</td><td>MD</td><td>Non-MD</td></tr><tr><td></td><td>% w/in 48 hrs</td><td>% w/in 48 hrs</td><td>% w/in 10 bus. days</td><td>% w/in 10 bus. days</td></tr><tr><td>Goal</td><td>80%</td><td>80%</td><td>80%</td><td>80%</td></tr><tr><td>YTD</td><td>97%</td><td>97%</td><td>72%</td><td>97%</td></tr></table> Results: <u>Urgent Services:</u> The access standard was met each quarter of 2023.		BH Urgent	BH Routine			All	MD	Non-MD		% w/in 48 hrs	% w/in 10 bus. days	% w/in 10 bus. days	Goal	80%	80%	80%	Q1	96%	73%	96%	Q2	98%	70%	96%	Q3	97%	71%	99%	Q4	97%	72%	99%		BH Urgent		BH Routine			MD	Non-MD	MD	Non-MD		% w/in 48 hrs	% w/in 48 hrs	% w/in 10 bus. days	% w/in 10 bus. days	Goal	80%	80%	80%	80%	YTD	97%	97%	72%	97%
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Accessibility of Services (NET 2)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps																				
			Non-Urgent Physician Services: The access standard was not met. Non-Urgent Non-Physician Services The access standard was met. Barriers: Access to urgent and routine care performed well in 2023. Facility specific access action plans in place addressing barriers to care that may arise. It is important to note that the NCQA standard for routine access to Psychiatrists (MDs) is higher than the standard of our California state regulator, DMHC (15 days). We also monitor member experience measures to ensure we are addressing the access needs of our members. Next Steps: BHQOC will continue to monitor NCQA access performance and request action plans from facilities that don't meet performance standards.																				
Improve CAHPS Results: Monitor CAHPS results and report to regional and local quality committees and all staff (health plan rating, health care rating, PCP rating, specialist rating)	- Survey results reported to MCC - CAHPS and METEOR results are also presented to other regional and local quality committees.	TPMG AED Annual: October 2023	<table><tr><th colspan="2" rowspan="2">Measure</th><th colspan="2">Score</th><th rowspan="2">2023 National Percent ile*</th></tr><tr><th>Spring 2022 CAHPS</th><th>Spring 2023 CAHPS</th></tr><tr><td rowspan="3">Rating</td><td>Health Plan</td><td>47%</td><td>45%</td><td>50th</td></tr><tr><td>Health Care</td><td>50%</td><td>44%</td><td>10th</td></tr><tr><td>PCP</td><td>62%</td><td>59%</td><td>5th</td></tr></table>	Measure		Score		2023 National Percent ile*	Spring 2022 CAHPS	Spring 2023 CAHPS	Rating	Health Plan	47%	45%	50th	Health Care	50%	44%	10th	PCP	62%	59%	5th
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Accessibility of Services (NET 2)										
Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation							
			1. Analysis of results including metrics 2. Barriers 3. Next steps							
				Specialist	65%	64%	25th	Composite	Rating Scores = % 9 or 10 score Composite Scores = % Usually or Always Analysis: CAHPS scores decreased overall from spring 2022 to spring 2023. Health Plan, Health Care, and PCP rating scores decreased dropped in NCQA percentile ranking. Customer Service scores increased in 2023. Barriers: Member experiences were less than favorable, overall, on survey questions that ask	
				Getting Needed Care	80%	77%	10th			
				Getting Care Quickly	75%	74%	10th			
				MD Communication	91%	89%	<5th			
				Care Coordination	82%	81%	25th			
				Customer Service	84%	85%	25th			
				Claims Processing	N/A	N/A	N/A			

Accessibility of Services (NET 2)			
Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
			members about access, Specialist Ratings, and Health Care ratings. Next Steps: Continue to monitor CAHPS and METEOR survey results and report to regional quality committees.

Appointment and Advice Call Center (AACC)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps																																				
Goal: To ensure that members receive service in a timely manner. Metric: Internal goal for ASA (Average Speed of Answer) for the Regional Tele Service Representatives (TSRs) is less than or equal to 1 minute; Abandonment Levels are less than 3%.	Monitor and report Average Speed of Answer and abandonment levels to improve member satisfaction. Ongoing 30-minute monitoring process for timeliness of service. Adjust staffing levels in response to COVID call surge due to infection and/or vaccine demand Evaluate staffing on a monthly basis to determine new hire plan and adjust accordingly based on attrition levels. Implement technology solutions to mitigate any potential clinical or environmental call volume surges.	AACC Medical Director AACC Operations Director Annual – January to December 2023	Regional TSR Average Speed of Answer by Quarter <table><thead><tr><th>Quarter</th><th>Approximate ASA</th></tr></thead><tbody><tr><td>1st 22</td><td>02:10</td></tr><tr><td>2nd 22</td><td>02:05</td></tr><tr><td>3rd 22</td><td>02:50</td></tr><tr><td>4th 22</td><td>01:40</td></tr><tr><td>1st 23</td><td>01:10</td></tr><tr><td>2nd 23</td><td>00:45</td></tr><tr><td>3rd 23</td><td>00:50</td></tr><tr><td>4th 23</td><td>00:45</td></tr></tbody></table> Regional TSR Abandonment Percentage by Quarter <table><thead><tr><th>Quarter</th><th>Approximate Abandonment %</th></tr></thead><tbody><tr><td>1st 22</td><td>7.5%</td></tr><tr><td>2nd 22</td><td>6.0%</td></tr><tr><td>3rd 22</td><td>8.5%</td></tr><tr><td>4th 22</td><td>5.5%</td></tr><tr><td>1st 23</td><td>3.0%</td></tr><tr><td>2nd 23</td><td>2.0%</td></tr><tr><td>3rd 23</td><td>2.5%</td></tr><tr><td>4th 23</td><td>2.4%</td></tr></tbody></table> 1. Average speed of answer (ASA) and abandonment continued to improve from the peaks of 2021. ASA ended the year at 35 seconds, with an abandonment rate ending at 2.24%, aligning with pre-COVID performance results. 2. No barriers identified. 3. Continue to monitor and report ASA and abandonment levels for 2024.	Quarter	Approximate ASA	1st 22	02:10	2nd 22	02:05	3rd 22	02:50	4th 22	01:40	1st 23	01:10	2nd 23	00:45	3rd 23	00:50	4th 23	00:45	Quarter	Approximate Abandonment %	1st 22	7.5%	2nd 22	6.0%	3rd 22	8.5%	4th 22	5.5%	1st 23	3.0%	2nd 23	2.0%	3rd 23	2.5%	4th 23	2.4%
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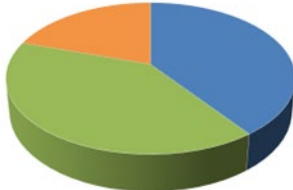
Appointment and Advice Call Center (AACC)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps																																																												
Goal: Ensure patient safety by focused review of Advice Registered Nurse (ARN) calls using symptomatic and/or high-risk protocols Metric 1: Maintain average clinical quality scores for all three AACC sites above 95% across all questions. Metric 2: Decrease serious clinical errors.	Focused monthly review of Advice Registered Nurses (ARNs) calls Trends and learnings from serious clinical errors will be shared with staff and training to enhance clinical content for new hires.	AACC Medical Director AACC Operations Director Annual – January to December 2023	<table><tr><th>2024 Triage Scores by Question</th><th>1st Qtr</th><th>2nd Qtr</th><th>3rd Qtr</th><th>4th Qtr</th><th>2024 Wtd Ave</th></tr><tr><td>Talked to Patient</td><td>99.4%</td><td>99.4%</td><td>99.5%</td><td>99.4%</td><td>99.5%</td></tr><tr><td>Service Line and Protocol best fit for symptoms</td><td>99.3%</td><td>99.3%</td><td>99.3%</td><td>99.0%</td><td>99.3%</td></tr><tr><td>Pertinent medical history obtained</td><td>99.3%</td><td>99.6%</td><td>99.3%</td><td>99.4%</td><td>99.4%</td></tr><tr><td>Nursing Assessment</td><td>98.7%</td><td>98.5%</td><td>98.9%</td><td>98.4%</td><td>98.7%</td></tr><tr><td>MySEAR</td><td>98.9%</td><td>98.4%</td><td>99.0%</td><td>98.6%</td><td>98.8%</td></tr><tr><td>Critical Thinking & Outcome</td><td>97.8%</td><td>97.9%</td><td>98.4%</td><td>97.9%</td><td>98.1%</td></tr><tr><td>Clinical Advice/Clinical information given</td><td>96.8%</td><td>97.6%</td><td>96.8%</td><td>97.0%</td><td>97.1%</td></tr><tr><td>Care documented appropriately</td><td>99.1%</td><td>99.1%</td><td>99.3%</td><td>99.2%</td><td>99.2%</td></tr><tr><td>Clinical follow up instructions given</td><td>98.4%</td><td>98.5%</td><td>98.6%</td><td>98.4%</td><td>98.5%</td></tr></table> 1. Review of RN calls in 2023 indicated clinical quality scores continuing to average greater than 95% in all three sites. 2. No barriers identified. 3. Continue to monitor, continue 2023 target to maintain average clinical quality scores greater than 95%. Metric 2:	2024 Triage Scores by Question	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	2024 Wtd Ave	Talked to Patient	99.4%	99.4%	99.5%	99.4%	99.5%	Service Line and Protocol best fit for symptoms	99.3%	99.3%	99.3%	99.0%	99.3%	Pertinent medical history obtained	99.3%	99.6%	99.3%	99.4%	99.4%	Nursing Assessment	98.7%	98.5%	98.9%	98.4%	98.7%	MySEAR	98.9%	98.4%	99.0%	98.6%	98.8%	Critical Thinking & Outcome	97.8%	97.9%	98.4%	97.9%	98.1%	Clinical Advice/Clinical information given	96.8%	97.6%	96.8%	97.0%	97.1%	Care documented appropriately	99.1%	99.1%	99.3%	99.2%	99.2%	Clinical follow up instructions given	98.4%	98.5%	98.6%	98.4%	98.5%
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Appointment and Advice Call Center (AACC)

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			1. New hire RNs (0–1-year tenure) accounted for nearly a third of serious clinical errors identified in 2023. Strategies to decrease serious clinical errors included a continued partnership with the Training Department in creation of computer-based trainings (CBTs), a robust remediation process to address individual RN clinical learning opportunities, and heightened monitoring of new hire RNs. 2. RN call volume was >300,000 calls higher than previous year, with nearly 200 new hire RNs added to staffing. 3. Continue Training partnership and monitoring of new hire RNs, and the creation of CBTs addressing the most common reasons for serious clinical errors. Continue to monitor.																																																
Goal: If Sentinel Events occur, review, and analyze each event for trends and learning. Metric 1: Achieve Sentinel Event error rates less than 3 clinical errors/1,000,000 calls	Monthly review of potential sentinel events by AACC Regional Quality Committee	AACC Medical Director AACC Operations Director	Metric 1:																																																

Appointment and Advice Call Center (AACC)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps																																						
Metric 2: Trends and learnings from Sentinel Events will be shared with staff.	Analysis of events to identify trends related to educational needs for AACC staff	Annual – January to December 2023	<table><tr><th>2023 AACC</th><th>1st Qtr</th><th>2nd Qtr</th><th>3rd Qtr</th><th>4th Qtr</th><th>2023 Total</th></tr><tr><td>Sentinel Events</td><td>5</td><td>0</td><td>0</td><td>0</td><td>5</td></tr><tr><td># Calls Handled</td><td>4,081,426</td><td>4,122,627</td><td>4,094,933</td><td>3,973,499</td><td>16,272,485</td></tr><tr><td>SE Errors per mil calls</td><td>1.23</td><td>0.00</td><td>0.00</td><td>0.00</td><td>0.31</td></tr></table> - In 2023 the AACC had 0.31 Sentinel Event errors per Million calls, achieving the goal of less than 3 clinical errors/1,000,000 calls. - No barriers identified. - Continue to monitor and address identified trends (see Metric 2). Metric 2: 2023 AACC Sentinel Event Root Cause <table><thead><tr><th>Root Cause</th><th>Count</th></tr></thead><tbody><tr><td>Consult CCMD Needed</td><td>1</td></tr><tr><td>SBAR Inaccurate/Incomplete</td><td>1</td></tr><tr><td>Incomplete Assessment & SBAR</td><td>1</td></tr><tr><td>Incomplete Assessment</td><td>1</td></tr><tr><td>Protocol Selection Incorrect</td><td>0</td></tr><tr><td>Emerg TS WF not followed</td><td>1</td></tr></tbody></table> - Analysis of sentinel events identified trends related to assessment, CCMD consult needed and inaccurate/incomplete SBAR in emergent	2023 AACC	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	2023 Total	Sentinel Events	5	0	0	0	5	# Calls Handled	4,081,426	4,122,627	4,094,933	3,973,499	16,272,485	SE Errors per mil calls	1.23	0.00	0.00	0.00	0.31	Root Cause	Count	Consult CCMD Needed	1	SBAR Inaccurate/Incomplete	1	Incomplete Assessment & SBAR	1	Incomplete Assessment	1	Protocol Selection Incorrect	0	Emerg TS WF not followed	1
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Appointment and Advice Call Center (AACC)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
			calls, protocol selection errors, and warm transfer to RN needed. 2. No barriers were identified. 3. Continue the development and distribution of Computer Based Training Modules as indicated by the identified trends. Continue to monitor.

Assessment of Network Adequacy (NET 3)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps

Non-Behavioral Health Network Adequacy

To assess network adequacy using access and availability data; and complaint, appeal, and member experience data in order to prioritize access opportunities for KPNC (NET 1, NET 2).	• Conduct an assessment of network adequacy using member complaint and appeal data, and member experience surveys. • Identify opportunities to improve member experience with BH and non-BH network adequacy. • Implement at least one opportunity and measure effectiveness	TPMG Consulting Services Annual: December 2023		Q3'22 – Q2'23		Target
				Access Complaint Volume	Per 10K Rate	Per 10k
			Commercial	7,105	22.56	18.29
			Covered CA	771	21.92	17.99
			Medicare	5,287	79.00	58.48
			Medi-Cal	882	21.54	17.62
			Total	14,045	145.03	112.37
			Analysis/Barriers:			
			<u>Commercial/QHP Exchange</u>			
			The commercial and QHP exchange network opportunities for improvement are being combined for this analysis.			
Opportunity: The ability to schedule timely appointments was identified by members as an opportunity for improvement through complaint issues, appeal requests, and member experience surveys. Specifically, members identified the following areas of focus.						
• <u>Provider Groups:</u> Internal Medicine and OBYN have the highest level of complaints, but also represent the highest utilized services; Specialty Care Services – Ophthalmology and Radiology • <u>Service Areas:</u> Roseville and Walnut Creek						

Assessment of Network Adequacy (NET 3)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
			Medicare Opportunity: The ability to schedule timely appointments was identified by members as an opportunity for improvement through complaint issues, appeal requests, and member experience surveys. Specifically, members identified the following areas of focus. <u>Provider Groups:</u> Internal Medicine and Ophthalmology have the highest level of complaints <u>Service Areas:</u> Roseville and Walnut Creek Next Steps: Continue to Monitor

Behavioral Health Network Adequacy

To assess network adequacy using access and availability data; and complaint, appeal, and member experience data in order to prioritize access opportunities for KPNC (NET 1, NET 2).	- Conduct an assessment of network adequacy using member complaint and appeal data, and member experience surveys. - Identify opportunities to improve member experience with BH and non-BH network adequacy. - Implement at least one opportunity and measure effectiveness	TPMG Consulting Services Annual: December 2023		Q3'21 – Q2'22		Q3'22 – Q2'23	
				BH Access Complaint Volume	Per 10K Rate	BH Access Complaint Volume	Per 10K Rate
			Commercial	1,894	5.99	1,798	5.71
			Covered CA	228	6.11	176	5.00
			Medicare	286	4.4	305	4.56
			Medi-Cal	284	7.66	334	8.16

Assessment of Network Adequacy (NET 3)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps																		
			Analysis: - Overall, NCAL received 2,613 behavioral complaints related to network adequacy between Q3’22 and Q2’23 which decreased 3% from the previous period. Between Q3’22 and Q2’23, there were 1,798 Commercial complaints, 176 Marketplace complaints, 305 Medicare complaints, and 334 Medi-Cal complaints. - In addition, there was a total of 23.43 behavioral complaints per 10k members related to network adequacy which comprised 5.71 Commercial complaints per 10k members, 5.00 Marketplace complaints per 10k members, 4.56 Medicare complaints per 10k members, and 8.16 Medi-Cal complaints per 10k members. Barriers: <table><tr><th>LOB</th><th>Top Access to Care Issue Type</th><th>Top Access to Care Issues & Requests</th></tr><tr><td colspan="3">Complaints</td></tr><tr><td>Commercial</td><td>Appointments</td><td>Unable to schedule timely appointment</td></tr><tr><td>Covered CA</td><td>Appointments</td><td>Unable to schedule timely appointment</td></tr><tr><td>Medicare</td><td>Appointments</td><td>Unable to schedule timely appointment</td></tr><tr><td>Medi-Cal</td><td>Appointments</td><td>Unable to schedule timely appointment</td></tr></table> Next Steps/Actions:	LOB	Top Access to Care Issue Type	Top Access to Care Issues & Requests	Complaints			Commercial	Appointments	Unable to schedule timely appointment	Covered CA	Appointments	Unable to schedule timely appointment	Medicare	Appointments	Unable to schedule timely appointment	Medi-Cal	Appointments	Unable to schedule timely appointment
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Assessment of Network Adequacy (NET 3)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
			- Implemented the following programs to increase return access and graduate patients through episodes of care. The goal of these evidence-based care tracks is to get patients to remission faster. - Created regional pop care program (Virtual ADAPT) to treat mild to moderate depression and anxiety patients to remission - Created regional pop care program for SPMI patients, published in NEJM Catalyst (May 2022) and Journal of Clinical Psychiatry (Jan 2024) - Created and spread Depression treatment track at KPNC Medical Centers - Created and spread ADHD treatment track at KPNC Medical Centers - Creating Trauma treatment track to spread across KPNC Medical Centers - Regional rollout of e-visit for anxiety and depression. The program allows members to self-book their new appointment with Mental Health, reducing time spent on triage.

Availability of Practitioners (NET 1, DMHC)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2023) 1. Analysis of results including metrics 2. Barriers 3. Next steps

Primary Care Practitioners

Ensure adequate availability of providers within target ratios and geoaccess standards <u>Geoaccess:</u> 95% of members will be within 15 miles OR 30 minutes of a PCP <u>Ratios:</u> 1 PCP per 2,000 all members (MD head count) 1 PCP per 2,000 adult members (MD head count) 1 PCP per 2,000 pediatric members (MD head count) 1 PCP FTE per 2,000 members 1 pediatric practitioner per 2,000 members 1 family medicine practitioner per 6,000 members 1 internal medicine practitioner per 2,500 Members	- As needed and subject to changes in membership and staff turnover, increase physician staffing by hiring new primary care physicians. - Recruit bilingual PCPs as needed. - Expand and remodel facilities. - Report annual findings to MCC.	Annual: September 2022 TPMG AED of Adult & Family Medicine TPMG AED of Women's Health & Pediatrics	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="4" style="text-align: center;">Primary Care Geoaccess Performance</th> </tr> <tr> <th style="text-align: center;">Standard</th><th style="text-align: center;">Goal</th><th style="text-align: center;">2022 Performance</th><th style="text-align: center;">2023 Performance</th></tr> </thead> <tbody> <tr> <td style="text-align: center;">15 miles to a PCP</td><td style="text-align: center;">95%</td><td style="text-align: center;">99.4%</td><td style="text-align: center;">99.6%</td></tr> <tr> <td style="text-align: center;">30 minutes to a PCP</td><td style="text-align: center;">95%</td><td style="text-align: center;">99.9%</td><td style="text-align: center;">99.9%</td></tr> </tbody> </table> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="4" style="text-align: center;">Primary Care Practitioner Ratio Performance</th> </tr> <tr> <td colspan="4" style="text-align: center;">The PCP/Member ratios include individual headcounts of TPMG MDs and contracted/affiliated MDs. The PCP FTE ratio is based on physician's clinical time spend with patients. Pool MDs are not included.</td> </tr> <tr> <th style="text-align: center;">Standard</th><th style="text-align: center;">Goal</th><th style="text-align: center;">2022 Performance</th><th style="text-align: center;">2023 Performance</th></tr> </thead> <tbody> <tr> <td style="text-align: center;">All PCP: Member</td><td style="text-align: center;">1/2,000</td><td style="text-align: center;">1/1,052</td><td style="text-align: center;">1/1,336</td></tr> <tr> <td style="text-align: center;">Pediatric PCP: Member</td><td style="text-align: center;">1/2,000</td><td style="text-align: center;">1/961</td><td style="text-align: center;">1/1,252</td></tr> <tr> <td style="text-align: center;">Adult PCP: Adult Member</td><td style="text-align: center;">1/2,000</td><td style="text-align: center;">1/1,080</td><td style="text-align: center;">1,359</td></tr> <tr> <td style="text-align: center;">PCP FTE: Member</td><td style="text-align: center;">1/2,000</td><td style="text-align: center;">1/2,286</td><td style="text-align: center;">1/1,973</td></tr> </tbody> </table> Analysis: KPNC met the established targets, regionally. Upon review of Timeliness of Access reporting there were no notable concerns with regional access performance in Primary Care during this time. Will continue to monitor.	Primary Care Geoaccess Performance				Standard	Goal	2022 Performance	2023 Performance	15 miles to a PCP	95%	99.4%	99.6%	30 minutes to a PCP	95%	99.9%	99.9%	Primary Care Practitioner Ratio Performance				The PCP/Member ratios include individual headcounts of TPMG MDs and contracted/affiliated MDs. The PCP FTE ratio is based on physician's clinical time spend with patients. Pool MDs are not included.				Standard	Goal	2022 Performance	2023 Performance	All PCP: Member	1/2,000	1/1,052	1/1,336	Pediatric PCP: Member	1/2,000	1/961	1/1,252	Adult PCP: Adult Member	1/2,000	1/1,080	1,359	PCP FTE: Member	1/2,000	1/2,286	1/1,973
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Availability of Practitioners (NET 1, DMHC)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2023) 1. Analysis of results including metrics 2. Barriers 3. Next steps																
			Barriers: None Next Steps: As needed, continue to increase physician staffing by hiring new primary care physicians. Continue recruitment of bilingual PCPs as needed. Continue to expand and remodel facilities.																
Ensure that all members are linked to a primary care provider PCP Member Linkage: 85% of members will be linked with a PCP.	- Monitor the transition of young adults from pediatrics to adult medicine - Ensure process in place so that members are appropriately linked to a PCP - Monitor PCP Member Linkage reports	Annual: December 2023 TPMG AED of Adult & Family Medicine TPMG AED of Women's Health & Pediatrics	PCP Member Linkage with PCP <table border="1"> <thead> <tr> <th></th><th>Goal</th><th>2022</th><th>2023</th></tr> </thead> <tbody> <tr> <td>Medicine</td><td>85%</td><td>97.8%</td><td>96.6%</td></tr> <tr> <td>OB-GYN</td><td>85%</td><td>94.3%</td><td>99.1%</td></tr> <tr> <td>Pediatric</td><td>85%</td><td>99.4</td><td>92.8%</td></tr> </tbody> </table> Analysis: Targets have been exceeded for this measure in 2023. Barriers: None Next Steps: Continue to ensure that all members are linked to a primary care provider.		Goal	2022	2023	Medicine	85%	97.8%	96.6%	OB-GYN	85%	94.3%	99.1%	Pediatric	85%	99.4	92.8%
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Ensure adequate availability of high volume and high impact SCP providers within target ratios and geoaccess standards High Volume SCPs: Dermatology, General Surgery, Head & Neck	- As needed and subject to membership change and staff turnover, increase physician staffing by hiring new specialty care physicians. - Recruitment of bilingual SCPs. - Expand and remodel facilities.	September 2023 Access Committee																	

Availability of Practitioners (NET 1, DMHC)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2023) 1. Analysis of results including metrics 2. Barriers 3. Next steps																															
Surgery, OBGYN, Ophthalmology, Orthopedics High Impact SCPs: Oncology Geoaccess: 80% of members will be within 30 miles OR 60 minutes of a high-volume SCP High Volume SCP Ratios – 1 Dermatology MD per 40,000 Members 1 General Surgery MD per 35,000 Members 1 Head & Neck MD per 40,000 Members 1 OB/GYN MD per 10,000 Members 1 Ophthalmology MD per 28,000 Members 1 Orthopedic MD per 26,000 Members	Report annual findings to MCC		Results: <table border="1"><tr><th colspan="4">High-Volume Specialty Care Geoaccess Performance</th></tr><tr><th>Standard</th><th>Goal</th><th>2022 Performance</th><th>2023 Performance</th></tr><tr><td>30 Miles to a SCP</td><td>80%</td><td>99.9%</td><td>99.9%</td></tr><tr><td>60 Minutes to a SCP</td><td>80%</td><td>100%</td><td>100%</td></tr></table> Specialty Care Practitioner Ratio Performance High Volume Specialists: The high-volume specialist definition is based on volume of visits by “Functional Cost Center.” The high-volume specialist definition includes the following specialties: Dermatology, General Surgery, Head & Neck, OB/GYN, Ophthalmology and Orthopedics. All KNPC members are included in the analysis. <table border="1"><tr><th>Standard Category</th><th>Standard</th><th>2023 Performance</th></tr><tr><td>Dermatology</td><td>1:40,000</td><td>1:19,439</td></tr><tr><td>General Surgery</td><td>1:35,000</td><td>1:27,146</td></tr><tr><td>Head and Neck</td><td>1:40,000</td><td>1:28,673</td></tr><tr><td>OBGYN</td><td>1:10,000</td><td>1:5,829</td></tr></table>	High-Volume Specialty Care Geoaccess Performance				Standard	Goal	2022 Performance	2023 Performance	30 Miles to a SCP	80%	99.9%	99.9%	60 Minutes to a SCP	80%	100%	100%	Standard Category	Standard	2023 Performance	Dermatology	1:40,000	1:19,439	General Surgery	1:35,000	1:27,146	Head and Neck	1:40,000	1:28,673	OBGYN	1:10,000	1:5,829
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Ensure adequate availability of high volume and high impact SCP providers within target ratios and geoaccess standards - BHP FTE/Member Ratio: 1 BHP per 3,200 members, 1 CD specialist per 40,000 - Types of High-Volume BHP: 1 Psychiatrist per 20,000 members and 1 Psychologist per 20,000 members.	- As needed and subject to membership change and staff turnover, increase BH practitioner staffing. - Report annual findings to MCC and BHQOC.	September 2023 Behavioral Health Quality Oversight Committee	KPNC behavioral health geoaccess and practitioner ratio performance as of 6/30/2023 is included in this analysis. <table><tr><th>Behavioral Health Geoaccess Performance</th></tr><tr><td>Behavioral Health Practitioner (BHP) includes all Mental Health and Chemical Dependency providers in the following categories: psychiatrists, psychologists, nurse practitioners, clinical social workers,</td></tr></table>	Behavioral Health Geoaccess Performance	Behavioral Health Practitioner (BHP) includes all Mental Health and Chemical Dependency providers in the following categories: psychiatrists, psychologists, nurse practitioners, clinical social workers,																
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Availability of Practitioners (NET 1, DMHC)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2023) 1. Analysis of results including metrics 2. Barriers 3. Next steps																																	
Geographic distribution or driving time to BHP: 80% of members will be within 30 miles OR 60 minutes of a BHP.			<table><tr><td colspan="3">marriage/family therapists, and Chemical Dependency Recovery Program counselors.</td></tr><tr><th>Standard</th><th>Performance Target</th><th>2022 Performance</th></tr><tr><td>30 Miles to a BHP</td><td>80%</td><td>100%</td></tr><tr><td>60 Minutes to a BHP</td><td>80%</td><td>100%</td></tr></table> <table><tr><th colspan="3">Behavioral Health Practitioner Ratio Performance</th></tr><tr><td colspan="3">Analysis excludes contracted and affiliated practitioners</td></tr><tr><th>Standard Category</th><th>Standard</th><th>2023 Performance</th></tr><tr><td>All BHP</td><td>1:3,200</td><td>1:2,065</td></tr><tr><td>Psychiatrist</td><td>1:20,000</td><td>1:13,410</td></tr><tr><td>Psychologist</td><td>1:20,000</td><td>1:7,467</td></tr><tr><td>Chemical Dependency</td><td>1:40,000</td><td>1:17,071</td></tr></table> KPNC's 2023 ratios for each type of BHP met the established targets. Barriers: None Next Steps: Continue to increase BH practitioner staffing as needed. Report annual findings to MCC/QOC.	marriage/family therapists, and Chemical Dependency Recovery Program counselors.			Standard	Performance Target	2022 Performance	30 Miles to a BHP	80%	100%	60 Minutes to a BHP	80%	100%	Behavioral Health Practitioner Ratio Performance			Analysis excludes contracted and affiliated practitioners			Standard Category	Standard	2023 Performance	All BHP	1:3,200	1:2,065	Psychiatrist	1:20,000	1:13,410	Psychologist	1:20,000	1:7,467	Chemical Dependency	1:40,000	1:17,071
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Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2023) 1. Analysis of results including metrics 2. Barriers 3. Next steps

Facility Standards

Ensure adequate availability of facilities within target geoaaccess standards Hospital/Emergency Room Geographic Distribution Standard: Geographic distribution or driving time to hospitals/emergency rooms: 100% of members will be within 15 miles OR 30 minutes of a KP or contracted hospital with an emergency department. Other Facility Standards: Geographic distribution or driving time to Skilled Nursing Facilities and Home Health Agencies: 100% of Members will be within 30 minutes of a KP or contracted facility. Psychiatric Inpatient Hospitals and Behavioral Health Residential Facility Standards: 80% of Members will be within 50 miles OR 75 minutes of a KP or contracted facility. Ambulatory Surgical Centers, Mammography/Radiology clinics and other Ambulatory Clinics (including Behavioral Health): 80% of Members will be within 30 miles OR 60 minutes of a KP or contracted facility.	Annual analysis and monitoring of Geoaccess and report findings to MCC.	Annual: September 2023 Access Committee	Results/Analysis: <table><tr><th colspan="3">Other Standards - Geoaccess Performance</th></tr><tr><th>Standard</th><th>Performance Target</th><th>2023 Performance</th></tr><tr><td colspan="3">Hospital/Emergency Room</td></tr><tr><td>15 miles</td><td>100%</td><td>96.4%</td></tr><tr><td>30 minutes</td><td>100%</td><td>99.3%</td></tr><tr><td colspan="3">Skilled Nursing Facility</td></tr><tr><td>30 minutes</td><td>100%</td><td>100%</td></tr><tr><td colspan="3">Home Health Agency</td></tr><tr><td>30 minutes</td><td>100%</td><td>98.9%</td></tr><tr><td colspan="3">Inpatient Psychiatric Facility</td></tr><tr><td>50 miles</td><td>80%</td><td>99.8%</td></tr><tr><td>75 minutes</td><td>80%</td><td>99.7%</td></tr><tr><td colspan="3">Residential Behavioral Health Facility</td></tr><tr><td>50 miles</td><td>80%</td><td>100%</td></tr><tr><td>75 minutes</td><td>80%</td><td>100%</td></tr><tr><td colspan="3">Ambulatory Behavioral Health</td></tr><tr><td>30 miles</td><td>80%</td><td>99.2%</td></tr><tr><td>60 minutes</td><td>80%</td><td>99.9%</td></tr><tr><td colspan="3">Ambulatory Surgery</td></tr><tr><td>30 miles</td><td>80%</td><td>100%</td></tr><tr><td>60 minutes</td><td>80%</td><td>100%</td></tr></table>	Other Standards - Geoaccess Performance			Standard	Performance Target	2023 Performance	Hospital/Emergency Room			15 miles	100%	96.4%	30 minutes	100%	99.3%	Skilled Nursing Facility			30 minutes	100%	100%	Home Health Agency			30 minutes	100%	98.9%	Inpatient Psychiatric Facility			50 miles	80%	99.8%	75 minutes	80%	99.7%	Residential Behavioral Health Facility			50 miles	80%	100%	75 minutes	80%	100%	Ambulatory Behavioral Health			30 miles	80%	99.2%	60 minutes	80%	99.9%	Ambulatory Surgery			30 miles	80%	100%	60 minutes	80%	100%
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Availability of Practitioners (NET 1, DMHC)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2023) 1. Analysis of results including metrics 2. Barriers 3. Next steps																		
			<table><tr><th colspan="3">Mammography/Radiology</th></tr><tr><td>30 miles</td><td>80%</td><td>99.8%</td></tr><tr><td>60 minutes</td><td>80%</td><td>100%</td></tr><tr><th colspan="3">Ambulatory Clinic</th></tr><tr><td>30 miles</td><td>80%</td><td>99.7%</td></tr><tr><td>60 minutes</td><td>80%</td><td>100%</td></tr></table> KPNC met the established targets, regionally, in most reported categories. Barriers: In the Fresno and Central Valley areas, longer distances are considered the typical geographic pattern of travel for members living in those areas. Next Steps: Any complaint regarding travel distance will be resolved at the facility level with support from the KPNC Regional Continuum Administrator, as needed. Continue to monitor and report AAR annually to Access Committee.	Mammography/Radiology			30 miles	80%	99.8%	60 minutes	80%	100%	Ambulatory Clinic			30 miles	80%	99.7%	60 minutes	80%	100%
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Behavioral Health

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Intensive Community Treatment (ICT) Program Enhance the quality of life to or a small population of very high acuity and complex behavioral health members who do not benefit from traditional outpatient treatment by providing targeted treatment and interventions specific to each patient's needs. Metrics: 1. Expand ICT enrollment by 10% to meet demand. 2. Decrease by 5% in psych utilization (IP Psychiatry, ED Visits, Partial hospitalizations) 3. Increase the kept appointments in psychiatry, medication pick up and refills, life ability scales alcohol and drug use, quality of life measurement by 5%	• Monthly review of census and capacity in each service area in joint operations committee • Leverage KP insight dashboard to gain insight into enrollment <12 months. • Provide education to local leaders on utilization of KPHC enrollment and discharge form.	Regional Director of Behavioral Health, TPMG Regional Director of Behavioral Health, KFHP Vice President of Behavioral Health & Specialty Services, KFHP Chair of Chiefs of Psychiatry & Behavioral Medicine, TPMG 12/31/2023	Results for Metrics 1 & 2 ▪ Expanded the ICT enrollment (referral capacity) by 10% ▪ Patient Day Rate decreased from 17k to 9k (46%) ▪ ED admission rate decreased from 1.44 k to 900 (33%) ▪ Psych Inpatient days decreased from 280 to 120(57%) Results for Metrics 3 ▪ Although the percentages for appointments and medication pickup did not experience an increase, the life ability scales for alcohol and drug use have successfully reached the target, showing a 3% improvement. Next Steps: 1. Facilitate the transition of GMC patients to the county

Claims

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
Maintain timeliness at the required compliance targets for each line of business. Medicare: 95% within 30 Calendar Day TAT (Non-Contracted Clean) 99% within 60 Calendar Day TAT (Non-Contracted Unclean) Commercial: DMHC Regulatory Metric 95% within 45 working days Medi-Cal: 95% within 45 working days 99% within 90 calendar days 90% within 30 calendar days	Continue to monitor on a monthly basis and remediate when/if necessary.	National Claims Administration - California Region Annually	<i>2023 Analysis</i> Medicare: 97.00%¹ within 30 Calendar Day TAT (Non-Contracted Clean) 97.60%¹ within 60 Calendar Day TAT (Non-Contracted Unclean) Barriers and Next Steps Unexpected staffing issues resulted in an increased number of aged claims. The Following steps have been taken to ensure that all metrics are met: - New examiners hired, starting on 02/20/2024. - Education and training have been provided to the Medicare Supervisor on timeliness metrics. - Aged inventory has been reduced significantly by implementing a burn down plan and offering overtime. Commercial: DMHC Regulatory Metric 99.90% within 45 working days Medi-Cal: 87.80% within 30 calendar days 99.94% within 45 working days 99.99% within 90 calendar days Barriers and Next Steps Increased NCAL receipts and unexpected staffing issues led to processing delays, resulting in some claims being resolved after 30 calendar days.

Claims

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
			The Following steps have been taken to ensure that all metrics are met: 1. Expeditiously backfilled open position on 11/6/2023. 2. Implemented load balancing amongst internal NCAL team for Q4 to assist with backlog. 3. Continue to monitor processing timeliness and determine root cause(s) for late claims. 4. Continue to ramp up production for the new hire to maintain timeliness.
Maintain industry standards for financial accuracy, payment accuracy and overall accuracy. <u>Turnaround Time Targets:</u> 30 Day Clean 95% <u>Accuracy Targets (for claims and encounters end-to-end):</u> Financial Accuracy 99.3% Payment Incident Accuracy 98.0% Overall Accuracy 95.0%	NCA has a robust QA process inclusive of configuration and claims processing audits. The audits are conducted daily and feedback provided to claims operations for resolution. QA results are reported monthly to claims leadership.	National Claims Administration Monthly	2023 results for timeliness for all lines of business. <u>Turnaround Time Results:</u> ➤ Actual TAT = 99.7%¹ <u>Accuracy Results:</u> ➤ Financial Accuracy = 99.98%¹ ➤ Payment Incident = 99.97%¹ ➤ Overall Processing = 99.94%¹

Continuity and Coordination between Behavioral Health and Medical Care (QI 4)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
Continuity and Coordination of Care – Med/BH 1. Exchange of Clinical Information NCQA standard requires a process goal. Goal: Annually collect data on opportunities to improve collaboration between medical care and behavioral healthcare related to exchange of information.	Continue to annually assess exchange of clinical information between medical care providers and behavioral healthcare practitioners.	TPMG Consulting Services Annually	<u>Analysis</u> Successful. Receive automatic credit for use of fully integrated electronic medical record (EPIC). <u>Next Steps</u> Continue to annually assess exchange of clinical information between medical care providers and behavioral healthcare practitioners.
2. Appropriate Diagnosis, Treatment, and Referral for BH Disorders NCQA standard requires a process goal. Goal #1: Annually collect data on opportunities to improve collaboration between medical care and behavioral healthcare related to appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care. Goal #2: Measure members for >= 50% improvement over a 4-8 month period, based on PHQ-9 depression screening tool. Goal target: 17%	• Ongoing promotion of processes to improve the screening, diagnosis, and referral of depression in primary care through the KP Depression Monitoring and Depression Response initiatives. • Improve PHQ-9 capture through use of mobile technology, automatic distribution of screening tool, and piloting a PHQ-9 reminder alert system. • Increase use of the Tridium tool by our external contracted providers. We are now able to monitor the use of the tool by these external providers and receive alerts when members may need more	See above	<u>Analysis</u> Goal #1: Target achieved. Successfully measured opportunities to improve collaboration between medical care and behavioral healthcare related to appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care, by monitoring progress on the Depression Response measure, as well as improvement with “Last PHQ-9” capture. Goal #2: Target not achieved. As of December 2023, KPNC was at 16%, short of the 17% improvement target for the Depression Response: Significant Improvement 4-8 Months measure. KPNC performance on Follow-up PHQ-9 capture within 4-8 months after IESD improved slightly from 40% in Oct. 2022 to 42% in Sept. 2023. <u>Barriers</u>

Continuity and Coordination between Behavioral Health and Medical Care (QI 4)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
	intervention or are ready for discharge.		Although NCAL achieved significant improvement in PHQ-9 completion in recent years, response rates and intervals for questionnaire completion became more inconsistent during the pandemic and have remained below pre-pandemic levels. Continued barriers include change management for adoption of tools, variability of workflows, and limited pharmD and embedded therapist workforce to hire in support of a full population management program for primary care. <u>Next Steps</u> • Ongoing promotion of processes to improve the screening, diagnosis, and referral of depression in primary care through the KP Depression Monitoring and Depression Response initiatives. • In Adult Family Medicine: KP is continuing to pilot a PHQ-9 reminder alert system in four facilities that fires when a depression-related diagnosis is added to the patient's problem list. Consequently, if an elevated PHQ-9 score is entered with an encounter diagnosis present, another reminder alert triggers with the option to send a follow-up PHQ-9 series to the patient for 8 months. If successful, this reminder will be the first tool in our technology suite strategy that the region is designing to support depression care management work. • In Adult and Child Psychiatry and Addiction Medicine: Increasing use of the Lucet

Continuity and Coordination between Behavioral Health and Medical Care (QI 4)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
			assessment tool by our external contracted providers has been identified as an improvement opportunity over the next few years. We are now able to monitor the use of the tool by these external providers and receive alerts when members may need more intervention or are ready for discharge. All information obtained through external provider use of the Lucet tool goes into the member's medical record and is included in the "Depression Response" significant improvement reports – further enhancing continuity and coordination across the continuum of care. • KPNC also is working to continuously increase the number of internal KP providers using the Lucet assessment tool for completion of the PHQ-9, leveraging a variety of educational interventions.
3. Appropriate Use of Psychotropic Medications NCQA standard requires a process goal. Goal #1: Annually collect data on opportunities to improve collaboration between medical care and behavioral healthcare related to appropriate use of psychotropic medications.	Continue collaborative efforts between psychiatry and pediatrics, exploring inreach and outreach strategies to make sure patients are scheduling follow-up visits by phone and video within the HEDIS specified timeline. Continue to monitor HEDIS ADHD measure.	See above	<u>Analysis</u> Goal #1. Target Achieved. Successfully measured opportunities to improve collaboration between medical care and behavioral healthcare related to appropriate use of psychotropic medications. Goal #2: Target Achieved. KPNC far exceeded the HEDIS ADHD Initiation and ADHD Continuation targets (based on the most recently reported for MY2022). ADHD Initiation Goal: HEDIS 90th percentile: 51.46 ADHD Initiation Performance: 81.96

Continuity and Coordination between Behavioral Health and Medical Care (QI 4)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
Goal #2: Achieve 2023 NCQA HEDIS 90th percentile targets for: ADHD Meds Initiation ADHD Meds Continuation			ADHD Continuation Goal: HEDIS 90th percentile: 58.82 ADHD Continuation Performance: 82.28 <u>Next Steps</u> - Continue collaborative efforts between psychiatry and pediatrics, leveraging inreach and outreach strategies to make sure patients are scheduling follow-up visits by phone and video within the HEDIS specified timeline. - Continue to monitor HEDIS ADHD measure.
4. Treatment Access for Coexisting Medical and Behavioral Disorders NCQA standard requires a process goal. Goal: Annually collect data on opportunities to improve collaboration between medical care and behavioral healthcare related to management of treatment access and follow-up for members with coexisting medical and behavioral disorders.	Continue programs to ensure access to members with co-existing medical and behavioral disorders Monitor toxicology screening rate for Early Start program	See above	<u>Analysis</u> Target Achieved. Successfully measured treatment access and follow-up for members with coexisting medical and behavioral disorders, by measuring toxicology screening volumes for the Early Start program. Toxicology Screening Measure Goal: 90% 7/1/2022 to 6/30/23 performance: 90.1% <u>Next Steps</u> - Continue programs to ensure access to members with co-existing medical and behavioral disorders. - Monitor toxicology screening rate for Early Start program.
5. Primary and Secondary Prevention Programs NCQA standard requires a process	Continue to monitor access to the behavioral health education programs to understand impact.	See above	<u>Analysis</u> Target Achieved. Successfully measured opportunities to improve collaboration between medical care and behavioral healthcare related to

Continuity and Coordination between Behavioral Health and Medical Care (QI 4)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
goal. Goal: Annually collect data on opportunities to improve collaboration between medical care and behavioral healthcare related to primary or secondary preventive behavioral healthcare program implementation.			primary or secondary preventive behavioral healthcare program implementation. The NCQA standard requires choosing an area of opportunity that would benefit from primary and secondary prevention; identifying appropriate preventive services; and measuring access to those preventive services. KPNC chose anxiety and depression, measuring the prevalence of these conditions both within and outside of KPNC, and monitoring access to a set of Behavioral Health Education programs focused on anxiety, depression, couples communication, insomnia, emotional wellness, and stress. The goal is to see year-over-year reductions in the length of time it takes to book patients in Behavioral Health Education classes, as measured in the Initiated to Triage and Triage to Book columns below. As of September 2023: • # of Referrals Submitted to Behavioral Health Education classes: 2,287 • Initiated to Triage* (days): 0.06 • Triage to Book** (days): 0.74 * Number of days between initial submission of eConsult and when Health Education staff responds (if direct booked by physician or self-booked by patient, then 0 days) ** Number of days between triage of eConsult and when staff or patient self-books appointment (if direct booked, then 0 days).

Continuity and Coordination between Behavioral Health and Medical Care (QI 4)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
			<u>Next Steps</u> Continue to monitor access to the behavioral health education programs to understand impact.
6. Special Needs of Members with Severe and Persistent Mental Illness NCQA standard requires a process goal. Goal: Annually collect data on opportunities to improve collaboration between medical care and behavioral healthcare related to special needs of members with severe and persistent mental illness. Note: In 2023 NCQA changed the definition of patients covered under this requirement, from Members with Severe and Persistent Mental Illness (SMI) to Members with Severe Mental Illness or Severe Emotional Disturbance (SMI/SED).	- Continue to assess the effectiveness of the ICT program throughout the region. - Monitor the percentage of members with SPMI diagnosis in the ICT program who had a primary care appointment within 30 days of hospital discharge, and who had a primary care follow-up appointment made on discharge.	See above	<u>Analysis</u> Target Achieved. Successfully measured opportunities to improve collaboration between medical care and behavioral healthcare related to special needs of members with severe and persistent mental illness. Through the Intensive Community Treatment (ICT) program, KPNC partners with a local community-based organization (CBO) to provide 24/7 services to a select group of members with SPMI who have been identified as high risk. Results of the ICT program continue to be encouraging. Between July 2022 and August 2023, an expanded cohort of 1,025 ICT patients had 1,176 fewer visits to the E.D., and 1,284 fewer psychiatric hospital admits. These results continue to represent a reduction far greater than the goal of 5% (47% reduction in E.D. visits, 60% reduction in psych hospital admits). NCAL is also monitoring the ICT program to assess improvement on several different quality measures. Based on August 2023 data looking at all current ICT patients, there has been a decline in the number of appointment no-shows, from 129 no-shows pre-ICT, to 83 during ICT. KPNC is also continuing to monitor the rate of follow-up appointments for members with SMI or SED enrolled in the Intensive Community Treatment (ICT) program after they are seen in the Emergency

Continuity and Coordination between Behavioral Health and Medical Care (QI 4)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps																																												
			department or are hospitalized. The data comparison below shows an increase between 2022 and 2023 in the percentage of follow-up visits in primary care for active ICT patients after an E.D. visit or hospitalization, for every measure except 30-Day Followup. <table><tr><th rowspan="2">Measure</th><th colspan="2">2022</th><th colspan="2">2023</th></tr><tr><th colspan="2">Active ICT Patients</th><th colspan="2">Active ICT Patients</th></tr><tr><th></th><th>Rate</th><th>% of FU visits in Primary Care*</th><th>Rate</th><th>% of FU visits in Primary Care*</th></tr><tr><td>Follow-up After E.D. Visit - Members with SMI or SED</td><td></td><td></td><td></td><td></td></tr><tr><td>7-Day FU</td><td>79.7%</td><td>8.1%</td><td>83.0%</td><td>12.3%</td></tr><tr><td>30-Day FU</td><td>91.9%</td><td>28.4%</td><td>87.5%</td><td>24.7%</td></tr><tr><td>Follow-up After Hospitalization - Members with SMI or SED</td><td></td><td></td><td></td><td></td></tr><tr><td>7-Day FU</td><td>74.0%</td><td>9.2%</td><td>73.1%</td><td>10.7%</td></tr><tr><td>30-Day FU</td><td>86.1%</td><td>26.0%</td><td>86.8%</td><td>32.4%</td></tr></table> *Primary care departments include MED, FPR, GYN, FMS, FAM <u>Next Steps</u> - Continue to assess the effectiveness of the ICT program throughout the region. - Monitor the percentage of members with SMI/SED diagnosis in the ICT program who had a primary care appointment within 30 days of hospital discharge, and who had a primary care follow-up appointment made on discharge.	Measure	2022		2023		Active ICT Patients		Active ICT Patients			Rate	% of FU visits in Primary Care*	Rate	% of FU visits in Primary Care*	Follow-up After E.D. Visit - Members with SMI or SED					7-Day FU	79.7%	8.1%	83.0%	12.3%	30-Day FU	91.9%	28.4%	87.5%	24.7%	Follow-up After Hospitalization - Members with SMI or SED					7-Day FU	74.0%	9.2%	73.1%	10.7%	30-Day FU	86.1%	26.0%	86.8%	32.4%
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Care Coordination Readmissions

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Standardize patient identification and outreach across our 13 Excellent Transitions Programs implementing a patient benefit model and leveraging automated outreach for patient engagement. The overall objective is to reach a Readmission Observed/Expected (O/E) of 0.88. *Baseline performance required adjustment due to KPinsight reporting logic error and caused a restatement of the baseline and target for the 2023 performance year updated target is O/E of 0.92 for 2023.	Patient Benefit Model 1. Optimize Transitions Model of Care by establishing standard staffing ratio and metrics for oversight of standard outreach 2. Enhance Dashboard Reporting to include 7 day follow up apt, Excellent Transitions Enrollment, Palliative Care Consult 3. Establish Performance Improvement Tracking Functionality across Region and Medical Centers Automated Outreach 1. Implement Patient Satisfaction survey to be given quarterly to patients who completed a live transfer or inbound call to the program 2. Develop and Integrate OAE into KPHC through TRB funded project funding 3. Leverage ACD performance metrics and Cipher performance reports to develop standard outreach targets for initial assessment outreach	Care Coordination Due Date 7/2023 for tactics 12/31/23 for overall readmission O/E performance	Patient Benefit Model 1. In order to establish standardized staffing ratios the excellent transitions program deployed ACD telephony with reporting metrics for outbound and inbound calling to enhance the staffing model. 2. Enhanced dashboarding reporting was provided by KPinsight and delivered to each medical center for 2022-May 2023 for all reported metrics. 3. Deployed adherence reporting pushed weekly to all medical centers for Readmission Review performance tracking and adherence. Automated Outreach 1. Patient satisfaction survey went live in Dec 2023 2. Work to integrate OAE into KPHC through TRB was approved and launched in 2023 finishing the year in QA testing with a deployment date for Feb 2024. 3. Finalized standard outreach metric requirements for ensuring post discharge outreach occurred timely. Readmission performance for 2023 PY was successful with O/E at 0.92 on a target of 0.92 Next Steps include completion of the deployment of KPHC integration on Feb 15 and updating dashboard reporting leveraging new Compass Rose.

Continuity and Coordination of Medical Care (QI 3)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Continuity and Coordination of Medical Care NCQA standard requires a process goal, to ensure members receive coordination of care across the continuum. Metric: - Identify four opportunities for improvement of coordination of medical care by collecting data on movement of members across settings of care, and conducting quantitative and causal analysis - Act on at least three opportunities - Measure the effectiveness of at least three improvement actions The following opportunities and actions were identified for 2023, based on results of the 2022 Physician Satisfaction Survey: <i>Opportunity and Action 1:</i> In an effort to improve the transition process for patients who are receiving home health services from a contracted home health agency, a redesigned IT project has been funded which will evaluate electronic order signatures, leveraging Adobe Sign functionality. The project will investigate the feasibility of communication from	- Administer 2023 Provider Satisfaction Survey to TPMG network and contracted physicians to identify opportunities to improve coordination of care across the continuum - Collaborate with Continuum leadership to identify actions to improve coordination of care - Measure effectiveness of action taken on three opportunities	TPMG Consulting Services Annually	<u>Analysis</u> Results of the 2023 Physician Satisfaction Survey were used to measure the effectiveness of opportunities and actions identified based on the 2022 survey, and to identify opportunities and improvement actions for 2024. Opportunity and Action 1 Results: Survey remeasurement of satisfaction with the transition process to and from contracted home health agencies: +1% change compared to 2022. This represents a slight increase in satisfaction with the transition process for contracted home health agencies, and points to a need for continuing work to improve communication with these agencies. <i>Status of implementation:</i> Goal met. The planned electronic order pilot went live in the GSAA and East Bay service areas. All physicians who participated in the pilot and responded to the survey were very satisfied with the process. Physicians felt orders were complete and accurate and that the workflow was somewhat or extremely easy to use. There is an opportunity to spread to other facilities in 2024. Opportunity and Action 2 Results: Survey remeasurement of satisfaction with the transition process to and from Skilled Nursing Facilities: -1% change compared to 2022. This represents a slight decrease in satisfaction with the transition process to and from SNFs and speaks to a need for continuing

Continuity and Coordination of Medical Care (QI 3)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
contracted Home Health agencies to physicians via KP HealthConnect in basket messaging rather than the current use of faxes. The technology enhancement could provide greater insight into the patient's care during the home health episode of care. This project was scheduled for 2021 but was not implemented due to technology challenges. After reevaluation, Affiliate Link was not a viable option and additional scoping was done in 2022 to design a more streamlined solution. Funding for this alternative solution has been approved for 2023 and the project is expected to move forward. <i>Opportunity and Action 2:</i> TPMG physicians document notes and care plans for patients in a SNF in KPHC. However, this clinical information is not always obvious to other care providers. Additional technical improvements are being evaluated to facilitate awareness of patient's SNF admission and the availability of this documentation in KPHC. These include color changes, banners, hovers and additional text. At least one of these options will be implemented in 2023. <i>Opportunity and Action 3:</i> To continue to improve ease of access to DME information, there will be efforts in 2023 to optimize DME orders in KP			work to improve communication through care plans notes. <i>Status of implementation:</i> Goal not met. Due to other KPHC priorities, enhancements were not implemented in 2023, but are in progress for 2024 implementation. Opportunity and Action 3 Results: Survey remeasurement of satisfaction with ease of access to DME information: +2% change compared to 2022. This represents a modest increase in satisfaction with the DME tracking and ordering process. Although there has been steady improvement in satisfaction since 2021, there is a need for continuing provider education. <i>Status of implementation:</i> Goal met. The planned 2023 improvement opportunities were partially implemented. Three additional optimized orders were developed and set to release in 2023: Breast Pump, Commode, and Enterals. However, in order to support broader and more far-reaching DME optimization on the national level in which these orders will eventually be optimized, their Northern California releases were put on hold. It is anticipated that national DME order optimization will begin implementation in Northern California in mid-2024. Multiple efforts to educate ordering clinicians commenced in 2023, including: a DME Summer Education series; DME Physician Champions shared best practices and resources for educating other physicians locally; and two new KPHC functionalities to

Continuity and Coordination of Medical Care (QI 3)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
HealthConnect, including ensuring relevant clinical information is available from the order. In addition, educational offerings designed for ordering clinicians will be developed. <i>Opportunity and Action 4:</i> A communication strategy was implemented in 2022 with the aim of raising physician awareness and knowledge of new tools and technical improvements implemented in 2021 to improve ease of access to Advance Health Care Directives (AHCD) in KP HealthConnect. Because there was no corresponding increase in physician satisfaction with ease of access to this type of clinical information in 2022, there will be additional focused training/strategies in 2023 that go beyond AHCD into the role of the physician in the goals of care conversation. There will be a more intentional approach to connecting with each specialty in 2023, as well as efforts to scale up the learnings/successes from small tests of change carried out in 2022 that increased physician documentation of planning work. Lastly, work will continue on the ongoing communication strategy of spreading education through physician groups. A positive impact on physician satisfaction is expected as awareness			enable easier order transmission for medical assistants (MAs) and non-physician ordering clinicians were released in 2023. Opportunity and Action 4 Results: Survey remeasurement of satisfaction with ease of access to this type of clinical information on Advance Health Care Directives (AHCD): +3% change compared to 2022. This increase in satisfaction with ease of access to AHCD information comes after a 2% decrease in satisfaction in 2021. In order to continue the progress, there is a need for a broader communication strategy as well as updated job aids and support documents to raise provider awareness and knowledge of AHCD information and tools. <i>Status of implementation:</i> Goal Met. Accomplished providing a series of trainings and informational sessions geared towards physicians that included building awareness of how to easily access AHCD and ACP related documentation. This was accomplished through a series of specialty engagement sessions from grand rounds to informal updates at standard meetings. <u>Next Steps</u> The following opportunities and actions were identified for 2024, based on results of the 2023 Physician Satisfaction Survey: <i>2024 Opportunity and Action 1:</i>

Continuity and Coordination of Medical Care (QI 3)

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and knowledge of the AHCD tools continues to spread.			Although there was +2% change in practitioner satisfaction compared to 2023, there is a need for additional improvement in ease of access to DME information. Satisfaction remains low relative to ease of access to other types of clinical information. Planned 2023 efforts to optimize DME orders in KP HealthConnect were put on hold in order to support broader and more far-reaching DME optimization on the national level. It is anticipated that national DME order optimization will begin implementation in Northern California in mid-2024. These optimization efforts are expected to improve ease of access to DME information, including ensuring relevant clinical information is available from the order. In addition, comprehensive DME education for non-physician ordering clinicians is in its final stages of development. There are plans to include this education in training materials for regional rollout of a care management program. Transitioning DME order transmission to non-physician team members, within their scope of practice, is key to improving physician ease in approving DME orders as it builds expertise in ordering and presents information to clinicians for easy approval. Additional opportunities for dissemination and delivery are being explored. <i>2024 Opportunity and Action 2:</i> Practitioner satisfaction with the transition process for their patients to and from contracted home health agencies increased only slightly in 2023. Providers continue to express that they have little insight into a patient's care during the home health episode of care.

Continuity and Coordination of Medical Care (QI 3)

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			The planned 2023 pilot to investigate the feasibility of communication from contracted Home Health agencies to physicians via KP HealthConnect in basket messaging rather than the current use of faxes went live in two service areas, and physicians who participated in the pilot and responded to the survey were very satisfied with the process. However, this process is currently only available in the GSAA and East Bay. There is an opportunity to spread the above technology enhancement, known as the External Home Health Order Signature solution, to other facilities in 2024. In addition to the electronic orders, KP NCAL is piloting a streamlined process to address change of condition for patients on Home Health service. Home Health agency staff can call into a centralized team of KP nurses who will clearly and consistently document the reason for the call and current patient status. This patient summary is forwarded to a HH Virtual hub physician on-call who will address the patient's needs. All communication is clearly documented in our EMR, which will improve the transition of care between KP and Home Health. <i>2024 Opportunity and Action 3:</i> Efforts in 2023 to raise physician awareness of tools and technical improvements to improve ease of access to Advance Health Care Directives (AHCD) in KP HealthConnect led to a 3% increase in physician satisfaction compared to 2022. However, some clinicians still express a lack of familiarity with information and tools to support advance care planning. In order to continue the progress, there is a need for a broader communication strategy as well as updated job aids and support documents to raise provider

Continuity and Coordination of Medical Care (QI 3)

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			awareness and knowledge of AHCD information and tools. There is additional opportunity for improvement with AHCD in 2024. Our AHCD document has gone through extensive revision and is planned to roll out in 2024. This rollout will include a broader communication strategy as well as updated job aids and support documents. The implementation and socialization of the document is anticipated to increase awareness, knowledge, and understanding of advance care planning related information like the AHCD and other documented goals of care. <i>2024 Opportunity and Action 4:</i> When asked their level of satisfaction with ease of access to clinical information on Assessments, Care Plans, or Communication from Case Management teams, 79% of physicians said that they were satisfied, a 2% improvement from 2022. As this is a relatively new question on the Practitioner Satisfaction Survey and targeted improvement efforts have not previously been carried out, there is an opportunity to further increase physician satisfaction in this area. KP is implementing "Compass Rose", an enhanced case management module in our EMR. Numerous Case Management / Care Coordination programs have moved to using this revised suite of tools which include standard assessment and consistent encounter structure and location within the EMR. Implementation of Compass Rose in 2024 is expected to increase physician satisfaction with ease of access to clinical

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			information on Assessments, Care Plans, or Communication from Case Management teams.

Credentialing and Privileging

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Region-wide transition to Teams for credentials and privileges data exchange. Metric: Move to secure data exchange through Teams for all C&P documents.	• Build data exchange Teams folder with secure channels for each MSO • Assign and maintain owners, members, and permissions • Train MSO staff on standardized process for submission of documents	Health Plan Quality Credentialing and Privileging- December 2023	The Health Plan Quality (HPQ) data exchange folder with secure channels for each MSO has been built. Owners, members, and permissions have been assigned and MSO staff have been trained. Beginning on June 1, 2023, C&P meeting minutes, reports, and Board memos have been submitted through the data exchange folders. Quarterly vital date audits transitioned from the shared drive to the Teams data exchange folder in Q3. The migration of historical documents was completed in Q4. Due to efficient planning and a tiered rollout, no barriers were experienced. Next steps are to move delegation oversight documents and audits to the Teams data exchange folder. Each delegate will have a secure folder with restricted access to allow sharing of delegation agreements, quarterly reports, and annual audit materials.
Evaluation of State regulation allowances and internal processes for region-wide realignment to 3-year reappointment cycle. Metric: Full assessment of transition to 3-year reappointment cycle with recommendations for future realignment.	• Research CDPH Program Flex • Engage SCAL partners to explore standardized approach • Evaluate and develop workflows, including data for implementation of process change	Health Plan Quality & Regional Credentialing and Privileging December 2023	Consultation by Kaiser Health Plan's Managing Director, Hospital and Health Plan Quality Services, and information provided by the California Hospital Association (CHA) revealed that California Business and Professions § Code 2282 requires staff appointments on an annual or biennial basis. Health Plan Quality and Regional Credentialing & Privileging will continue to monitor for changes in requirements.

Cultural & Linguistic Diversity

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
Cultural & Linguistic Trainings - Increase the capacity of KP staff and providers to address the language and cultural variations of our members and patients. Enhance the delivery of high quality cultural and linguistic care and services to all members and patients. 1) Ensure training completion of annual KP Staff Interpreter in-service by at least 90% KP staff interpreters by October 31, 2023. 2) Ensure training completion of Qualified Bilingual Status (QBS) Refresher Training by at least 90% QBS Level 2s by September 30, 2023 3) Ensure training completion of the Providing Culturally & Linguistically Appropriate Services by at least 85% Health Plan staff by November 30, 2023.	1) Administer at least 4 sessions of 8 hours each of the annual KP Staff Interpreter in-service classroom training. The training is designed to reinforce, support and further develop skills and proficiencies of the KP staff interpreters. 2) Deploy the Qualified Bilingual Status (QBS) Refresher Training for Level 2 QBS (QBS Level are used for basic clinical interpretation) to KP Learn in January 2023. The QBS Level 2 Refresher Training is designed to reinforce, support and assist QBS Level 2 employees in maintaining their skills and demonstrate their ongoing language proficiency to meet regulatory requirements. Beginning January 2023, all QBS Level 2 employees will be offered and are required to take QBS Level 2 Refresher Training every 3 years. 3) The Providing Culturally & Linguistically Appropriate Services training was successfully deployed to KP Learn in November 2022 and was	Regional Language Access Program Manager and Project Manager staff and LMP Coordinator December 31, 2023 – All Trainings	Analysis 1) As of December 31, 2023, the annual KP Staff Interpreter in-service has been completed by 100% of KP staff interpreters. 2) As of December 31, 2023, 95% of QBS Level 2s have completed the Qualified Bilingual Status (QBS) Refresher Training. The remainder of Level 2 employees are expected to complete training by February 29, 2024. 3) As of December 31, 2023, the Providing Culturally & Linguistically Appropriate Services training has been completed by 100% NCAL and California statewide Health Plan staff assigned to this training. Barriers – None Next Steps – The Regional Language Access Program will roll-out the 2024 annual KP staff interpreter in-service in Q1, 2024. Additionally, the Providing Culturally & Linguistically Appropriate Services training content will be updated, and a new version of the training will be rolled out in Q4, 2024.

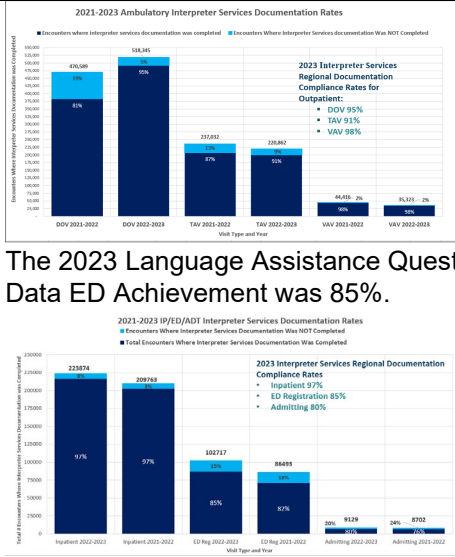
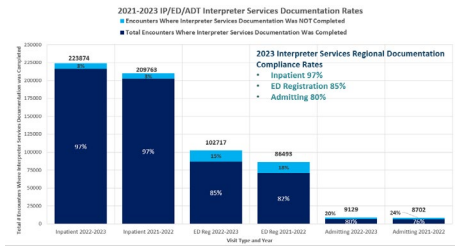
Cultural & Linguistic Diversity

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
	assigned to NCAL and statewide Health Plan employees as a required course. The training supports regulatory requirements designed to improve access to health care services for Limited English Proficient (LEP) population and persons with disabilities and to increase our capacity to address the language and cultural variations of our members and patients.		
Address inequities resulting from language barriers by expanding access to on-demand video interpreters in NCAL hospitals for Limited English Proficient and deaf and hard of hearing members/patients. Expansion and enhancement of existing KP LanguageConnect Video Remote Interpreting (VRI) Services in NCAL Hospitals for Limited English Proficient and Deaf and Hard of Hearing members and patients will improve interpreter access, ensure service sustainability and mitigate risks previously identified related to interpreter resources	To expand availability of qualified Language Assistance tools and resources in NCAL hospitals and to meet Language Assistance operational and regulatory requirements and non-English and Sign language needs of diverse membership - 1) Deploy a KP LanguageConnect Video Remote Interpreting (VRI) Services Dual Supplier Model in the Hospitals. The Dual supplier model will expand the pool of external contracted qualified video interpreters to be accessible 24/7 for the hospital staff and providers and assist in mitigating risks previously identified related to interpreter	Regional Language Access Program Manager and Project Manager staff. December 31, 2023	Analysis - As of December 31, 2023, the KP LanguageConnect Video Remote Interpreting (VRI) new supplier technology certification is completed, and the technology is ready for deployment in the Kaiser Permanente NCAL environment. Barriers – Supplier delay on technology preparedness required to deploy in KP environment pushed the VRI pilot to Q1, 2024. Next Steps - A VRI pilot will be launched in Feb 2024 at 2 hospital and ED sites, San Leandro, and South Sacramento Pilot duration is approx. 3 months. For the duration of the pilot, feedback will be gathered from front line staff to validate the VRI dual supplier model user experience and reliability.

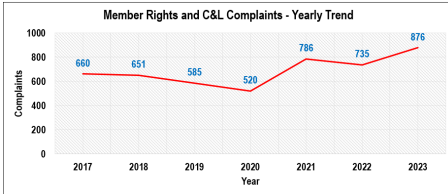
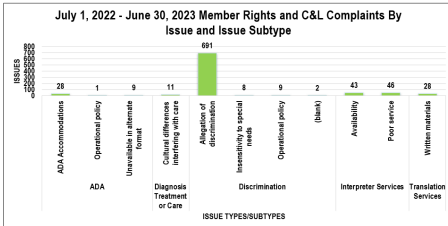
Cultural & Linguistic Diversity

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
availability, scalability and challenges securing just in time language assistance services when needed - 1) Expand the services to additional/new external contracted interpreter resources - Work with the second/new Video Remote Interpreting (VRI) Services interpreter supplier on VRI service and technology readiness by September 30, 2023. 2) Validate the service expansion plan with a VRI pilot in 2-4 hospitals by December 31, 2023.	resources availability, scalability and challenges securing just in time language assistance services when needed, along with an opportunity to expand language accessibility with addition of new video languages for our diverse members.		
Use of Interpreter Services - Language Assistance Questionnaire Data Collection to ensure consistent offering and documentation of Interpreter Services during clinical touchpoints with diverse members/patients. 1) Language Assistance Questionnaire Data Outpatient Achievement for over 85% 2) Achievement for over 80% in the ED Department	1) Monitor completion of Language Assistance questionnaire to ensure clinical discussions occur in the appropriate language for outpatient, ED, and inpatient settings, and follow up with managers/KPHC partners, i.e., Workflow Consultants, to train	Regional Language Access Program Manager and Project Manager staff. December 31, 2023	Analysis – The 2023 Language Assistance Questionnaire Data Outpatient Achievement for DOV, VAV and TAV averaged to 97%. This demonstrates that qualified interpreter services were consistently offered, and use and refusal of interpreter services was documented in the patient record.

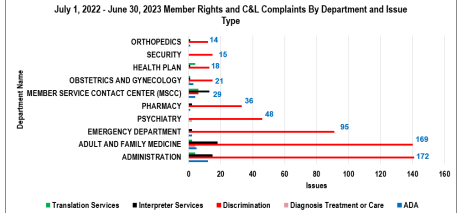
Cultural & Linguistic Diversity

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation - Analysis of results including metrics - Barriers - Next steps																																																								
	staff on accurate documentation to achieve completion rate.		 2021-2023 Ambulatory Interpreter Services Documentation Rates <table border="1"> <thead> <tr> <th>Year</th> <th>Encounters Where Documentation Was Completed</th> <th>Encounters Where Documentation Was NOT Completed</th> <th>Completion Rate</th> </tr> </thead> <tbody> <tr> <td>2021-2022</td> <td>450,000</td> <td>50,000</td> <td>89%</td> </tr> <tr> <td>2022-2023</td> <td>585,945</td> <td>54,055</td> <td>91%</td> </tr> <tr> <td>Year 2023-2024</td> <td>237,892</td> <td>32,108</td> <td>88%</td> </tr> <tr> <td>Year 2023-2024</td> <td>236,862</td> <td>33,138</td> <td>88%</td> </tr> <tr> <td>VAV 2023-2024</td> <td>16,415</td> <td>2,585</td> <td>86%</td> </tr> <tr> <td>VAV 2022-2023</td> <td>16,551</td> <td>2,449</td> <td>87%</td> </tr> </tbody> </table> 2023 Interpreter Services Regional Documentation Compliance Rates for Outpatient: - DOV 95% - TAV 91% - VAV 98% The 2023 Language Assistance Questionnaire Data ED Achievement was 85%.  2021-2023 IP/ED/ADT Interpreter Services Documentation Rates <table border="1"> <thead> <tr> <th>Year</th> <th>Encounters Where Documentation Was Completed</th> <th>Encounters Where Documentation Was NOT Completed</th> <th>Completion Rate</th> </tr> </thead> <tbody> <tr> <td>2021-2022</td> <td>238,874</td> <td>41,126</td> <td>85%</td> </tr> <tr> <td>2022-2023</td> <td>208,763</td> <td>31,237</td> <td>87%</td> </tr> <tr> <td>2023-2024</td> <td>182,717</td> <td>32,283</td> <td>85%</td> </tr> <tr> <td>2023-2024</td> <td>182,717</td> <td>32,283</td> <td>85%</td> </tr> <tr> <td>Admitting 2023-2024</td> <td>9,129</td> <td>28,871</td> <td>24%</td> </tr> <tr> <td>Admitting 2022-2023</td> <td>8,702</td> <td>27,298</td> <td>24%</td> </tr> </tbody> </table> 2023 Interpreter Services Regional Documentation Compliance Rates - Inpatient 97% - ED Registration 85% - Admitting 80% Barriers – None Next steps – Regional Language Access Program will continue monitoring the documentation compliance rates in the outpatient and inpatient setting to ensure consistent documentation completion and offering of qualified interpreter services at clinical touchpoints.	Year	Encounters Where Documentation Was Completed	Encounters Where Documentation Was NOT Completed	Completion Rate	2021-2022	450,000	50,000	89%	2022-2023	585,945	54,055	91%	Year 2023-2024	237,892	32,108	88%	Year 2023-2024	236,862	33,138	88%	VAV 2023-2024	16,415	2,585	86%	VAV 2022-2023	16,551	2,449	87%	Year	Encounters Where Documentation Was Completed	Encounters Where Documentation Was NOT Completed	Completion Rate	2021-2022	238,874	41,126	85%	2022-2023	208,763	31,237	87%	2023-2024	182,717	32,283	85%	2023-2024	182,717	32,283	85%	Admitting 2023-2024	9,129	28,871	24%	Admitting 2022-2023	8,702	27,298	24%
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Cultural & Linguistic Diversity

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Cultural & Linguistic (C&L) Member Grievances - Increase member satisfaction with C&L services and reduce the Interpreter Services complaint volume by 2%. 1) Perform Comparison and Trend analysis of 2022 and 2023 data 2) Identify Top Departments and Issue Types for the review period 3) Provide recommendations for improvement in the annual report to Member Concerns Committee (MCC).	1) C&L Complaints and Grievances: report, review, monitor and decrease complaints and grievances related to the delivery of C&L services as it relates to physician, staff, and other relevant personnel by incorporating an improvement plan which includes working with member services department on accurate coding for accurate C&Gs, sets priorities and pursues opportunities based on analysis of the complaint data. 2) Share complaints and grievances data with Medical Center leaders to communicate opportunities for improvement, educate on policies/best practices and to ensure availability and access to qualified Language Assistance tools & resources. 3) Present annual complaints and grievances aggregate report related to language assistance services, discrimination, cultural insensitivity or disability to the regional Member Concerns Committee (MCC) and collaborate	Regional Language Access Program Manager and Project Manager staff. December 31, 2023	Analysis: The Total C&L complaints reported for the 2023 review period was 876. This includes 20 complaints that belong to external contracted facilities. The volume of complaints and grievances has increased from the preceding review period by almost 19%. The higher volume mostly rests in complaints regarding members feeling discriminated during their interaction with Kaiser Permanente in clinical and administrative setting. However, the Interpreter Services complaints volume for the 2023 review period was 10%, which was a 2% decrease from last year. Member Rights and C&L Complaints - Yearly Trend <table border="1"><thead><tr><th>Year</th><th>Complaints</th></tr></thead><tbody><tr><td>2017</td><td>660</td></tr><tr><td>2018</td><td>651</td></tr><tr><td>2019</td><td>585</td></tr><tr><td>2020</td><td>520</td></tr><tr><td>2021</td><td>786</td></tr><tr><td>2022</td><td>735</td></tr><tr><td>2023</td><td>876</td></tr></tbody></table> July 1, 2022 - June 30, 2023 Member Rights and C&L Complaints By Issue and Issue Subtype <table border="1"><thead><tr><th>Issue Type/Subtype</th><th>Count</th></tr></thead><tbody><tr><td>ADA Accommodations</td><td>28</td></tr><tr><td>Operational policy</td><td>1</td></tr><tr><td>Unavailability in alternate format</td><td>9</td></tr><tr><td>Cultural differences interfering with care</td><td>11</td></tr><tr><td>Diagnosis Treatment or Care</td><td>8</td></tr><tr><td>Allegation of discrimination</td><td>891</td></tr><tr><td>Inaccessibility to special needs</td><td>9</td></tr><tr><td>Operational policy (blank)</td><td>2</td></tr><tr><td>Availability</td><td>43</td></tr><tr><td>Poor service</td><td>48</td></tr><tr><td>Written materials</td><td>28</td></tr></tbody></table> -Adult and Family Medicine and Regional Administration departments recorded the highest volume of Member Rights and C&L	Year	Complaints	2017	660	2018	651	2019	585	2020	520	2021	786	2022	735	2023	876	Issue Type/Subtype	Count	ADA Accommodations	28	Operational policy	1	Unavailability in alternate format	9	Cultural differences interfering with care	11	Diagnosis Treatment or Care	8	Allegation of discrimination	891	Inaccessibility to special needs	9	Operational policy (blank)	2	Availability	43	Poor service	48	Written materials	28
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Cultural & Linguistic Diversity

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	with regional leaders on implementation of improvements.		complaints member complaints for the 2023 review period.  Monthly grievance reports are shared with the Medical Center Language leads for review and follow-up with local departments. The Regional Language Access Program also presented the 2023 annual Member Rights and Cultural & Linguistics (C&L) report to the NCAL Member's Concerns Committee on September 20, 2023. The following recommendations/next steps were provided: - The Regional Language Access program will continue monthly and quarterly monitoring of C&L Complaints and Grievances and engage in resolution with departments and Member Services as necessary. This includes working with local Language, ADA/Civil Rights and regional Leaders to assess existing infrastructure, resources and workflow to identify areas for improvement and to ensure a higher level of awareness and optimization of use of language resources, partnering with Regional ADA/Civil Rights Coordinator to review documentation and evidence found in METRS to ensure appropriate actions have

Cultural & Linguistic Diversity

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			been taken to mitigate/resolve the issues and follow up with Medical Centers as necessary and providing ongoing education to staff/providers on cultural and linguistic best practices through release of bi-annual Quick tips/newsletters. - For discrimination related member grievances, the Regional Civil Rights and ADA Program in the Regional Compliance Office that manages the Affordable Care Act, ACA's Section 1557 compliance infrastructure and risk profile on behalf of the entire region is partnering with Member Services to make improvements to the documentation and reporting of discrimination grievances to demonstrate the thorough investigation and remediation of all discrimination allegations by the responsible departments.
Language Assistance Service Delivery and compliance Monitoring to ensure	To ensure consistent quality, adequacy and availability of qualified Language	Regional Language Access Program	Analysis - 2023 Vendor Quality Oversight audits were successfully completed in Q4, 2023 for 10

Cultural & Linguistic Diversity

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps																																										
timely access, adequacy and availability of Qualified Language Assistance Services to Limited English Proficient members at administrative and clinical touchpoints. Perform Quality Oversight audit & Monitoring of external contracted vendor resources to ensure 1) A 90% or better fill rate connecting to a phone interpreter within 30 seconds for Spanish 2) Maintaining a 90% or better fill rate connecting to a phone interpreter within 60 seconds for other languages 3) Maintaining a 95% or better fill rate for in-person non-emergent interpreter requests 4) Maintaining a 90% or better fill rate connecting within 30 seconds for Spanish, ASL, Mandarin, Cantonese, Russian, and Vietnamese Video interpreter. 5) Maintaining a 95% or better fill rate connecting to video	Assistance services at administrative and clinical touchpoints, perform annual quality oversight monitoring audits of external contracted vendor resources for provision of language interpretation (Spoken and Sign language) services. Performance Measures include their capacity to successfully meet NCAL Language needs of our members and patients based on time required to connect to an interpreter for phone/video interpreter services metrics and % of interpreter requests successfully fulfilled for in-person interpreters services.	Manager and Project Manager staff. December 31, 2023	Language Services vendors providing services to NCAL market. Audit findings were documented in audit reports and reports distributed to the vendors with a request for corrective action plan if the vendor did not meet the contractual interpreter fill rates or interpreter connect time Service level agreement. Further Details below. Language Services Contracted Suppliers' Performance Scorecard (Q4, 2022-Q3 2023) <table><tr><th colspan="4"></th><th colspan="4">Contractual Service Level Agreement MET/NOT MET</th></tr><tr><th>Mode of Services</th><th>KP's Written Service Expectations</th><th>KP's Service Quality Indicators</th><th>KP's Monitoring Frequency</th><th>Suppliers Monitored</th><th>Q4</th><th>Q1</th><th>Q2</th><th>Q3</th></tr><tr><td>In-Person Interpreting (Spoken and Sign Languages)</td><td>1) appropriate staffing levels to accommodate KP demand.</td><td>Contractual SLAs for Interpreter Fulfillment Rates for Appointments</td><td rowspan="3">Quarterly & Annual</td><td>7</td><td>4/7</td><td>4/7</td><td>5/7</td><td>4/7</td></tr><tr><td>Over the Phone Interpreting (OPI)</td><td>2) processes in place to ensure ongoing competency of staff 3) processes in place to ensure timely acknowledgment and resolution of customer complaints 4) Adhere to KP Vendor Code of Conduct, Health Screening Requirements and Interpreter Code of Ethics</td><td>Contractual SLAs for Interpreter Connect Time to Audio and Video Interpreters</td><td>2</td><td>1/2</td><td>1/2</td><td>2/2</td><td>2/2</td></tr><tr><td>Video Remote Interpreting (VRI)</td><td></td><td></td><td>1</td><td>0/1</td><td>0/1</td><td>0/1</td><td>0/1</td></tr></table> Highlights - 1) 4 Language Services suppliers (3 In-person and 1 VRI) did not meet the contractually set service level agreement (SLAs) for provision of Interpreter Services due to insufficient interpreter staff to meet KP demand (Contractual SLAs are set by KP to ensure quantifiable highest quality of services). 2) Nationwide shortage of medically qualified/certified interpreters. 3) Recruiting and staff turnover challenges as a result of the pandemic. 4) Fluctuating demand for Interpreter Services due to natural disasters and other political/economic conditions. 5) All Suppliers continue to implement extensive staffing efforts and hiring practices to meet the demand for services. To ensure timely provision of Interpreter Services and to avoid dependency on a single supplier, NCAL currently contracts with multiple language services suppliers for in-person interpretation services. Additionally, NCAL is planning to pilot and deploy an Alternate/Secondary supplier for Video Remote Interpreting Services in 2024. Barriers: None Next steps – The Regional Language Access Program will continue to perform quarterly monitoring and annual vendor quality oversight audits in 2024 to ensure that all contracted vendors are meeting service level expectations of consistent quality, adequacy, and availability					Contractual Service Level Agreement MET/NOT MET				Mode of Services	KP's Written Service Expectations	KP's Service Quality Indicators	KP's Monitoring Frequency	Suppliers Monitored	Q4	Q1	Q2	Q3	In-Person Interpreting (Spoken and Sign Languages)	1) appropriate staffing levels to accommodate KP demand.	Contractual SLAs for Interpreter Fulfillment Rates for Appointments	Quarterly & Annual	7	4/7	4/7	5/7	4/7	Over the Phone Interpreting (OPI)	2) processes in place to ensure ongoing competency of staff 3) processes in place to ensure timely acknowledgment and resolution of customer complaints 4) Adhere to KP Vendor Code of Conduct, Health Screening Requirements and Interpreter Code of Ethics	Contractual SLAs for Interpreter Connect Time to Audio and Video Interpreters	2	1/2	1/2	2/2	2/2	Video Remote Interpreting (VRI)			1	0/1	0/1	0/1	0/1
				Contractual Service Level Agreement MET/NOT MET																																									
Mode of Services	KP's Written Service Expectations	KP's Service Quality Indicators	KP's Monitoring Frequency	Suppliers Monitored	Q4	Q1	Q2	Q3																																					
In-Person Interpreting (Spoken and Sign Languages)	1) appropriate staffing levels to accommodate KP demand.	Contractual SLAs for Interpreter Fulfillment Rates for Appointments	Quarterly & Annual	7	4/7	4/7	5/7	4/7																																					
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Video Remote Interpreting (VRI)				1	0/1	0/1	0/1	0/1																																					

Cultural & Linguistic Diversity

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
interpreter within 60 seconds for other languages 6) Document audit and monitoring findings and any applicable corrective action plans for the designated audit period in the audit report to ensure timely resolution of issues and service gaps with the contracted resources.			of qualified Language Assistance services for provision of language interpretation (Spoken and Sign language) services at administrative and clinical touchpoints.

Cultural Diversity Needs Assessment (NET 1)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2023) 1. Analysis of results including metrics 2. Barriers 3. Next steps
- On an annual basis, assess the cultural, ethnic and linguistic needs of KPNC membership. - As needed and subject to changes in membership and staff turnover, make adjustments to provider network	- Complete Cultural Needs Assessment by March 2023. - Review cultural and linguistic complaints related to provider network to ensure that members are being linked to practitioners per their expressed preferences. - Monitor mechanisms used for diversity outreach and recruitment to ensure KPNC is able to provide TPMG Medical Center leaders with the broadest cross section of excellent physicians and that placement of minority physicians is meeting the needs of the membership.	March 2023 Director for Regulatory Compliance, Accreditation and Provider Network Reporting, TPMG Consulting Services	Cultural needs assessment completed in March 2023. Results as of April 30, 2023: Language 3,933,930 KPNC members listed English as their spoken language preference 5,630 physicians have language skills other than English 397 new physicians were hired with language skills other than English 72 different languages are spoken by the KPNC membership 119 different languages are spoken by KPNC physicians Race/Ethnicity During this reporting period, recruitment efforts resulted in 5.0% of new hires having a Hispanic background and 4.2% of new hires having an African American background which resulted in the Black (4.2%) and Hispanic (5.0%) workforces remaining stable. KPNC continues to maintain a diverse practitioner network to meet the needs of its membership. 2023 Network Adjustment <u>2023 Placement</u> In 2023 information was gathered on individual practitioner demographics, including ethnicity and language skills. The demographic characteristics of the

Cultural Diversity Needs Assessment (NET 1)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2023) 1. Analysis of results including metrics 2. Barriers 3. Next steps
			Medical Center are also gathered. This information is considered during the placement process to balance practitioner panels to meet the ethnic and cultural needs of the membership in a particular geographic area. With a diverse provider network in place, KPNC Member Services can link members to Primary Care, Specialty Care and Behavioral Health with practitioners who can meet the cultural, linguistic, ethnic and/or racial needs. Tools are also available at KP.org which allow members to peruse practitioner profiles to help them make selections to meet their needs. <u>Physician Training Opportunities</u> KPNC is embarking on a learning journey available to all physicians and staff members called Belong@KP. The first part of this journey encourages us to understand and disrupt bias through simple everyday behavior changes. In support of this journey, training and tools targeted toward different provider and staff types is available through the Equity, Inclusion, and Diversity program, to help them think and act more intentionally. <u>Language Access Tips and Tricks</u> To encourage the use of translation services among providers and providing culturally responsive care, the Northern California Language Access program published four Quick Tips. These tips are actively pushed to our providers and staff and archived on the Language Access website for future reference.

DMHC Timeliness Initiated to Seen (ITS) Average Days Wait (ADW) Appointment Access Report

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation									
			1. Analysis of results including metrics 2. Barriers 3. Next steps									
Monitor compliance with DMHC California State timely access standards through the KPNC Access Committee ITS per Average Days Wait standards: - Urgent care within 48 hours - Nonurgent primary care within 10 business days - Nonurgent specialty care within 10 business days - Nonurgent ancillary services within 15 business days - Nonurgent Nonphysician mental health care within 10 business days - Nonurgent physician mental health care within 15 business days	Implement action plans when departments/service areas exceed the standard.	KFHP Vice President of Quality and Co-Chair of Quality Oversight Committee TPMG Operational AEDs and Co-Chair of Quality Oversight Committee Quarterly: March 2023 June 2023 September 2023 December 2023			Q1 2023	Q2 2023	Q3 2023	Q4 2023				
			Standard	Goal 80%	%	%	%	%				
			Adult Primary Care									
			Urgent	<=48h	90%	90%	91%	93%				
			Non-Urgent	<=10 bus day	94%	93%	93%	94%				
			Pediatrics									
			Urgent	<=48h	97%	97%	95%	94%				
			Non-Urgent	<=10 bus day	98%	98%	98%	98%				
			Specialty Care									
			Urgent	<=48h	89%	89%	89%	91%				
			DERM	<=15 bus day	93%	91%	91%	94%				
			GEN SURG	<=15 bus day	93%	92%	89%	92%				
			OBGYN	<=15 bus day	93%	93%	93%	93%				
			HNS	<=15 bus day	92%	90%	88%	90%				
			OPHT	<=15 bus day	86%	82%	82%	82%				
			ORTHO	<=15 bus day	91%	92%	89%	93%				
			ONC	<=15 bus day	96%	96%	95%	91%				
			Mental and Behavioral Health Care									
			MD	<= 15 bus day	96%	97%	96%	96%				
			Non-MD	<=10 bus day	96%	96%	99%	99%				
			KPNC met the established targets, regionally, in all reported categories.									
			Barriers: None									
			Next Steps: Continue monitoring of ITS Access Reports and other compliance reports via quarterly reporting to the QOC and monthly reporting to the Access Committee. Continue to implement action plans when Medical Centers do not meet the standard.									

Durable Medical Equipment

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Establish baseline department telephony quality metrics	1. Implement Department leadership use of NICE telephony recording and live listen in application functionality 2. Define telephony call review and staff feedback assignment for dept. Supervisors. 3. Establish call quality metrics to obtain baseline performance and define operational goals	KP IT NCAL DME Dept. Due end of Q2 2023	DME Implemented NICE telephony system workflow Q2 2023 DME Supervisors are performing audit checks and providing feedback to DME Clerks upon review of recorded calls. Start Q2 2023 and ongoing. Telephony system call metrics report built but provides inaccurate data. Report needed to be rebuilt from scratch due to telephony system upgrade. First draft of report completed, ongoing modifications and updates to ensure accuracy of data based on business feedback.
Document and track DME customer service issues by implementing a CRM application into department workflow	1. Install CRM application on staff computers 2. Design Dept. workflow to enable staff to capture customer service queries, responses and actions taken using CRM application 3. Live implementation in Department	KP IT NCAL DME Dept. Due end of Q3 2023	Review of CRM platform available determined workflow too inefficient and cumbersome to feasibly implement. Assessment of multiple systems determined best potential solution to be AI based. Business plan created and submitted to TRB for concept funding Aug. 2023. Awaiting decision from TRB on funding. Concurrently assessing MS Dynamics platform enhancements as stop gap measure. Business requirement submitted, currently assessing cost estimate and value measure to determine whether to move forward with enhancements.
Implement DME Denial workflow that allows for tracking and adherence to late denial notification of <= 5% of total denial volume.	1. Build Report that captures denial processing timeliness 2. Create a workflow that allows for processing of late denials 3. Create workflow that monitors, analyzes and define actions to be take to minimize/reduce late	KP IT NCAL DME Dept. NCAL CDSU Dept.	1. Completed 2. Completed 3. Completed and initiated 1/1/2024.

Durable Medical Equipment			
Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
	denials to ensure adherence of <= 5% late notification.	Due end of Q4 2023	

Emergency Prospective Review Program (EPRP)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Monitoring of success at compliance with direct admission guidelines for EPRP repatriations. Maintain the Direct admission rate within +/- 5% of 19% for EPRP repatriations.	Follow current direct 18 direct admit criteria. Patients that do not meet direct admit criteria are transferred to the ED.	Brian Muir 2/2/2024	1. Year-end 2023 Direct admit equals 42.2%. This is higher than expected. 2. Patients that did not meet direct admit criteria were diverted to inpatient because ED capacity was limited. 3. NCAL leadership is focusing on improving ED capacity.

End State Renal Disease (ESRD) and Dialysis Center Oversight

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Dialysis Unit Quality Monitor dialysis unit quality: 1. BSI rate < 0.29 2. Peritonitis rates ≤ 0.33	Review clinical quality indicators and any corrective action or performance improvement plans. MD participation in monthly multidisciplinary care team meetings. Root-cause analysis of all BSI's and Peritonitis incidents.	Renal Quality and Performance Improvement Committee Chiefs of Nephrology Continuum Administrators By Dec. 31, 2023	Analysis: - For BSI: KP mean 0.38 Barriers: - For BSI: Central Venous Catheters placements in new ESRD patients have stayed consistently high. This may be due to lack of access to surgery, IR or patient's starting dialysis before permanent access is established. Next Steps: - For BSI: Local medical centers continue to monitor and collaborate locally with Nephrology, Surgery and other key stakeholders, including local dialysis providers. Analysis: - For Peritonitis: 64% of facilities are meeting peritonitis goal (23/36 facilities) Barriers: - For Peritonitis: Peritoneal dialysis is conducted by the patient or care giver and although routine education is provided, patients are at risk for infections. Next Steps: - For Peritonitis: Continue to monitor. Dialysis providers do routine home visits, provide

End State Renal Disease (ESRD) and Dialysis Center Oversight

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
			infection control education and assess patient connections and disconnections annually and after each case of peritonitis.
Home Dialysis [Peritoneal Dialysis (PD) + Home Hemodialysis (HHD) incidence Monitor the home dialysis incidence (peritoneal dialysis and home hemodialysis) and share practices and workflows of the highest performing medical centers. Target: ≥ 36% (changed from last year)	Partner with Vascular Surgery and Interventional Radiology Champions to enhance workflows and guidelines to support consistent peritoneal dialysis catheter placement and repair.	Chiefs of Nephrology Home Dialysis Workgroup By Dec. 31, 2023	Analysis: - Average of 33% of ESRD patients started Home PD or HHD in 2023. Barriers: - For Home Dialysis: Access to OR for PD catheter placements, PD first strategy in the clinics, encourage Home PD/HHD during Options Education with members, expand Home PD Assist program throughout region. Next Steps: - For Home Dialysis: Home Workgroup to meet and develop strategies to encourage Home PD/HHD. DSA to partner with Home Health to expand Home PD Assist program at all internal Home dialysis sites. Continuum to evaluate options to develop Home PD assisted programs with our external PD organizations for the rest of the medical centers.
Hemodialysis central venous catheter (CVC) prevalence Continue to monitor hemodialysis patients with a	Create and leverage weekly reports to proactively monitor patients to get vascular access placed (i.e., AVF or graft)	Chiefs of Nephrology Chiefs of IR and Vascular Surgery	Analysis: Average of 18% of prevalent in-center hemodialysis patients were dialyzing with a

End State Renal Disease (ESRD) and Dialysis Center Oversight

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
CVC in place for more than 90-days Target: ≤ 12% of Hemodialysis patients have a CVC in use for more than 90-days	Utilize tools to monitor timeliness of appointment and OR access for vascular surgery	TPMG Regional Nephrology By Dec. 31, 2023	central venous catheter for more than 90-days in 2023. Barriers: - IR and OR availability for AVF and AVG. - Availability of Vascular Surgeons. Next Steps: - Local adoption of regionally approved Vascular e-consult. OR Schedulers to adhere to booking guidelines as set forth in e-consult. - Partner with POM to create clinical guidelines to mitigate patient delay, surgery cancellations and denial for surgery.
Optimal Starts Target: ≥ 68% Pre-emptive kidney transplantation- National Benchmark is 3.1%	- Encourage consistent utilization of reporting tools and playbooks. - Partnership with vascular, general surgery and interventional radiology champions. - Strengthen shared decision making and supportive care services - Expand use of dialysis vendors' "Options Education" resources	Managers/Directors of Nephrology Chiefs of IR and Vascular Surgery By Dec. 31, 2023	Analysis: - For Optimal Start: Average of 59% of ESRD patients started renal-replacement therapy optimally in 2023. Barriers: - For Optimal Start: Timeliness of vein mapping, access to IR and OR Next Steps: - For Optimal Start: Nephrology departments to partner with IR and Vascular Surgery to develop

End State Renal Disease (ESRD) and Dialysis Center Oversight

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
			local agreements for timely vein mapping and access to surgery for access placement. Analysis: % of Pre-emptive Kidney Transplant: For Q3= 2.5% when comparing Optimal Starts derived data sets with other KP regions. (Q4 data available in April 2024) Barriers: - For Pre-emptive Kidney Transplantation: long wait times in California Next Steps: - For pre-emptive transplantation: HealthConnect trigger for early referral for transplant evaluation. Work with transplant programs to improve living donor identification and engagement. Expand out- of-California kidney transplant options.
Complaints and Grievances To ensure the overall contracted providers are providing adequate care.	Review the complaints and grievances filed by KP members regarding service, quality and care received at contracted dialysis providers and assess for trends. In addition to the standard resolution	Renal Quality and Performance Improvement Committee Chiefs of Nephrology	Analysis: 3 Complaints (all from 1 patient) 4 Grievances $\leq 1\%$ goal met Barriers:

End State Renal Disease (ESRD) and Dialysis Center Oversight

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Target: ≤ 1% of KP members who receive care at a contracted dialysis provider submit a complaint or grievance during the year.	process at the medical centers, complaints and grievances regarding care and services at contracted providers are reviewed monthly during Renal Quality and Performance Improvement committee meetings to identify trends. The committee to inform the local Continuum Administrators to ensure issues are addressed.	Continuum Administrators By Dec. 31, 2023	- Most KP members receive dialysis from a contracted dialysis provider. Site surveys to recredential are conducted every 3 years. Next Steps: - Continue to monitor, follow up and provide oversight for any complaints/grievances and incidents occurring at the dialysis facilities.

Health Engagement Consulting Services

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Local Health Ed Services support: Health Engagement Consulting Services supports medical center infrastructure to provide a standard set of services and ensure fidelity to the model of care and the highest quality and care experience for members.	• Support Motivational Interviewing Excellence with training and skill building for Health Educators • Enhance regional model for online classes in Health Education to support improved access to online classes • Launch a new online class on Whole Food Plant Based Eating	Health Engagement Consulting Services 12/31/23	Analysis • Motivational Interviewing Academy graduated 5 mentors. Skill building through call review is in process. A second cohort of mentors started the academy on Oct 2, 2023. • Regional model for online classes is fully in place and patients are booked into classes across the region. Self-service booking is also newly available. • Whole Food Plant Based Eating online class launched in May, 2023. Since then, 762 patients attended the class. Barriers • Unforeseen attrition during the Motivational Interviewing Academy reduced the number of mentors that completed the program Next Steps • Continue skill building sessions and supports for mentors and mentees • Monitor availability of online classes across the region to meet benchmarks. • Review patient feedback/evaluation of Whole Food Plant Based Eating class and content adjust as needed.
Patient Communication Consulting for Quality Goals: Continue outstanding consulting for	Asthma • Redesign Asthma Action Plans for traditional therapy applying American Academy of Pediatrics	Health Engagement Consulting Services	Analysis • Work was placed on hold

Health Engagement Consulting Services

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
patient messaging around chronic health conditions including: • Asthma • Diabetes • Depression • Colorectal Cancer Screening • Cervical Cancer Screening • Hypertension	recommendations to improve readability and suitability for patient's understanding of how to use their action plan.	12/31/23	Barrier • Resource constraints due to shifting priorities Next steps • Secure staffing to proceed in 2024
	Diabetes • Finalize 1:1 content guide for Type 2 DM and disseminate to Clinical Health Educators (CHEs). • Continue to revise Type 2 DM class curricula (English, Spanish) • Conduct needs assessment on Remote Glucose Monitoring (RGM) that drives increased uptake of tool to manage diabetes.	Health Engagement Consulting Services 12/31/23	Analysis • Revised 2 DM curricula (English). Working on Spanish versions with scheduled timeframe of end of Q1 2024. Barrier • 1:1 content guide was not completed due to resource constraints • Based on needs assessment, created multiple content pieces to promote RGM, including bilingual content on My Doctor Online Next steps • Evaluate success of projects and determine priorities for 2024
	Depression • Review and update depression content. • Conduct needs assessment for online mental health guide.	Health Engagement Consulting Services 12/31/23	Analysis • 12 patient facing depression content products were reviewed, updated or consolidated. • 4 automated patient messages were developed to support completion of online depression screening. Messaging will launch in December. • Developed patient messaging around care options for new depression eVisit.

Health Engagement Consulting Services

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
			Barrier - Teen mental health online health guide is currently paused due to resource constraints. Work will resume Q1 2024. Next steps - Monitor online screening completion rates - Integrate evisit into online resources and monitor utilization.
	Colorectal Cancer Screening - Complete and implement revised FIT kit inreach materials. - Revise FIT instructional video.	Health Engagement Consulting Services 12/31/23	Analysis - Inreach materials complete/live in English, Spanish and Chinese - FIT Kit video completed in English, Spanish and Chinese Barriers - Complex operational environment Next Steps - Integrate and promote instructional video
	Cervical Cancer Screening Pilot home HPV screening outreach.	Health Engagement Consulting Services 12/31/23	Analysis - Outreach materials developed Barrier - Implementation of pilot delayed due to tech issues in data sharing from vendor Next Steps - Implement pilot in Q1 2024

Health Engagement Consulting Services

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
	Hypertension - Develop and disseminate website for CVD Risk Reduction education. - Evaluate asynchronous learning tools to supplement CVD Risk Reduction patient education materials. - Promote and integrate “PHASE on a Page” clinical tool among MD CVD champions. - Update the quality tools button in KPHC to integrate updated quality tools into care delivery. - Conduct systematic review of all CVD prevention patient-facing content to align with national clinical guideline changes.	Health Engagement Consulting Services 12/31/23	Analysis - Heart Healthy Living site for CVD Risk Reduction education launched in English in Feb 2023. Spanish version launched Oct 2023. 500 average monthly views. - Evaluated Heart Health 1:1 appointment utilization by end of year. - Clinical Lead promoted Phase on a Page clinical tool (HTN Lunch & Learn). - Quality tools button was updated with new tools. - Conducted review of CVD prevention content and aligned with clinical guideline changes. Additional goals were prioritized: - Updated regional outreach content to include behavior change principles and implemented bilingual strategy for Spanish-speaking members. - Electronic Medical Record Smart Phrase optimization: evaluated HTN content to streamline options for clinical use. Barriers - Lead time for technology builds Next Steps - Go live with updated HTN Smart Phrases in electronic medical record in early 2024.
Communications Consulting on Patient Facing Tech Tools: Continue outstanding consulting support for TPMG technology	Consultants will work with TPMG Technology leadership, clinical leaders and IT consultants to develop new content on the My	Health Engagement Consulting Services	Results Enhanced Get Care Now virtual care guidance tool

Health Engagement Consulting Services

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
strategy to support patients with online engagement as defined by AED Sponsors	Doctor Online web site to support patient care paths, with a focus on virtual care resources. We will further enhance these digital products with new outreach channels and personalized, relevant information.	12/31/23	- Launched chemotherapy care guide - Launched 10+ health guides on My Doctor Online supporting clinical topics - Launched My Doctor Online App in Spanish Barriers - Resource constraints Next Steps - Continue to develop/enhance digital tools to support patient care

Regional Health Plan Quality

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
To meet NCQA requirements, the NCAL 2023 Quality Program's workplans will be evaluated at the end of the year. Metric: meet the NCQA standard for identifying the review of the 2022 workplans in the 2023 workplan and then evaluating the documents at the end of the year and early in the following year. Submit completed Health Plan Quality Program Description and supporting documents, including workplans and evaluations, to Kaiser Permanente Board of Directors by April 2023.	Facilitate and provide consultation to care delivery subject matter experts for the development of the current year's workplan and the evaluation of the previous year's workplan. Present the evaluations and workplans to the Regional Quality Oversight Committee (QOC) during its routine review of the current year workplans and for the KFHP Board of Directors Quality and Health Improvement Committee.	Regional Hospital Health Plan Quality team April 2023 – QOC September 2023 – QHIC	This goal was added to this workplan in 2023 to demonstrate the oversight of the Health Plan Quality Program Description and supporting documents are reviewed and evaluated annually. The NCAL Regional QOC approved the overall Health Plan Quality Program description and supporting documents that included 2022 evaluations and 2023 workplans in April 2023. The Health Plan Quality Program description and supporting documents were approved by Kaiser Foundation Health Plan Board of Directors at their June 21, 2023 Quality and Health Improvement Committee meeting. The Health Plan Quality Program description and supporting documents will continue to be reviewed and evaluated annually.
Achieve NCQA Accreditation for the Health Equity Program and sustain the Health Plan Accreditation Program Health Equity: - Complete mock survey with zero unachievable recommendations - Achieve Health Equity accreditation by December 2023. Health Plan: - Complete mock survey with zero unachievable recommendations	Key Actions: Host regular standard leads meetings to discuss opportunities for improvement and progress status exchanges. Communicate recommendations from the mock survey to standard leads and complete frequent status exchanges to ensure all recommendations are completed prior to the NCQA Health Equity Survey.	Regional Hospital Health Plan Quality team December 2023 for key actions	Goal met. Analysis: The NCQA Health Equity Accreditation (HEA) mock and Health Plan Accreditation (HPA) mock surveys were both completed with zero unachievable recommendations. Health Equity Accreditation was also achieved by December 2023. Barriers: There were no barriers to meet the listed goals. Next steps: Prepare for the March 2024 NCQA HPA renewal survey and work on a gap analysis for adding the Medicaid line of business to HPA. Maintain existing HEA program.

Regional Health Plan Quality

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
The Quality & Utilization Workgroup completes the DHCS Quality and Utilization Management requirements for the Medi-Cal Direct Contract. Develop the Quality Oversight structure and program for the Medicaid Direct Contract	Key Actions: Actively participate in the Quality and UM (Utilization Management) workgroup - Integrate contract quality improvement and health equity requirements into existing quality oversight structure - Update or create, as applicable, policies and procedures to meet contract requirements for quality and health equity	Regional Hospital Health Plan Quality team December 2023 for key actions	Goal met. Analysis: The Quality & Utilization Workgroup completed all required readiness deliverables and direct contract requirements have been integrated into existing quality oversight structure, including the Quality Program Description and Workplan for 2024. A new department in the Quality and Regulatory Services portfolio was developed to support the direct contract requirements related to quality oversight. Barriers: There are no barriers to report. Next Steps: This goal will be retired and all related work will be managed under the new Medi-Cal Quality team or, as applicable, incorporated into other existing reporting structures throughout the NCAL Quality Program.

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
HEDIS Measures			
The organizational goals for reporting year 2023 for all HEDIS Measures - Exceed or maintain the 75th or 90th percentile for all measures. - Internal targets per individual measure are based on a number of factors including past performance trends and comparison to national benchmarks such as HEDIS percentiles - Link HEDIS measures to quality goal activities. - Identify areas for improvement which link to strategic goals.	Planned Activities for all HEDIS Measures: Report: - HEDIS results to the Quality Oversight Committee Annually - Exceed or maintain the national percentile for HEDIS measures - Distribute the “Crossing the Quality Chasm” performance indicator report to medical centers monthly (some HEDIS measures are also CQC measures) Data: - All clinical leads to work with HealthConnect staff to ensure data collection remains consistent Outreach: - Provide member outreach through appointment reminder mailings, invitations to health classes, and phone calls. Inreach: - Refer to the CQC and PHM sections (HEDIS measures highlighted) attached below for additional interventions for select measures - Clinical Practice Guidelines (CPGs) are developed to assist clinicians by providing an evidence-based analytic framework for the evaluation and treatment of selected common problems in patients, and to support clinical decisions by practitioners at the point of care in the provision of	Regional Medical Director Outpatient Quality Annual June 2023	<u>Analysis of Results:</u> The organizational goals for reporting year 2023 for all HEDIS Measures (Note: Individual measure goals can be found in the HEDIS Measure Table in the Workplan Summary): - Exceed or maintain the 75th or 90th percentile for all members. - Link HEDIS measures to quality goal activities - Identify areas for improvement which link to strategic goals. The organization closely tracks and monitors the performance on all HEDIS measure and targets those critical measures on which the organization has not performed well for inclusion on the Crossing the Quality Chasm (CQC) dashboard. Inclusion on the dashboard ensures the focus of the entire organization in strategic efforts to improve performance for that performance year. National benchmarks are used to set internal targets for performance and improvement. <u>Barriers/ Next Steps:</u> Refer to the CQC sections attached below for Barriers/Next Steps by measure. Planned Activities for all HEDIS Measures: Report: - HEDIS results to the Quality Oversight Committee Annually - Exceed or maintain the national percentile for HEDIS measures. - Distribute the “Crossing the Quality Chasm” performance indicator report to medical centers

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
	acute, chronic, preventive care, and behavioral health services. The use of CPGs by practitioners assists KFHP by ensuring that the care provided to members is evidence-based and consistent with professionally recognized standards of care. Development of CPGs is prioritized based on established criteria, which include: number of patients affected by a particular condition/need, quality of care concerns and/or excessive variation in clinical practice, regulatory issues, payor interests, cost, operational needs, leadership priorities and prerogatives. CPGs are not used to make utilization management determinations regarding the medical necessity of a member's care. Reducing Variation: The regional team is assessing common practices among top five NCAL performers; spreading these techniques to achieve more standardization.		monthly (Some HEDIS measures are also CQC measures) Data: HealthConnect staff to ensure data collection remains consistent

HEDIS - Commercial			
Measure/Data Element	Rate RY 2022	Rate RY 2023	Change
Effectiveness of Care			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)</i>	90.51%	92.13%	1.62%
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)</i>	85.00%	83.68%	-1.32%

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)</i>	84.92%	83.62%	-1.30%
Childhood Immunization Status (CIS)			
<i>Childhood Immunization Status - DTaP</i>	90.99%	91.24%	0.25%
<i>Childhood Immunization Status - IPV</i>	94.61%	94.07%	-0.54%
<i>Childhood Immunization Status - MMR</i>	92.80%	94.35%	1.55%
<i>Childhood Immunization Status - HiB</i>	94.51%	94.63%	0.12%
<i>Childhood Immunization Status - Hepatitis B</i>	95.12%	95.20%	0.08%
<i>Childhood Immunization Status - VZV</i>	92.70%	94.63%	1.93%
<i>Childhood Immunization Status - Pneumococcal Conjugate</i>	89.69%	88.98%	-0.71%
<i>Childhood Immunization Status - Hepatitis A</i>	92.88%	94.92%	2.04%
<i>Childhood Immunization Status - Rotavirus</i>	91.00%	90.40%	-0.60%
<i>Childhood Immunization Status - Influenza</i>	78.30%	77.68%	-0.62%
<i>Childhood Immunization Status - Combo 3</i>	87.17%	87.01%	-0.16%
<i>Childhood Immunization Status - Combo 7</i>	84.81%	83.62%	-1.19%
<i>Childhood Immunization Status - Combo 10</i>	72.90%	71.75%	-1.15%
Immunizations for Adolescents (IMA)			
<i>Immunizations for Adolescents - Meningococcal</i>	89.08%	90.24%	1.16%
<i>Immunizations for Adolescents - Tdap</i>	93.31%	94.63%	1.32%
<i>Immunizations for Adolescents - HPV</i>	62.27%	67.45%	5.18%
<i>Immunizations for Adolescents - Combination 1</i>	87.95%	89.33%	1.38%
<i>Immunizations for Adolescents - Combination 2</i>	60.89%	66.34%	5.45%
Breast Cancer Screening (BCS)			
<i>Breast Cancer Screening</i>	75.63%	83.39%	7.76%
Cervical Cancer Screening (CCS)			
<i>Cervical Cancer Screening</i>	85.89%	83.86%	-2.03%
Colorectal Cancer Screening (COL)			
<i>Colorectal Cancer Screening</i>	76.16%	68.72%	-7.44%
Chlamydia Screening in Women (CHL)			

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
<i>Chlamydia Screening in Women (16-20)</i>	51.58%	50.89%	-0.69%
<i>Chlamydia Screening in Women (21-24)</i>	67.21%	64.58%	-2.63%
<i>Chlamydia Screening in Women (Total)</i>	60.44%	58.59%	-1.85%
Appropriate Testing for Pharyngitis (CWP)			
<i>Appropriate Testing for Pharyngitis (3-17)</i>	16.15%	73.52%	57.37%
<i>Appropriate Testing for Pharyngitis (18-64)</i>	10.83%	29.73%	18.90%
<i>Appropriate Testing for Pharyngitis (65+)</i>	5.00%	19.79%	14.79%
<i>Appropriate Testing for Pharyngitis (Total)</i>	11.69%	36.55%	24.86%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)			
<i>Use of Spirometry Testing in the Assessment and Diagnosis of COPD</i>	25.19%	24.14%	-1.05%
Pharmacotherapy Management of COPD Exacerbation (PCE)			
<i>Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid</i>	86.03%	88.08%	2.05%
<i>Pharmacotherapy Management of COPD Exacerbation - Bronchodilator</i>	91.59%	93.83%	2.24%
Asthma Medication Ratio (AMR)			
<i>Asthma Medication Ratio (5-11)</i>	93.07%	91.36%	-1.71%
<i>Asthma Medication Ratio (12-18)</i>	90.08%	88.64%	-1.44%
<i>Asthma Medication Ratio (19-50)</i>	85.17%	84.44%	-0.73%
<i>Asthma Medication Ratio (51-64)</i>	90.09%	89.25%	-0.84%
<i>Asthma Medication Ratio (Total)</i>	87.90%	87.06%	-0.84%
Controlling High Blood Pressure (CBP)			
<i>Controlling High Blood Pressure</i>	71.12%	75.78%	4.66%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)			
<i>Persistence of Beta-Blocker Treatment After a Heart Attack</i>	93.89%	91.91%	-1.98%
Statin Therapy for Patients With Cardiovascular Disease (SPC)			
<i>Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (M 21-75)</i>	90.67%	90.51%	-0.16%

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
<i>Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (M 21-75)</i>	83.25%	82.27%	-0.98%
<i>Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (F 40-75)</i>	84.01%	84.36%	0.35%
<i>Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (F 40-75)</i>	81.84%	80.82%	-1.02%
<i>Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)</i>	89.17%	89.19%	0.02%
<i>Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)</i>	82.95%	81.97%	-0.98%
Cardiac Rehabilitation			
<i>Initiation (Total)</i>	22.26%	22.50%	0.24%
<i>Engagement 1 (Total)</i>	0.15%	0.65%	0.50%
<i>Engagement 2 (Total)</i>	0.00%	0.46%	0.46%
<i>Achievement (Total)</i>	0.00%	0.36%	0.36%
Comprehensive Diabetes Care (CDC)			
<i>Comprehensive Diabetes Care - Poor HbA1c Control</i>	24.45%	27.68%	3.23%
<i>Comprehensive Diabetes Care - HbA1c Control (<8%)</i>	62.38%	60.18%	-2.20%
<i>Comprehensive Diabetes Care - Eye Exams</i>	69.77%	77.10%	7.33%
<i>Comprehensive Diabetes Care - Blood Pressure Control (<140/90)</i>	69.42%	75.42%	6.00%
Kidney Health Evaluation for Patients With Diabetes (KED)			
<i>Kidney Health Evaluation for Patients With Diabetes (18-64)</i>	80.85%	77.16%	-3.69%
<i>Kidney Health Evaluation for Patients With Diabetes (65-74)</i>	87.29%	84.58%	-2.71%
<i>Kidney Health Evaluation for Patients With Diabetes (75-85)</i>	79.27%	76.13%	-3.14%
<i>Kidney Health Evaluation for Patients With Diabetes (Total)</i>	81.47%	77.90%	-3.57%
Statin Therapy for Patients With Diabetes (SPD)			
<i>Statin Therapy for Patients With Diabetes - Received Statin Therapy</i>	76.46%	75.21%	-1.25%
<i>Statin Therapy for Patients With Diabetes - Statin Adherence 80%</i>	78.91%	78.58%	-0.33%
Antidepressant Medication Management (AMM)			

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
<i>Antidepressant Medication Management - Effective Acute Phase Treatment</i>	81.38%	82.35%	0.97%
<i>Antidepressant Medication Management - Effective Continuation Phase Treatment</i>	59.98%	59.31%	-0.67%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)			
<i>Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase</i>	74.15%	81.96%	7.81%
<i>Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase</i>	76.05%	82.28%	6.23%
Follow-up After Hospitalization for Mental Illness (FUH)			
<i>Follow-Up After Hospitalization For Mental Illness - 30 days (6-17)</i>	79.18%	92.46%	13.28%
<i>Follow-Up After Hospitalization For Mental Illness - 7 days (6-17)</i>	52.74%	80.60%	27.86%
<i>Follow-Up After Hospitalization For Mental Illness - 30 days (18-64)</i>	74.75%	83.86%	9.11%
<i>Follow-Up After Hospitalization For Mental Illness - 7 days (18-64)</i>	50.30%	68.67%	18.37%
<i>Follow-Up After Hospitalization For Mental Illness - 30 days (65+)</i>	82.50%	73.53%	-8.97%
<i>Follow-Up After Hospitalization For Mental Illness - 7 days (65+)</i>	50.00%	55.88%	5.88%
<i>Follow-Up After Hospitalization For Mental Illness - 30 days (Total)</i>	76.30%	86.52%	10.22%
<i>Follow-Up After Hospitalization For Mental Illness - 7 days (Total)</i>	51.11%	72.37%	21.26%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			
<i>Follow-Up After Emergency Department Visit for Mental Illness - 30 days (6-17)</i>	79.85%	86.68%	6.83%
<i>Follow-Up After Emergency Department Visit for Mental Illness - 7 days (6-17)</i>	72.24%	81.48%	9.24%
<i>Follow-Up After Emergency Department Visit for Mental Illness - 30 days (18-64)</i>	68.64%	76.29%	7.65%
<i>Follow-Up After Emergency Department Visit for Mental Illness - 7 days (18-64)</i>	60.60%	67.47%	6.87%
<i>Follow-Up After Emergency Department Visit for Mental Illness - 30 days (65+)</i>	54.05%	60.47%	6.42%

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
<i>Follow-Up After Emergency Department Visit for Mental Illness - 7 days (65+)</i>	51.35%	53.49%	2.14%
<i>Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)</i>	71.23%	78.95%	7.72%
<i>Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)</i>	63.39%	71.16%	7.77%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)			
<i>Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (13-17)</i>	47.06%	55.79%	8.73%
<i>Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (13-17)</i>	19.61%	29.47%	9.86%
<i>Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (18-64)</i>	62.71%	67.40%	4.69%
<i>Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64)</i>	42.55%	47.06%	4.51%
<i>Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)</i>	61.76%	66.92%	5.16%
<i>Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)</i>	41.04%	46.36%	5.32%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)			
<i>Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (13-17)</i>	32.47%	42.05%	9.58%
<i>Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (13-17)</i>	25.97%	31.82%	5.85%
<i>Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (18+)</i>	37.00%	45.53%	8.53%
<i>Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (18+)</i>	26.28%	32.44%	6.16%
<i>Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (Total)</i>	36.87%	45.34%	8.47%
<i>Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (Total)</i>	26.27%	32.41%	6.14%
Pharmacotherapy for Opioid Use Disorder (POD)			
<i>Pharmacotherapy for Opioid Use Disorder (18-64)</i>	21.90%	27.27%	5.37%
<i>Pharmacotherapy for Opioid Use Disorder (65+)</i>	34.21%	NA	NA

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
<i>Pharmacotherapy for Opioid Use Disorder (Total)</i>	22.21%	27.75%	5.54%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)			
<i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia</i>	69.59%	71.00%	1.41%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)			
<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (1-11)</i>	64.26%	63.14%	-1.12%
<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (1-11)</i>	59.67%	55.77%	-3.90%
<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (1-11)</i>	58.69%	54.49%	-4.20%
<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (12-17)</i>	65.69%	74.86%	9.17%
<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (12-17)</i>	59.19%	56.08%	-3.11%
<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (12-17)</i>	57.65%	55.25%	-2.40%
<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)</i>	65.44%	72.78%	7.34%
<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)</i>	59.27%	56.02%	-3.25%
<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)</i>	57.83%	55.11%	-2.72%
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)			
<i>Non-Recommended Cervical Cancer Screening in Adolescent Females (low rate better)</i>	0.07%	0.08%	0.01%
Appropriate Treatment for Upper Respiratory Infection (URI)			
<i>Appropriate Treatment for Upper Respiratory Infection (3 Months-17 Years)</i>	98.48%	98.59%	0.11%
<i>Appropriate Treatment for Upper Respiratory Infection (18-64)</i>	95.73%	94.26%	-1.47%
<i>Appropriate Treatment for Upper Respiratory Infection (65+)</i>	93.38%	92.95%	-0.43%
<i>Appropriate Treatment for Upper Respiratory Infection (Total)</i>	96.50%	96.34%	-0.16%

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)			
<i>Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 -17 Years)</i>	98.48%	94.34%	-4.14%
<i>Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)</i>	95.73%	82.28%	-13.45%
<i>Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (65+)</i>	93.38%	73.08%	-20.30%
<i>Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)</i>	96.50%	86.39%	-10.11%
Use of Imaging Studies for Low Back Pain (LBP)			
<i>Use of Imaging Studies for Low Back Pain</i>	85.00%	82.90%	-2.10%
Use of Opioids at High Dosage (HDO)			
<i>Use of Opioids at High Dosage (low rate better)</i>	2.39%	2.09%	-0.30%
Use of Opioids From Multiple Providers (UOP) (low rate better)			
<i>Use of Opioids From Multiple Providers - Multiple Prescribers</i>	24.85%	24.52%	-0.33%
<i>Use of Opioids From Multiple Providers - Multiple Pharmacies</i>	1.68%	1.76%	0.08%
<i>Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies</i>	1.10%	1.11%	0.01%
Risk of Continued Opioid Use (COU) (low rate better)			
<i>Risk of Continued Opioid Use - >=15 Days (18-54)</i>	3.74%	3.47%	-0.27%
<i>Risk of Continued Opioid Use - >=31 Days (18-54)</i>	1.23%	1.16%	-0.07%
<i>Risk of Continued Opioid Use - >=15 Days (65+)</i>	8.05%	7.96%	-0.09%
<i>Risk of Continued Opioid Use - >=31 Days (65+)</i>	2.50%	2.86%	0.36%
<i>Risk of Continued Opioid Use - >=15 Days (Total)</i>	3.92%	3.67%	-0.25%
<i>Risk of Continued Opioid Use - >=31 Days (Total)</i>	1.28%	1.23%	-0.05%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP)			
<i>Adults' Access to Preventive/Ambulatory Health Services (20-44)</i>	91.96%	91.64%	-0.32%
<i>Adults' Access to Preventive/Ambulatory Health Services (45-64)</i>	94.21%	93.91%	-0.30%
<i>Adults' Access to Preventive/Ambulatory Health Services (65+)</i>	95.47%	94.94%	-0.53%

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management				
Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024)	
			1. Analysis of results including metrics 2. Barriers 3. Next steps	
<i>Adults' Access to Preventive/Ambulatory Health Services (Total)</i>	93.17%	92.84%	-0.33%	
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)				
<i>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (Total)</i>	55.58%	49.62%	-5.96%	
<i>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (Total)</i>	28.28%	17.83%	-10.45%	
<i>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (Total)</i>	64.13%	72.16%	8.03%	
<i>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (Total)</i>	39.36%	42.79%	3.43%	
<i>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (Total)</i>	46.68%	51.06%	4.38%	
<i>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (Total)</i>	16.57%	13.69%	-2.88%	
<i>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (Total)</i>	52.99%	51.48%	-1.51%	
<i>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (Total)</i>	25.13%	18.00%	-7.13%	
Prenatal and Postpartum Care (PPC)				
<i>Prenatal and Postpartum Care - Timeliness of Prenatal Care</i>	95.39%	95.35%	-0.04%	
<i>Prenatal and Postpartum Care - Postpartum Care</i>	94.77%	91.86%	-2.91%	
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
<i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1-11)</i>	76.67%	73.44%	-3.23%	
<i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12-17)</i>	76.92%	77.87%	0.95%	
<i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)</i>	76.89%	77.46%	0.57%	

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
<i>Well-Child Visits in the First 30 Months of Life (First 15 Months) (MY 2022 - 6 or more)</i>	56.78%	64.29%	7.51%
<i>Well-Child Visits in the First 30 Months of Life (15 Months-30 Months) (MY 2022 - 2 or more)</i>	59.47%	75.67%	16.20%
Child and Adolescent Well-Care Visits (WCV)			
<i>Child and Adolescent Well-Care Visits (3-11)</i>	59.55%	60.71%	1.16%
<i>Child and Adolescent Well-Care Visits (12-17)</i>	57.27%	53.51%	-3.76%
<i>Child and Adolescent Well-Care Visits (18-21)</i>	24.29%	24.50%	0.21%
<i>Child and Adolescent Well-Care Visits (Total)</i>	51.05%	50.29%	-0.76%
Electronic Clinical Data Systems			
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)			
<i>Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Total)</i>	12.55%	11.77%	-0.78%
<i>Depression Screening and Follow-Up for Adolescents and Adults - Follow-up on Positive Screen (Total)</i>	84.09%	83.52%	-0.57%
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)			
<i>Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period1 (Total)</i>	58.73%	59.67%	0.94%
<i>Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period2 (Total)</i>	58.56%	58.99%	0.43%
<i>Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period3 (Total)</i>	59.42%	58.46%	-0.96%
<i>Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Total (Total)</i>	58.90%	59.04%	0.14%
Depression Remission or Response for Adolescents and Adults (DRR-E)			
<i>Depression Remission or Response for Adolescents and Adults - Follow-up PHQ-9 (Total)</i>	41.99%	43.01%	1.02%
<i>Depression Remission or Response for Adolescents and Adults - Depression Remission (Total)</i>	8.34%	7.57%	-0.77%

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
<i>Depression Remission or Response for Adolescents and Adults - Depression Response (Total)</i>	16.27%	15.32%	-0.95%
Prenatal Immunization Status (PRS-E)			
<i>Prenatal Immunization Status - Influenza</i>	68.39%	58.70%	-9.69%
<i>Prenatal Immunization Status - Tdap</i>	90.06%	90.17%	0.11%
<i>Prenatal Immunization Status - Combination</i>	65.75%	57.10%	-8.65%

HEDIS - MediCare

Measure/Data Element	Reporting Year 2022	Reporting Year 2023	Change
Effectiveness of Care			
Breast Cancer Screening (BCS)			
<i>Breast Cancer Screening - Non-LIS/DE Nondisability</i>	82.28%	88.04%	5.76%
<i>Breast Cancer Screening - LIS/DE</i>	75.92%	83.76%	7.84%
<i>Breast Cancer Screening - Disability</i>	75.16%	82.54%	7.38%
<i>Breast Cancer Screening - LIS/DE and Disability</i>	68.65%	76.65%	8.00%
<i>Breast Cancer Screening - Other</i>	83.86%	87.88%	4.02%
<i>Breast Cancer Screening - Unknown</i>	82.86%	NA	NA
<i>Breast Cancer Screening - Total</i>	80.73%	86.83%	6.10%
Colorectal Cancer Screening (COL)			
<i>Colorectal Cancer Screening - Non-LIS/DE Nondisability</i>	88.12%	87.92%	-0.20%
<i>Colorectal Cancer Screening - LIS/DE</i>	85.30%	84.28%	-1.02%
<i>Colorectal Cancer Screening - Disability</i>	83.00%	82.19%	-0.81%
<i>Colorectal Cancer Screening - LIS/DE and Disability</i>	77.64%	74.13%	-3.51%
<i>Colorectal Cancer Screening - Other</i>	88.97%	87.20%	-1.77%
<i>Colorectal Cancer Screening - Unknown</i>	85.15%	88.10%	2.95%
<i>Colorectal Cancer Screening - Total</i>	87.12%	86.61%	-0.51%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)			

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
<i>Use of Spirometry Testing in the Assessment and Diagnosis of COPD</i>	26.89%	28.83%	1.94%
Pharmacotherapy Management of COPD Exacerbation (PCE)			
<i>Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid</i>	82.05%	87.09%	5.04%
<i>Pharmacotherapy Management of COPD Exacerbation - Bronchodilator</i>	92.94%	96.06%	3.12%
Controlling High Blood Pressure (CBP)			
<i>Controlling High Blood Pressure</i>	78.80%	83.87%	5.07%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)			
<i>Persistence of Beta-Blocker Treatment After a Heart Attack</i>	95.29%	96.29%	1.00%
Statin Therapy for Patients With Cardiovascular Disease (SPC)			
<i>Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (M 21-75)</i>	90.77%	91.44%	0.67%
<i>Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (M 21-75)</i>	91.99%	91.36%	-0.63%
<i>Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (F 40-75)</i>	87.73%	87.97%	0.24%
<i>Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (F 40-75)</i>	90.50%	90.44%	-0.06%
<i>Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)</i>	89.81%	90.33%	0.52%
<i>Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)</i>	91.53%	91.07%	-0.46%
Comprehensive Diabetes Care (CDC)			
<i>Comprehensive Diabetes Care - Poor HbA1c Control >9% (low rate better)</i>	11.68%	14.64%	2.96%
<i>Comprehensive Diabetes Care - HbA1c Control (<8%)</i>	76.56%	75.70%	-0.86%
<i>Comprehensive Diabetes Care - Blood Pressure Control (<140/90)</i>	79.13%	85.30%	6.17%
<i>Comprehensive Diabetes Care - Eye Exams - Non-LIS/DE Nondisability</i>	83.96%	88.31%	4.35%
<i>Comprehensive Diabetes Care - Eye Exams - LIS/DE</i>	83.89%	88.50%	4.61%

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
<i>Comprehensive Diabetes Care - Eye Exams - Disability</i>	77.87%	82.96%	5.09%
<i>Comprehensive Diabetes Care - Eye Exams - LIS/DE and Disability</i>	77.33%	82.39%	5.06%
<i>Comprehensive Diabetes Care - Eye Exams - Other</i>	62.60%	72.65%	10.05%
<i>Comprehensive Diabetes Care - Eye Exams - Unknown</i>	84.09%	N/A	N/A
<i>Comprehensive Diabetes Care - Eye Exams - Total</i>	82.60%	87.14%	4.54%
Kidney Health Evaluation for Patients With Diabetes (KED)			
<i>Kidney Health Evaluation for Patients With Diabetes (18-64)</i>	82.29%	80.14%	-2.15%
<i>Kidney Health Evaluation for Patients With Diabetes (65-74)</i>	89.26%	87.32%	-1.94%
<i>Kidney Health Evaluation for Patients With Diabetes (75-85)</i>	83.46%	81.28%	-2.18%
<i>Kidney Health Evaluation for Patients With Diabetes (Total)</i>	86.79%	84.71%	-2.08%
Statin Therapy for Patients With Diabetes (SPD)			
<i>Statin Therapy for Patients With Diabetes - Received Statin Therapy</i>	86.87%	87.24%	0.37%
<i>Statin Therapy for Patients With Diabetes - Statin Adherence 80%</i>	89.87%	90.01%	0.14%
Osteoporosis Management in Women Who Had a Fracture (OMW)			
<i>Osteoporosis Management in Women Who Had a Fracture</i>	82.56%	84.68%	2.12%
<i>Osteoporosis Screening in Older Women</i>	70.40%	73.02%	2.62%
Antidepressant Medication Management (AMM)			
<i>Antidepressant Medication Management - Effective Acute Phase Treatment</i>	86.39%	87.81%	1.42%
<i>Antidepressant Medication Management - Effective Continuation Phase Treatment</i>	65.03%	67.11%	2.08%
Follow-up After Hospitalization for Mental Illness (FUH)			
<i>Follow-Up After Hospitalization For Mental Illness - 30 days (18-64)</i>	84.87%	86.14%	1.27%
<i>Follow-Up After Hospitalization For Mental Illness - 7 days (18-64)</i>	68.77%	72.87%	4.10%
<i>Follow-Up After Hospitalization For Mental Illness - 30 days (65+)</i>	73.12%	82.96%	9.84%
<i>Follow-Up After Hospitalization For Mental Illness - 7 days (65+)</i>	53.23%	66.17%	12.94%

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
<i>Follow-Up After Hospitalization For Mental Illness - 30 days (Total)</i>	79.98%	84.73%	4.75%
<i>Follow-Up After Hospitalization For Mental Illness - 7 days (Total)</i>	62.30%	69.89%	7.59%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			
<i>Follow-Up After Emergency Department Visit for Mental Illness - 30 days (18-64)</i>	81.82%	82.24%	0.42%
<i>Follow-Up After Emergency Department Visit for Mental Illness - 7 days (18-64)</i>	74.83%	71.65%	-3.18%
<i>Follow-Up After Emergency Department Visit for Mental Illness - 30 days (65+)</i>	66.07%	73.87%	7.80%
<i>Follow-Up After Emergency Department Visit for Mental Illness - 7 days (65+)</i>	58.63%	66.03%	7.40%
<i>Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)</i>	73.31%	77.49%	4.18%
<i>Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)</i>	66.08%	68.46%	2.38%
Follow-Up After High-Intensity Care for Substance Use Disorder			
<i>Within 30 days of Visit or Discharge (18+)</i>	52.62%	52.92%	0.30%
<i>Within 7 days of Visit or Discharge (18+)</i>	30.37%	30.67%	0.30%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)			
<i>Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (18+)</i>	54.22%	53.65%	-0.57%
<i>Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (18+)</i>	45.24%	37.35%	-7.89%
Pharmacotherapy for Opioid Use Disorder			
<i>Total (Ages 18+)</i>	36.01%	49.85%	13.84%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)			
<i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia</i>	80.76%	80.89%	0.13%
Transitions of Care (TRC)			
<i>Transitions of Care - Notification of Inpatient Admission (Total)</i>	94.00%	93.75%	-0.25%

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

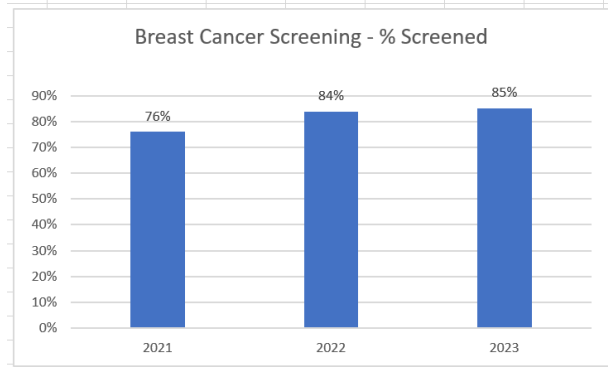
Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
<i>Transitions of Care - Receipt of Discharge Information (Total)</i>	79.00%	80.90%	1.90%
<i>Transitions of Care - Patient Engagement After Inpatient Discharge (Total)</i>	97.64%	99.65%	2.01%
<i>Transitions of Care - Medication Reconciliation Post-Discharge (Total)</i>	97.04%	99.65%	2.61%
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)			
<i>Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (18-64)</i>	82.55%	78.07%	-4.48%
<i>Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (65+)</i>	78.55%	74.84%	-3.71%
<i>Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (Total)</i>	78.89%	75.10%	-3.79%
Non-Recommended PSA-Based Screening in Older Men (PSA)			
<i>Non-Recommended PSA-Based Screening in Older Men</i>	14.36%	11.26%	-3.10%
Potentially Harmful Drug-Disease Interactions in Older Adults (DDE)			
<i>Potentially Harmful Drug-Disease Interactions in Older Adults - DDI Falls + Anticonvulsants, Nonbenzodiazepine hypnotics, SSRIs, Antiemetics, Antipsychotics, Benzodiazepines or Tricyclic Antidepressants</i>	29.13%	30.01%	0.88%
<i>Potentially Harmful Drug-Disease Interactions in Older Adults - DDI Dementia + Antiemetics, Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine hypnotics or Anticholinergic Agents</i>	22.51%	23.45%	0.94%
<i>Potentially Harmful Drug-Disease Interactions in Older Adults - DDI Chronic Kidney Disease + Cox-2 Selective NSAIDs or Nonaspirin NSAIDs</i>	2.98%	3.54%	0.56%
<i>Potentially Harmful Drug-Disease Interactions in Older Adults - Total</i>	20.73%	21.70%	0.97%
Use of High-Risk Medications in Older Adults (DAE)			
<i>Use of High-Risk Medications in Older Adults - High Risk Medications to Avoid (MY 2022: Two Dispensings from Same Drug Class)</i>	5.68%	5.82%	0.14%

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management				
Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps	
Use of High-Risk Medications in Older Adults - High Risk Medication to avoid except for Appropriate diagnosis (Two Dispensings - Except Appropriate Diagnoses)	2.83%	2.72%	-0.11%	
Use of High-Risk Medications in Older Adults - Total	8.09%	8.13%	0.04%	
Use of Opioids at High Dosage (HDO)				
Use of Opioids at High Dosage (low rate better)	3.23%	2.84%	-0.39%	
Use of Opioids From Multiple Providers (UOP)- (low rate better)				
Use of Opioids From Multiple Providers - Multiple Prescribers	22.38%	23.41%	1.03%	
Use of Opioids From Multiple Providers - Multiple Pharmacies	1.01%	1.15%	0.14%	
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies	0.64%	0.67%	0.03%	
Risk of Continued Opioid Use (COU)				
Risk of Continued Opioid Use - >=15 Days (18-64)	8.30%	7.59%	-0.71%	
Risk of Continued Opioid Use - >=31 Days (18-64)	4.56%	4.35%	-0.21%	
Risk of Continued Opioid Use - >=15 Days (65+)	7.29%	6.72%	-0.57%	
Risk of Continued Opioid Use - >=31 Days (65+)	3.22%	2.96%	-0.26%	
Risk of Continued Opioid Use - >=15 Days (Total)	7.39%	6.79%	-0.60%	
Risk of Continued Opioid Use - >=31 Days (Total)	3.34%	3.08%	-0.26%	
Access/Availability of Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Adults' Access to Preventive/Ambulatory Health Services (20-44)	96.55%	96.32%	-0.23%	
Adults' Access to Preventive/Ambulatory Health Services (45-64)	97.18%	96.93%	-0.25%	
Adults' Access to Preventive/Ambulatory Health Services (65+)	95.69%	95.53%	-0.16%	
Adults' Access to Preventive/Ambulatory Health Services (Total)	95.75%	95.58%	-0.17%	
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (18+)	47.97%	50.04%	2.07%	

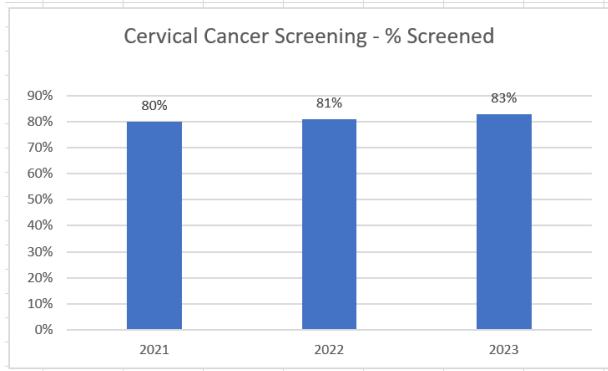
HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
<i>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (18+)</i>	12.77%	7.85%	-4.92%
<i>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (18+)</i>	48.09%	63.86%	15.77%
<i>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (18+)</i>	14.31%	21.36%	7.05%
<i>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (18+)</i>	41.74%	54.11%	12.37%
<i>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (18+)</i>	7.35%	7.13%	-0.22%
<i>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (18+)</i>	46.43%	52.22%	5.79%
<i>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (18+)</i>	11.61%	8.98%	-2.63%

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps								
Crossing the Quality Chasm											
Breast Cancer • 2023 target 84%	- Continue monitoring performance - Continue partnering with Radiology and Quality to ensure access needs - Continue supporting inreach efforts - Identify and share best practices for access	Medical Director for Quality Monthly	<u>Analysis</u> Target achieved. 85% of patients screened within the past 24 months as of December 2023. The chart below shows trended performance data for the past three years.  <table><caption>Breast Cancer Screening - % Screened</caption><thead><tr><th>Year</th><th>% Screened</th></tr></thead><tbody><tr><td>2021</td><td>76%</td></tr><tr><td>2022</td><td>84%</td></tr><tr><td>2023</td><td>85%</td></tr></tbody></table> <u>Next steps</u> - Share best practices from top performing facilities - Prepare for potential USPSTF changes in screening start age - Monitor screening for the 40-49 age group in the CQC backpage - Update PROMPT and all inreach and outreach content with new screening start age	Year	% Screened	2021	76%	2022	84%	2023	85%
Year	% Screened										
2021	76%										
2022	84%										
2023	85%										
Cervical Cancer Screening • 2023 target 84%	Anticipated increased appointment access (March 2023-September 2023) to focus on backlog reduction. There will be	Medical Director for Quality	<u>Analysis</u> Target not achieved. 83% of patients screened within the past 36 months as of December 2023.								

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
	coordination of regional and local outreach efforts to address this backlog. - Regional support of inreach view adjustments to maximize backlog reduction and simultaneously continue screening the coming due population - Identify and share best practices for access	Monthly	The chart below shows trended performance data for the past three years.  Barriers - Staffing challenges particularly in certain facilities - No resources available to add extra CCS units Next steps - Share best practices from top performing facilities - PROMPT updates to support 2024 demand smoothing - Focus on presweep and inreach efforts in 2024 - Home HPV self-collection pilot in NVL
Colorectal Cancer Screening • 2023 target 81% (for 51–75-year-olds)	Conduct a current state assessment of how local outreach is conducted across	Medical Director for Quality	Analysis Target Not Achieved. 79% of 51–75-year-old patients screened as of December 2023. The chart

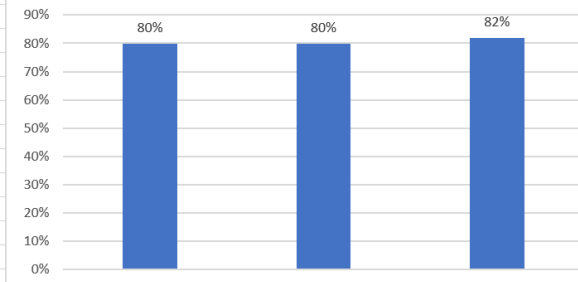
HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps								
	the region to help identify solutions to improve local outreach. • Implement new FIT kit instruction sheet designed to make instructions clearer for members. • Hold a training for Inreach best practices for Medical Assistants. • Pilot and implement new Small Media postcard during Regional Outreach for the general population (similar to tailored material currently used for African American and Latino American populations).	Monthly	below shows trended performance data for the past three years. Note: 2024 CRC Target will align with HEDIS Specs • Frontpage measure: 45-75 yr olds (target=78%) Colorectal Cancer Screening - % Screened <table><thead><tr><th>Year</th><th>% Screened</th></tr></thead><tbody><tr><td>2021</td><td>79%</td></tr><tr><td>2022</td><td>78%</td></tr><tr><td>2023</td><td>79%</td></tr></tbody></table> <u>Barriers</u> • Lab capacity concerns • USPS mailing changes • Bad addresses in the electronic medical record/challenges in correcting • Proper FIT labeling/expired FIT kit • Cologuard uptake lower than expected due a conservative approach to offering the test <u>Next steps</u> • Participation in the American Medical Group Association (AMGA) Colorectal Cancer Best Practices Learning	Year	% Screened	2021	79%	2022	78%	2023	79%
Year	% Screened										
2021	79%										
2022	78%										
2023	79%										

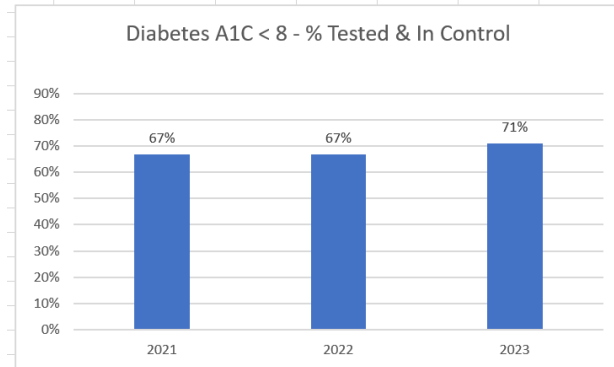
HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
			Collaborative to gather innovative ideas from outside organizations • Development of a robust 'back-to-basics for Inreach' campaign that will launch during CRC Awareness Month (Mar) • Investigate the appropriateness of replicating and spreading the Midreach plan developed by the Diablo Service Area • Circulate new FIT instruction video (launched Jan 2024) • Expanding the Cologuard program to a wider and targeted audience • Support lab initiative to streamline processing efficiency to improve Test Not Done (TND) rates
Cardiovascular Health			
Diabetes A1C ≤ 9 • 2023 target 83%	• Continue to explore new outreach channels • Increase remote glucose monitoring/continuous glucose monitoring adoption and utilization • Partner with low-performing medical centers to remove barriers and offer regional support	Medical Director for Population Care Monthly	<u>Analysis</u> Target Not Achieved. 82% of patients tested and in control as of December 2023. This is a 2 percentage point increase from December 2022. The chart below shows trended performance data for the past three years.

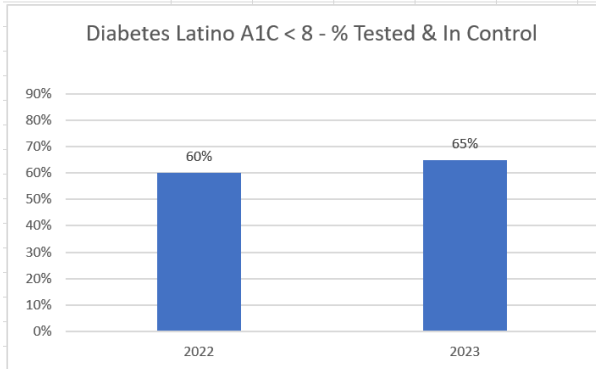
HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps								
			Diabetes A1C ≤ 9 - % Tested & In Control <table><thead><tr><th>Year</th><th>% Tested & In Control</th></tr></thead><tbody><tr><td>2021</td><td>80%</td></tr><tr><td>2022</td><td>80%</td></tr><tr><td>2023</td><td>82%</td></tr></tbody></table> <u>Barriers</u> • Growing incidence of Diabetes in Northern California relative to the rest of the nation <u>Next steps</u> • Improve use of remote glucose monitoring devices. • Encourage expanded lab access and after hours outreach. • Encourage treatment intensification for patients who are in and out of control. • Encourage use of health education support; encourage patient direct-booking of online HED classes. • Routine communication about best practices and promoting the use of performance dashboards. • Expanding creative outreach channels such as texting • Utilize THRIVE local to address SDOH.	Year	% Tested & In Control	2021	80%	2022	80%	2023	82%
Year	% Tested & In Control										
2021	80%										
2022	80%										
2023	82%										

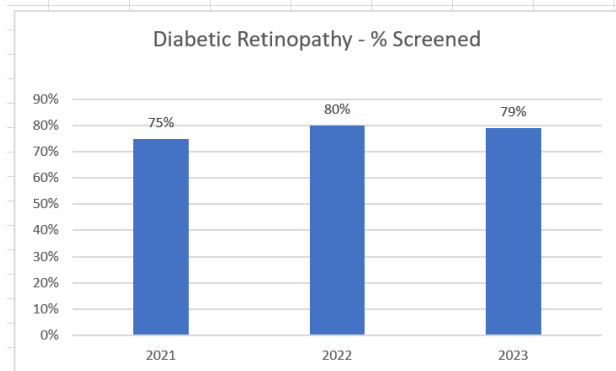
HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps								
Diabetes A1C < 8 • 2023 target 73%	- Overcome therapeutic inertia by engaging with patients at risk of flipping out of glycemic control earlier - Continue to explore new outreach channels - Increase remote glucose monitoring/continuous glucose monitoring adoption and utilization - Partner with low-performing medical centers to remove barriers and offer regional support - Explore expanded access to Thrive Local resources to address social determinants of health	See above	<u>Analysis</u> Target Not Achieved. 71% of patients tested and in control as of December 2023. This is a 4 percentage point increase from December 2022. The chart below shows trended performance data for the past three years. Diabetes A1C < 8 - % Tested & In Control <table><thead><tr><th>Year</th><th>% Tested & In Control</th></tr></thead><tbody><tr><td>2021</td><td>67%</td></tr><tr><td>2022</td><td>67%</td></tr><tr><td>2023</td><td>71%</td></tr></tbody></table> <u>Barriers</u> - Growing incidence of Diabetes in Northern California relative to the rest of the nation <u>Next steps</u> - Improve use of remote glucose monitoring devices - Encourage expanded lab access and after hours outreach - Encourage treatment intensification for patients who are in and out of control - Encourage use of health education support; encourage patient direct-booking of online HED classes	Year	% Tested & In Control	2021	67%	2022	67%	2023	71%
Year	% Tested & In Control										
2021	67%										
2022	67%										
2023	71%										

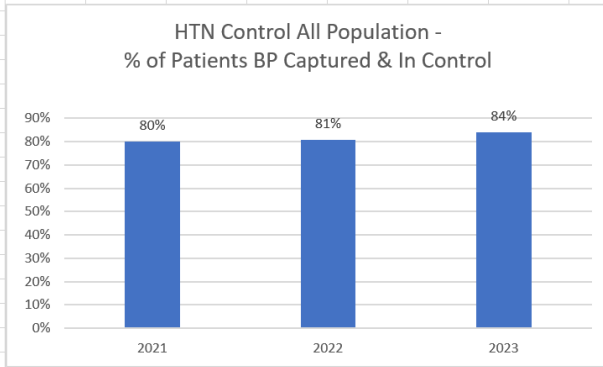
HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

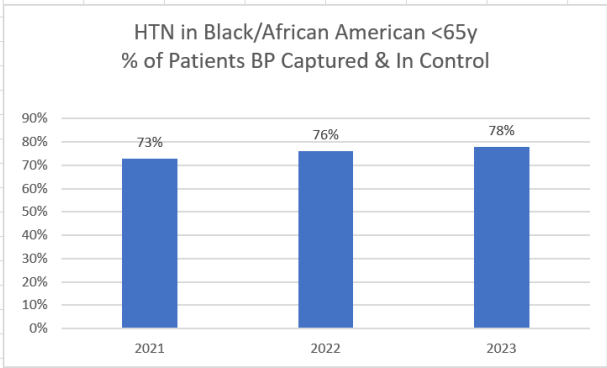
Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps						
			• Routine communication about best practices and promoting the use of performance dashboards • Expanding creative outreach channels such as texting • Utilize THRIVE local to address SDOH						
Diabetes Latino A1C < 8 • 2023 target 73%	• Create Latino Taskforce • Offer cultural training to Diabetes Care Managers • Conduct root cause analysis on high ‘fail to keep appointment’ (FTKA) rates for Health Education classes	See above	<u>Analysis</u> Target Not Achieved. 65% of patients tested and in control as of December 2023. This is a 5 percentage point increase from December 2022. The chart below shows trended performance data for the past three years.  <table><caption>Diabetes Latino A1C < 8 - % Tested & In Control</caption><thead><tr><th>Year</th><th>% Tested & In Control</th></tr></thead><tbody><tr><td>2022</td><td>60%</td></tr><tr><td>2023</td><td>65%</td></tr></tbody></table> <u>Barriers</u> • Growing incidence of Diabetes in Northern California relative to the rest of the nation <u>Next steps</u> • Improve use of remote glucose monitoring devices	Year	% Tested & In Control	2022	60%	2023	65%
Year	% Tested & In Control								
2022	60%								
2023	65%								

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

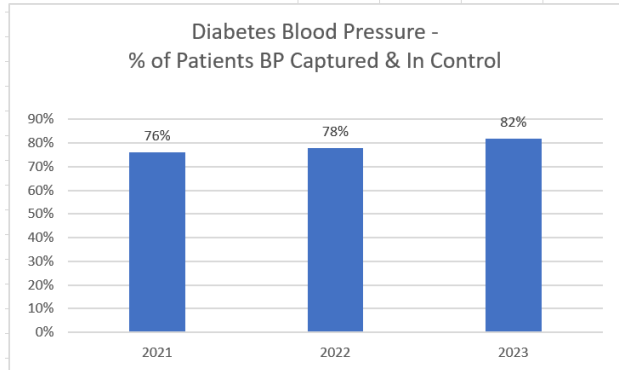
Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps								
			- Encourage expanded lab access and after hours outreach - Focus on culturally appropriate outreach - Encourage treatment intensification for patients who are in and out of control. - Encourage use of health education support; encourage patient direct-booking of online HED classes - Routine communication about best practices and promoting the use of performance dashboards - Expanding creative outreach channels such as texting - Utilize THRIVE local to address SDOH								
Diabetic Retinopathy/DM Eye Screening • 2023 target 79%	- Enhance current regional outreach methods through improved tracking capability - Test new outreach messaging and evaluate which is most impactful (i.e., results with highest follow up screening rate) - Ensure camera resources are located based on population needs - Support local medical centers with outreach through best practice dissemination	Medical Director for Quality Monthly	<u>Analysis</u> Target achieved. 79% of patients screened as of December 2023. The chart below shows trended performance data for the past three years.  <table><caption>Diabetic Retinopathy - % Screened</caption><thead><tr><th>Year</th><th>% Screened</th></tr></thead><tbody><tr><td>2021</td><td>75%</td></tr><tr><td>2022</td><td>80%</td></tr><tr><td>2023</td><td>79%</td></tr></tbody></table> <u>Next steps</u>	Year	% Screened	2021	75%	2022	80%	2023	79%
Year	% Screened										
2021	75%										
2022	80%										
2023	79%										

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps								
			• Transition to new modes of regional outreach and track impact to booking/screening rates • Explore opportunities to expand the regional outreach reminder population • Assess effectiveness of current camera resources and new locations with need • Continue to support local medical centers through best practice dissemination								
Hypertension (HTN) control all population • 2023 target 83%	• Ensure all members have their BPs checked (improve on 2% to close goal gap) • Continued communication of tech updates to smooth transition of updated tools (e.g. BP Due Banner) • Conduct bi-annual regional outreach to support local outreach efforts • Ongoing partnership with health education and health engagement teams to promote importance of BP collection and lifestyle modifications • Continue to monitor and explore regional best practices to scale and spread • Monitor monthly and weekly performance reports to identify opportunities for improvement • Identify opportunities to collaborate with specialty depts to collect BPs	Medical Director for Population Care Monthly	<u>Analysis</u> Target Achieved. 84% of patients achieved HTN control as of December 2023. This is a 3-percentage point increase from 2022. The chart below shows trended performance data for the past three years.  <table><caption>HTN Control All Population - % of Patients BP Captured & In Control</caption><thead><tr><th>Year</th><th>% of Patients BP Captured & In Control</th></tr></thead><tbody><tr><td>2021</td><td>80%</td></tr><tr><td>2022</td><td>81%</td></tr><tr><td>2023</td><td>84%</td></tr></tbody></table> <u>Next steps</u> • Continue with semi-annual HTN reminders to patients due for BP check	Year	% of Patients BP Captured & In Control	2021	80%	2022	81%	2023	84%
Year	% of Patients BP Captured & In Control										
2021	80%										
2022	81%										
2023	84%										

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management											
Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps								
			- Evaluate opportunities to enhance performance reports - Encourage after hours outreach and access for BP checks. - Utilize THRIVE local to address SDOH								
HTN in Black/African-American • 2023 target: 83%	- Identify medical sites who have developed programs/best practices that may be scaled and spread across the organization - Review of improvement work done to date and results for purposes of lessons learned - Eliciting patient voice to find best practice around engagement - Explore Thrive Local for social determinants of health resources	See above	<u>Analysis</u> Target Not Achieved. 78% of patients achieved HTN control as of December 2023. This is a 2 percentage point increase from 2022. The chart below shows trended performance data for the past three years.  <table><caption>HTN in Black/African American <65y % of Patients BP Captured & In Control</caption><thead><tr><th>Year</th><th>% of Patients BP Captured & In Control</th></tr></thead><tbody><tr><td>2021</td><td>73%</td></tr><tr><td>2022</td><td>76%</td></tr><tr><td>2023</td><td>78%</td></tr></tbody></table> <u>Barriers</u> Opportunity to close disparity gap in HTN control and understand and address unique drivers of high BP in the African American population. <u>Next steps</u>	Year	% of Patients BP Captured & In Control	2021	73%	2022	76%	2023	78%
Year	% of Patients BP Captured & In Control										
2021	73%										
2022	76%										
2023	78%										

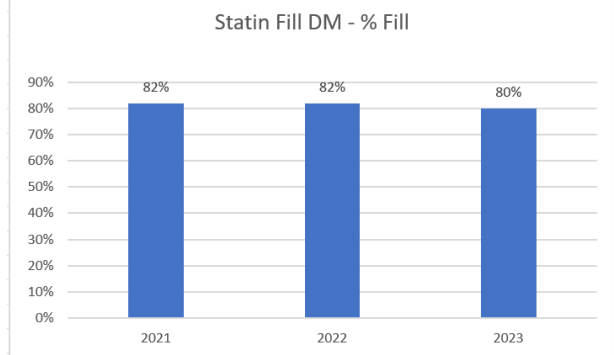
HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
			- Follow up with high performances in AA HTN to learn of best practices for spread - Continue with semi-annual HTN reminders to patients overdue for a BP check - Encourage after hours outreach and access for BP checks. - Utilize THRIVE local to address SDOH
Diabetes Blood Pressure • 2023 target 83%	- Ensure all members have their BPs checked (improve on 2% to close goal gap) - Continued communication of tech updates to smooth transition of updated tools (e.g. BP Due Banner) - Conduct bi-annual regional outreach to support local outreach efforts - Ongoing partnership with health education and health engagement teams to promote importance of BP collection and lifestyle modifications - Continue to monitor and explore regional best practices to scale and spread - Monitor monthly and weekly performance reports to identify opportunities for improvement - Identify opportunities to collaborate with specialty depts to collect BPs	See above	<u>Analysis</u> Target Not Achieved. 82% of patients screened as of December 2023. This is a 4 percentage point increase from 2022. The chart below shows trended performance data for the past three years.  <u>Barriers</u> - The Diabetes population has grown nearly 10% in 2023 - Opportunity to increase awareness and education for patients with DM regarding the importance of routine BP Checks.

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps								
			<u>Next steps</u> - Follow up with high performers to learn of best practices for spread - Include DM on the monthly performance reports - Utilize THRIVE local to address SDOH								
Statin Appropriate Fill/Adherence Combined Fill • 2023 targets: Statin Fill ASCVD: 92% Statin fill DM: 80%	- Technology enhancements to provide efficiency and organization in Statin outreach - Development of new statin patient-facing educational materials that addresses patient hesitancy and informs them of the benefits to their health - Training opportunities to adjust medication instructions to reflect correct statin usage - Provide high-yield lists for targeted live outreach - New patient-facing Heart Health Guide on MDO - Exploring THRIVE local to address SDOH needs	Medical Director for Population Care Monthly	<u>Analysis</u> <i>Statin Fill ASCVD:</i> Target Not Achieved. 90% of members in the ASCVD subset of the PHASE registry had at least one dispensing event of an appropriate statin as of December 2023. <i>Statin Fill Diabetes:</i> Target Achieved. 80% of members in the diabetes subset of the PHASE registry had at least one dispensing event of an appropriate statin, as of December 2023. The charts below show trended performance data for the past three years. Statin Fill ASCVD - % Fill <table><thead><tr><th>Year</th><th>% Fill</th></tr></thead><tbody><tr><td>2021</td><td>89%</td></tr><tr><td>2022</td><td>89%</td></tr><tr><td>2023</td><td>90%</td></tr></tbody></table>	Year	% Fill	2021	89%	2022	89%	2023	90%
Year	% Fill										
2021	89%										
2022	89%										
2023	90%										

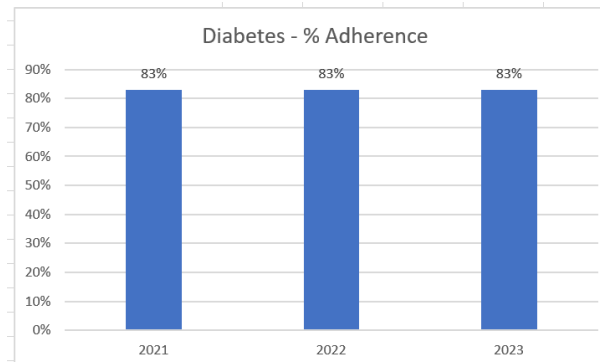
HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps								
			Statin Fill DM - % Fill <table><thead><tr><th>Year</th><th>% Fill</th></tr></thead><tbody><tr><td>2021</td><td>82%</td></tr><tr><td>2022</td><td>82%</td></tr><tr><td>2023</td><td>80%</td></tr></tbody></table> <u>Barriers for Statin Fill ASCVD:</u> - Hesitancy about starting a Statin prescription <u>Next steps</u> - Technology enhancements to provide efficiency and organization in Statin outreach - Provide high-yield lists for targeted outreach and exclusion clean up - Training opportunities to adjust medication instructions to reflect correct statin usage - Utilize THRIVE local to address SDOH	Year	% Fill	2021	82%	2022	82%	2023	80%
Year	% Fill										
2021	82%										
2022	82%										
2023	80%										
ASCVD Adherence • See above • 2023 target 92%	- Technology enhancements to provide efficiency and organization in Statin outreach - Training opportunities to adjust medication instructions to reflect correct statin usage	See above	<u>Analysis</u> Target Not Achieved. 88% of members in the ASCVD subset of the PHASE registry remained on a high or moderate intensity statin for at least 92% of the time since the first fill, as of December 2023.								

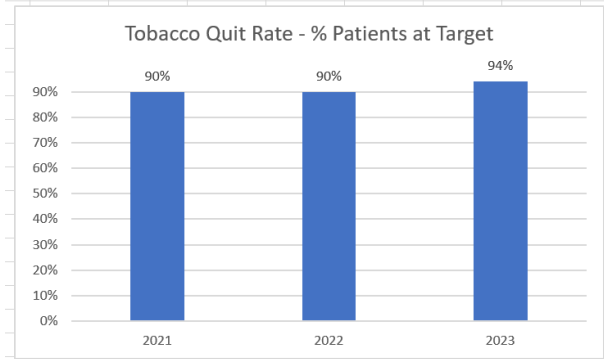
HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps								
	• Provide high-yield lists for targeted live outreach • Patient voice analysis to determine root cause of post-Q1 adherence dip • New patient-facing Heart Health Guide on MDO Exploring THRIVE local to address SDOH needs		The chart below shows trended performance data for the past three years. ASCVD - % Adherence <table border="1"><thead><tr><th>Year</th><th>% Adherence</th></tr></thead><tbody><tr><td>2021</td><td>88%</td></tr><tr><td>2022</td><td>87%</td></tr><tr><td>2023</td><td>88%</td></tr></tbody></table> <u>Barriers for Statin Adherence ASCVD</u> • Patient statin hesitancy <u>Next Steps</u> • Technology enhancements to provide efficiency and organization in Statin outreach • Provide high-yield lists for targeted outreach and exclusion clean up • Training opportunities to adjust medication instructions to reflect correct statin usage • Utilize THRIVE local to address SDOH	Year	% Adherence	2021	88%	2022	87%	2023	88%
Year	% Adherence										
2021	88%										
2022	87%										
2023	88%										
DM Adherence • See above • 2023 target 86%	• Technology enhancements to provide efficiency and organization in Statin outreach • Training opportunities to adjust medication instructions to reflect correct statin usage	See above	<u>Analysis</u> Target Not Achieved. 83% of members in the diabetes subset of the PHASE registry remained on a high or moderate intensity statin for at least 86% of the time since the first fill, as of December								

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps								
	• Provide high-yield lists for targeted live outreach • Patient voice analysis to determine root cause of post-Q1 adherence dip • New patient-facing Heart Health Guide on MDO • Exploring THRIVE local to address SDOH needs		2023. The chart below shows trended performance data for the past three years. Diabetes - % Adherence <table border="1"><thead><tr><th>Year</th><th>% Adherence</th></tr></thead><tbody><tr><td>2021</td><td>83%</td></tr><tr><td>2022</td><td>83%</td></tr><tr><td>2023</td><td>83%</td></tr></tbody></table> <u>Barriers for Statin Adherence Diabetes</u> • Post-Q1 dip in adherence • Oversupply of medications • Patient statin hesitancy <u>Next steps</u> • Technology enhancements to provide efficiency and organization in Statin outreach • Provide high-yield lists for targeted outreach and exclusion clean up • Training opportunities to adjust medication instructions to reflect correct statin usage • Utilize THRIVE local to address SDOH	Year	% Adherence	2021	83%	2022	83%	2023	83%
Year	% Adherence										
2021	83%										
2022	83%										
2023	83%										
Tobacco Quit Rate • 2023 target 90%	• Goal remains unchanged for Quitters Campaign at 30,000 quitters in 2023, with the 2023 quit rate target remaining at 90%.	Medical Director for Quality Monthly	<u>Analysis</u> Achieved regional quit rate of 94% by the end of December 2023.								

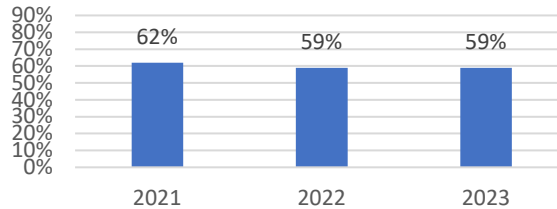
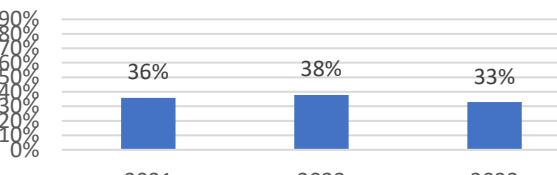
HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
	- Focus on teachable moments: - Quit / Counseling / Medication upon admission to hospital - Encourage Periop quits - Continue to hardwire previous efforts: - APICQ, Tobacco consultants, quality leaders review CQC monthly for Quit Rate. - AMGAs and Managers review MA Rooming Tool Report monthly for tobacco status completions - Teach/monitor for warm handoffs between MAs & PCPs during DOVs - Remind physicians and staff that all KP NCAL members can be prescribed over-the-counter (OTC) nicotine replacement therapies (NRT) at no cost share. - Multi-disciplinary tobacco team (with designated team lead) meets regularly (recommend monthly). - Ensure ongoing training -- MAs: Accurately document tobacco use in the social hx and alert physicians about current smoker status. Physicians: Trained in effective conversations, uses SmartRx for NRT Rx and referrals to wellness coaching. - Promote the Quality Tools button to review Tobacco guidelines and to share information with patients. - Use My Panel Manager and other tools to outreach to targeted smoking populations (i.e., recent quitters, current smokers). Use a		- In 2023, Regional prevalence dropped from 6.1 to 5.8. 13 medical centers met the quit target (prevalence is part of the quit target calculation). The chart below shows trended performance data for the past three years.  Next steps - Design targeted outreach efforts to focus on high risks groups. - Continue bulk secure messaging (BSM)/Robo calls. - Collaborate with pediatrics on prevention rather than cessation. - Remind physicians and staff to utilize the updated NCAL Tobacco Cessation Clinical Practice Guidelines, and SmartRx – prescribing Varenicline (Chantix) as first-line therapy. - Continue to hardwire previous efforts:

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
	small number of centralized MAs or PrAs to run outreach for a module or facility vs PCPs personal MAs. Sustain communication structure to ensure tobacco performance data is shared with providers and staff (i.e., posted on huddle boards & shared during dept meetings).		- Ensure ongoing training -- MAs: Accurately document tobacco use in the social hx and alert physicians about current smoker status. Physicians: Trained in effective conversations, uses SmartRx for NRT Rx and referrals to wellness coaching. - Sustain communication structure to ensure tobacco performance data is shared with providers and staff (i.e., posted on huddle boards & shared during dept meetings).
ESRD			
Optimal Start 2023 Targets: • Optimal Starts ≥ 68% • Home Dialysis [Peritoneal Dialysis (PD) + Home Hemodialysis (HHD)] incidence ≥ 36% • Pre-emptive kidney transplantation benchmark is 3.1%	- Create weekly report to identify New Start patients for timely access for root cause analysis and problem solving for managers - Creating managers tools for process mapping for New Starts - Create report for PD churn to do root cause analysis	Medical Director for Quality Monthly	<u>Analysis:</u> 59% of ESRD patients started renal-replacement therapy optimally by December 2023. Target not achieved. 33% of ESRD patients started Home PD or HHD by December 2023. Target not achieved. NCAL % for pre-emptive transplants for Q3 is 2.5% when comparing Optimal Starts derived data sets with other KP regions. (Q4 data is not available until April 2024). The charts below show trended performance data for the past three years.

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps																								
			Optimal Start: % Pts Started Therapy Optimally <table><tr><th>Year</th><th>% Pts Started Therapy Optimally</th></tr><tr><td>2021</td><td>62%</td></tr><tr><td>2022</td><td>59%</td></tr><tr><td>2023</td><td>59%</td></tr></table> % Home Dialysis Incidence ≥ 36% <table><tr><th>Year</th><th>% Home Dialysis Incidence ≥ 36%</th></tr><tr><td>2021</td><td>36%</td></tr><tr><td>2022</td><td>38%</td></tr><tr><td>2023</td><td>33%</td></tr></table> % Pre-emptive Transplants (Q3) <table><tr><th>Year</th><th>% Pre-emptive Transplants (Q3)</th></tr><tr><td>2021</td><td>0%</td></tr><tr><td>2022</td><td>0%</td></tr><tr><td>2023</td><td>2.5%</td></tr></table>	Year	% Pts Started Therapy Optimally	2021	62%	2022	59%	2023	59%	Year	% Home Dialysis Incidence ≥ 36%	2021	36%	2022	38%	2023	33%	Year	% Pre-emptive Transplants (Q3)	2021	0%	2022	0%	2023	2.5%
Year	% Pts Started Therapy Optimally																										
2021	62%																										
2022	59%																										
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2021	0%																										
2022	0%																										
2023	2.5%																										

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
			<u>Barriers:</u> • For hemodialysis vascular access improvements: Timeliness of vein mapping in Radiology for surgical planning, access to IR and OR, availability of Vascular Surgeons. • For Home Dialysis: Access to OR for PD catheter placements, PD first strategy in the clinics, encourage Home PD/HHD during Options Education with members, expand Home PD Assist program throughout region. • For pre-emptive kidney transplantation: long wait time in California <u>Next steps:</u> • For hemodialysis vascular access improvements: Nephrology departments to partner with IR and Vascular Surgery to develop local agreements for timely vein mapping and access to surgery for access placement. • For Home Dialysis: Home Workgroup to meet and develop strategies to encourage Home PD/HHD. DSA to partner with Home Health to expand Home PD Assist program at all internal Home dialysis sites. Continuum to evaluate options to develop Home PD assisted programs with our external PD organizations for the rest of the medical centers.

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Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps						
			For pre-emptive transplantation: HealthConnect trigger for early referral for transplant evaluation. Work with transplant programs to improve living donor identification and engagement. Expand out- of-California kidney transplant options.						
Hemodialysis patients with Central Venous Catheter (CVC) in use for ≥ 90 days • 2023 target =<12%	- Continue conversations with Vascular Surgery - Creation of weekly tracking reports for dialysis prep patients and may need permanent access	Medical Director for Quality Monthly	<u>Analysis:</u> Target not achieved. 18% of prevalent in-center hemodialysis patients were dialyzing with a central venous catheter for more than 90-days by December 2023. The chart below shows trended performance data for the past three years. Optimal Start: % w/ (CVC) in use for ≥ 90 days <table><tr><td>2021</td><td>2022</td><td>2023</td></tr><tr><td>18%</td><td>19%</td><td>18%</td></tr></table> <u>Barriers:</u> - IR and OR availability for AVF and AVG. - Availability of Vascular Surgeons <u>Next steps:</u> - Local adoption of regionally approved Vascular e-consult. OR Schedulers to adhere to booking guidelines as set forth in e-consult.	2021	2022	2023	18%	19%	18%
2021	2022	2023							
18%	19%	18%							

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Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps								
			Partner with POM to create clinical guidelines to mitigate patient delay, surgery cancellations and denial for surgery.								
Asthma Care											
Asthma Med Ratio • 2023 target 90%	- Looking into new internal reporting that can help local teams prioritize patients for outreach - Will conder simplifying our active asthma registry to only include the HEDIS defined patient population	Medical Director for Quality Monthly	<u>Analysis</u> Target Not Achieved. 86% of members age 5-85 in the active asthma registry were compliant with the Asthma Medication Ratio (AMR) of 0.5 or greater, based on medication adherence from the past 12 months (rolling rate) as of December 2023. The chart below shows trended performance data for the past three years. AMR: % Compliant <table><thead><tr><th>Year</th><th>AMR: % Compliant</th></tr></thead><tbody><tr><td>2021</td><td>86%</td></tr><tr><td>2022</td><td>87%</td></tr><tr><td>2023</td><td>86%</td></tr></tbody></table> <u>Barriers</u> - Asthma CQC Population different from external reporting - Lack of focused tools on PMT registry <u>Next steps</u>	Year	AMR: % Compliant	2021	86%	2022	87%	2023	86%
Year	AMR: % Compliant										
2021	86%										
2022	87%										
2023	86%										

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management			
Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
			- Adjustment of CQC Population to be more focused to match HEDIS specifications. - Adding PMT priority fields to allow for more focused data pulls.
Behavioral Health			
Depression Monitoring • 2023 target: 52% Depression Response • 2023 target: 17%	- Create new technology tools such as BPA and PROMPT to support broader depression population - Socialize new measures with co-consultants and quality leaders for familiarity and planning - Utilize bi-directional feedback forums to learn more about workflow needs and best practices from local sites during this preparatory year	Medical Director for Quality Monthly	<u>Analysis:</u> Depression Monitoring: DMS metric met, 65% of patients with Major Depressive Disorder were screened with a PHQ9 (a validated patient health questionnaire to measure the severity of depression) either 30 days prior or 30 days after the diagnosis of Major Depressive Disorder as of December 2023. Depression Response: Target Not Achieved. 16% of members 18+ years old with a diagnosis of major depression and a baseline elevated PHQ9 score over 9, had evidence of response within 4 to 8 months of the baseline elevated score as of December 2023. The charts below shows trended performance data for the past three years.

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps																
			Depression Monitoring: % Screened <table><thead><tr><th>Year</th><th>% Screened</th></tr></thead><tbody><tr><td>2021</td><td>0%</td></tr><tr><td>2022</td><td>48%</td></tr><tr><td>2023</td><td>65%</td></tr></tbody></table> Depression Response: % with Evidence of Response <table><thead><tr><th>Year</th><th>% with Evidence of Response</th></tr></thead><tbody><tr><td>2021</td><td>0%</td></tr><tr><td>2022</td><td>0%</td></tr><tr><td>2023</td><td>16%</td></tr></tbody></table> Barriers (Depression Response): • Change management – time lag for understanding and adoption of new metric specs to workflows • New tools were in development in 2023 to support the work and were not released until late into the year.	Year	% Screened	2021	0%	2022	48%	2023	65%	Year	% with Evidence of Response	2021	0%	2022	0%	2023	16%
Year	% Screened																		
2021	0%																		
2022	48%																		
2023	65%																		
Year	% with Evidence of Response																		
2021	0%																		
2022	0%																		
2023	16%																		

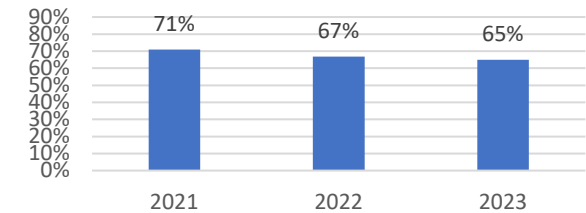
HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
			- Some tools have been delayed and expected to be released Q2 or Q3 2024. - Challenges with staffing support monitoring and following up with patients <u>Next steps</u> Depression Monitoring: - Continued refinement of workflows with the integration of inreach tool (PROMPT) - Release of additional tools to aid in identification of patients requiring a PHQ-9 Depression Response: - Additional outreach support tools scheduled to be released in 2024 - Best practices to be more widely collated and shared across the region
Alcohol and Other Drugs – Initiation and Engagement in Treatment (IET) 2023 target 48% (Note: AOD measure is now referred to as Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment [IET]. 2023 target changed from 60% to 48% due to IET spec changes – utilized national benchmarks to finalize new target)	Maintain performance in 2023 through partnership with AMRS, AFM, MH, and ED.	Medical Director for Quality Monthly	<u>Analysis:</u> Target Achieved. 57% of members with a substance abuse diagnosis initiated treatment within 14 days as of December 2023. The chart below shows trended performance data for the past three years. (Note: 2023 target changed from 60% to 48% due to IET spec changes)

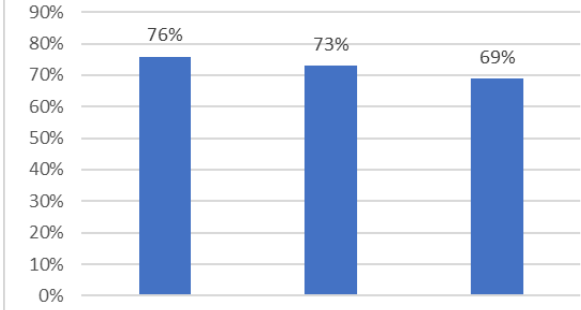
HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps								
			IET: % Treatment Initiated <table><thead><tr><th>Year</th><th>% Treatment Initiated</th></tr></thead><tbody><tr><td>2021</td><td>67%</td></tr><tr><td>2022</td><td>69%</td></tr><tr><td>2023</td><td>57%</td></tr></tbody></table> <u>Next Steps:</u> Adjusted current IET daily outreach lists to match new specifications and will distribute to all medical centers early 2024.	Year	% Treatment Initiated	2021	67%	2022	69%	2023	57%
Year	% Treatment Initiated										
2021	67%										
2022	69%										
2023	57%										
Immunization											
Childhood Immunization – COMBO 10 • 2023 target 75%	Patient outreach/inreach workflows (supported via Regional Outreach Lists and PROMPT patient views), education and ongoing focus on overall Combo 10 rates, including flu. Initiate collaboration with Pediatric Quality and Immunization leadership and Regional Flu Outreach leadership on development/implementation of outreach strategy tailored to Pediatrics.	Medical Director for Quality Monthly	<u>Analysis</u> Target Not Achieved. 65% of members age 2 had the following vaccines by their second birthday: all from Combo 3, one hepatitis A (HepA), two or three rotavirus (RV), and two influenza (flu) as of December 2023. The chart below shows trended performance data for the past three years:								

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
			Combo 10: % Vaccinated  Barriers - Childhood flu (doses #1 & #2) comprise the largest challenge/opportunity for overall Childhood Immunizations – Combo 10. Next steps - Please see below for Childhood Immunization – Flu next steps
Childhood Immunization – Flu • 2023 target 79%	Please see above	Medical Director for Quality Monthly	<u>Analysis</u> Target Not Achieved. 69% of members age 2 had two influenza (flu) vaccines by their second birthday as of December 2023. The chart below shows trended performance data for the past three years.

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps								
			Flu: % Vaccinated <table><thead><tr><th>Year</th><th>% Vaccinated</th></tr></thead><tbody><tr><td>2021</td><td>76%</td></tr><tr><td>2022</td><td>73%</td></tr><tr><td>2023</td><td>69%</td></tr></tbody></table> <u>Barriers</u> • Parent education/persuasion for both dose #1 and dose #2; ensuring dose #1 administered on or after 6 months; ensuring dose #2 scheduled/administered prior to 24 months <u>Next steps</u> • Engaging and training MD Pediatric Immunization Consultants to train front-line MD colleagues and clinic support staff on patient-facing flu persuasion and communication techniques; convening Regional Pediatric Immunization Strategies peer group meeting (virtual + in-person) with MD Pediatric Immunization Consultants – AND – Pediatric Directors/Managers to highlight/share best practices for flu #1 & #2 outreach/inreach workflows, promote performance	Year	% Vaccinated	2021	76%	2022	73%	2023	69%
Year	% Vaccinated										
2021	76%										
2022	73%										
2023	69%										

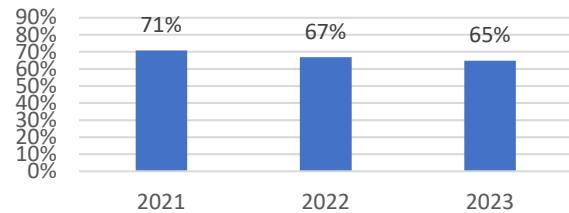
HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps								
			improvement tools and strategies to support tests of change for improving flu #1 & #2 patient communication and inreach								
Adolescent Immunization – Adol. COMBO 2 (replacing Adol. Combo 1) • 2023 target 62%	Pediatric Quality & Immunization leadership will continue to maintain focus on timely and appropriate administration of meningococcal, Tdap, and HPV to our eligible pediatric adolescent patients.	Medical Director for Quality Monthly	<u>Analysis</u> Target Achieved. 70% of adolescent members who turned 13 years of age during the measurement year were numerator compliant for all three indicators (meningococcal, Tdap, HPV) as of December 2023. The chart below shows trended performance data for the past three years. Combo 2: % Vaccinated <table><tr><th>Year</th><th>% Vaccinated</th></tr><tr><td>2021</td><td>61%</td></tr><tr><td>2022</td><td>66%</td></tr><tr><td>2023</td><td>70%</td></tr></table> <u>Barriers</u> N/A: NCAL continues to perform above regional target and substantially above HEDIS 90thile benchmark (MY 2022: 46.23%) <u>Next steps</u>	Year	% Vaccinated	2021	61%	2022	66%	2023	70%
Year	% Vaccinated										
2021	61%										
2022	66%										
2023	70%										

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps								
			Pediatric clinics will continue meeting internal regional target (2024: 62%)								
Fracture Prevention: Treat or Scan											
Fracture Prevention: Treat or Scan • 2023 target 82%	- Creating effective communication materials - Developing personalized workflow for “Unable to Schedule” members	Medical Director for Quality Monthly	<u>Analysis:</u> Target Achieved. 84% of women members suffered a HEDIS-defined fracture and received either a bone mineral density test or a RX for HEDIS approved osteoporosis therapy (except calcitonin) in the 6 months since fracture as of December 2023. The chart below shows trended performance data for the past three years. Fracture: % Pts Rcvd Text/Rx <table><thead><tr><th>Year</th><th>% Pts Rcvd Text/Rx</th></tr></thead><tbody><tr><td>2021</td><td>82%</td></tr><tr><td>2022</td><td>84%</td></tr><tr><td>2023</td><td>84%</td></tr></tbody></table> <u>Next Steps:</u> - Leverage collaboration between participating departments (RAD, ORTHO, ED/HBS) - Add Virtual class for fracture pts - Educational efforts with AFM docs (Steal this Talk)	Year	% Pts Rcvd Text/Rx	2021	82%	2022	84%	2023	84%
Year	% Pts Rcvd Text/Rx										
2021	82%										
2022	84%										
2023	84%										
Population Health Management											
Childhood Immunization – COMBO 10	Patient outreach/inreach workflows (supported via Regional Outreach Lists and	Medical Director for Quality	<u>Analysis</u>								

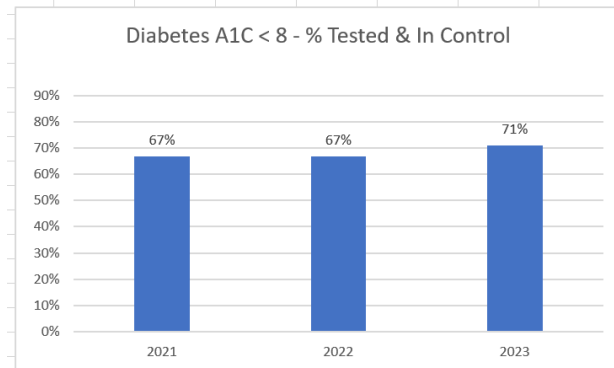
HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps								
• 2023 target 75%	PROMPT patient views), education and ongoing focus on overall Combo 10 rates, including flu. Initiate collaboration with Pediatric Quality and Immunization leadership and Regional Flu Outreach leadership on development/implementation of outreach strategy tailored to Pediatrics.	Monthly	Target Not Achieved. 65% of members age 2 had the following vaccines by their second birthday: all from Combo 3, one hepatitis A (HepA), two or three rotavirus (RV), and two influenza (flu) as of December 2023. The chart below shows trended performance data for the past three years Combo 10: % Vaccinated <table><caption>Combo 10: % Vaccinated Data</caption><thead><tr><th>Year</th><th>% Vaccinated</th></tr></thead><tbody><tr><td>2021</td><td>71%</td></tr><tr><td>2022</td><td>67%</td></tr><tr><td>2023</td><td>65%</td></tr></tbody></table> <u>Barriers</u> • Childhood flu (doses #1 & #2) comprise the largest challenge/opportunity for overall Childhood Immunizations – Combo 10. <u>Next steps</u> • Please see Childhood Immunization – Flu next steps	Year	% Vaccinated	2021	71%	2022	67%	2023	65%
Year	% Vaccinated										
2021	71%										
2022	67%										
2023	65%										
Colorectal Cancer Screening • 2023 target 81% (for 51–75-year-olds)	• Conduct a current state assessment of how local outreach is conducted across the region to help identify solutions to improve local outreach. • Implement new FIT kit instruction sheet designed to make instructions clearer for members.	Medical Director for Quality Monthly	<u>Analysis</u> Target Not Achieved. 79% of 51–75-year-old patients screened as of December 2023. Note: 2024 CRC Target will align with HEDIS Specs • Frontpage measure: 45-75 yr olds (target=78%)								

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps								
	• Hold a training for Inreach best practices for Medical Assistants. • Pilot and implement new Small Media postcard during Regional Outreach for the general population (similar to tailored material currently used for African American and Latino American populations).		Colorectal Cancer Screening - % Screened <table><thead><tr><th>Year</th><th>% Screened</th></tr></thead><tbody><tr><td>2021</td><td>79%</td></tr><tr><td>2022</td><td>78%</td></tr><tr><td>2023</td><td>79%</td></tr></tbody></table> <u>Barriers</u> • Lab capacity concerns • USPS mailing changes • Bad addresses in the electronic medical record/challenges in correcting • Proper FIT labeling/expired FIT kit • Cologuard uptake lower than expected due a conservative approach to offering the test <u>Next steps</u> • Participation in the American Medical Group Association (AMGA) Colorectal Cancer Best Practices Learning Collaborative to gather innovative ideas from outside organizations • Development of a robust 'back-to-basics for Inreach' campaign that will launch during CRC Awareness Month (Mar)	Year	% Screened	2021	79%	2022	78%	2023	79%
Year	% Screened										
2021	79%										
2022	78%										
2023	79%										

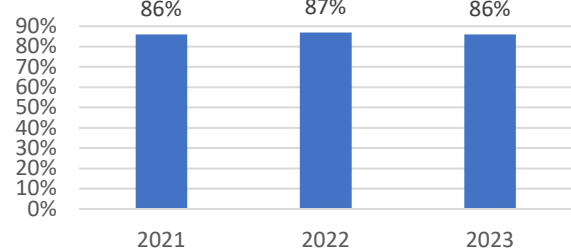
HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps								
			- Investigate the appropriateness of replicating and spreading the Midreach plan developed by the Diablo Service Area - Circulate new FIT instruction video (launched Jan 2024) - Expanding the Cologuard program to a wider and targeted audience - Support lab initiative to streamline processing efficiency to improve Test Not Done (TND) rates								
Diabetes A1C < 8 • 2023 target 73%	- Overcome therapeutic inertia by engaging with patients at risk of flipping out of glycemic control earlier - Continue to explore new outreach channels - Increase remote glucose monitoring/continuous glucose monitoring adoption and utilization - Partner with low-performing medical centers to remove barriers and offer regional support - Explore expanded access to Thrive Local resources to address social determinants of health	See above	<u>Analysis</u> Target Not Achieved. 71% of patients tested and in control as of December 2023. This is a 4 percentage point increase from December 2022. Diabetes A1C < 8 - % Tested & In Control <table><thead><tr><th>Year</th><th>% Tested & In Control</th></tr></thead><tbody><tr><td>2021</td><td>67%</td></tr><tr><td>2022</td><td>67%</td></tr><tr><td>2023</td><td>71%</td></tr></tbody></table> <u>Barriers</u> Growing incidence of Diabetes in Northern California relative to the rest of the nation <u>Next steps</u>	Year	% Tested & In Control	2021	67%	2022	67%	2023	71%
Year	% Tested & In Control										
2021	67%										
2022	67%										
2023	71%										

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
			• Improve use of remote glucose monitoring devices • Encourage expanded lab access and after hours outreach • Encourage treatment intensification for patients who are in and out of control • Encourage use of health education support; encourage patient direct-booking of online HED classes • Routine communication about best practices and promoting the use of performance dashboards • Expanding creative outreach channels such as texting • Utilize THRIVE local to address SDOH
Asthma Med Ratio • 2023 target 90%	• Looking into new internal reporting that can help local teams prioritize patients for outreach • Will consider simplifying our active asthma registry to only include the HEDIS defined patient population	Medical Director for Quality Monthly	<u>Analysis</u> Target Not Achieved. 86% of members age 5-85 in the active asthma registry were compliant with the Asthma Medication Ratio (AMR) of 0.5 or greater, based on medication adherence from the past 12 months (rolling rate) as of December 2023. The chart below shows trended performance data for the past three years.

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps								
			AMR: % Compliant <table><thead><tr><th>Year</th><th>% Compliant</th></tr></thead><tbody><tr><td>2021</td><td>86%</td></tr><tr><td>2022</td><td>87%</td></tr><tr><td>2023</td><td>86%</td></tr></tbody></table> <u>Barriers</u> - Asthma CQC Population different from external reporting - Lack of focused tools on PMT registry <u>Next steps</u> - Adjustment of CQC Population to be more focused to match HEDIS specifications. - Adding PMT priority fields to allow for more focused data pulls.	Year	% Compliant	2021	86%	2022	87%	2023	86%
Year	% Compliant										
2021	86%										
2022	87%										
2023	86%										
Kaiser Permanente medical centers across Northern California maintain a C. diff standardized infection ratio (SIR) of 0.55 or below.	- Members targeted for the C. diff program care bundle receive close monitoring of any loose stools to determine cause and identify cases of C. diff infection (vs. carriers) - Members with confirmed cases of C. diff infection are acted upon quickly, including isolation and treatment with antibiotics.	TPMG Consulting Services and PHM/Quality Director 12/31/2023	- At year-end 2023, regional performance for the C.diff metric had a standardized infection ratio (SIR) of 0.45, which met the target of below 0.55. - Going forward, members will continue to receive the program care bundle and close monitoring as appropriate to maintain program performance.								
Over 95% of members in the Special Needs Plan program and over 90% of	Complex Chronic Conditions Intensive case management conducted	TPMG Consulting	The Special Needs Plan program had year-end performance of 98%, which met								

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
patients in the Complex Chronic Conditions program affirm through a feedback survey that the interdisciplinary care team successfully assists them in achieving their goals.	by nurses and social workers consisting of face-to-face clinic visits, telephone appointments, family conferences, and home visits if indicated. - During these visits, nurse/social worker teams develop a personalized care plan designed to be completed in the limited time span intended for the program (no more than 6 months) - Nurse/social worker teams assess the member's needs, provide education and self-care skill building, and link the member to appropriate internal and external resources. Special Needs Plan - Members in the Special Needs Plan program receive a comprehensive health assessment upon enrollment and annually thereafter, as well as during a transition in care venue - Members jointly develop a care plan customized to their specific health needs and preferences with the assistance of a nurse - Members' progress against the individualized care plan is tracked closely by Special Needs Plan teams at each of the medical centers, including nurses and social workers.	Services and Complex Needs Director 12/31/2023	this PHM program goal of 95% performance. The Complex Chronic Conditions program, however, had year end performance of 100%, which met the PHM program goal of 90% In 2024, we plan to seek insight from program staff to help understand members' perceived lack of utility of each program. In addition, we plan to continue to deliver program services as outlined in the relevant program descriptions.
Receive no complaints or grievances related to the Complex Chronic Conditions (CCC) program	Continue to provide service according to the CCC program description	TPMG Consulting Services and Complex Needs Director 12/31/2023	In 2023, CCC program enrollees provided no complaints or grievances that specifically mentioned the CCC program.

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Appropriate members are informed about eligibility to participate, how to use program services, and how to opt in or out for the following programs: • Asthma • Diabetes • Special Needs Plan • Complex Chronic Conditions	Utilize print and secure electronic communications to reach members who are identified for program participation through registry inclusion, insurance coverage, or referral	TPMG Consulting Services, PHM/Quality Director, and Complex Needs Director 12/31/2023	Members in all four of the listed programs received outreach in 2023 as outlined in the Population Health Management Program Description.
Complete population assessment report detailing demographics and disease burden of KPNC member population.	• KP will assess our member population to inform appropriate PHM strategies • KP will plan for the programs/services, goals and metrics that will address the identified strategies. • The assessment and the Strategy Program will be reviewed by the Quality Oversight Committee. • Strategies will be implemented. • Measure the impact of our population management program and identify opportunities for improvement.	TPMG Consulting Services, PHM/Quality Director, and Complex Needs Director 12/31/2023	The annual PHM Population Assessment report was completed in 2023 and submitted to the Quality Oversight Committee in January 2024. A 2024 Population Assessment will be completed in 2024 and will be submitted to the Quality Oversight Committee for approval before year end.
Conduct annual analysis of program effectiveness, including the following metrics: • Childhood Immunization Status Combo 10 • Well Child visits in the first 15 months of life • Interactive Voice Response Satisfaction Survey for SNP and CCC programs • CCC complaints and grievances	Complete narrative report and analysis for quality leadership	TPMG Consulting Services, PHM/Quality Director, and Complex Needs Director 12/31/2023	A PHM Impact Report was completed in December 2023; this report is completed annually. In 2024, a PHM Impact Report will be completed before the end of the year.

Home Health and Hospice Member Experience

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Metric-Overall Rating of Home Health Agency NCAL Goal is 94.0 based on current work, baseline performance, expected likely continued challenges from COVID and average historical improvement. The purpose of this goal is to improve the overall experience that a Home Health agency member receives. Acknowledging the ongoing impact of COVID-19 to care provision, the goal for 2023 will be to increase current performance levels with a glidepath driving towards a 4-star rating of 94.5 in PY 2025. Baseline: 93.8 2023 Target: 94.0	1. Develop and implement agency specific interventions based on driver related data analysis across all agencies 2. Leadership rounding via tracer visits will continue to assess real-time care experience, with any changes to the care experience questions informed by data analysis. 3. Sharing of best practices at peer groups as a standing agenda item 4. Sharing of real-time care experience data and feedback with frontline staff 5. Report and analytics development, training and utilization for data captured within tracer tool will be incorporated to drive targeted efforts	Each Home Health Agency Service Director and Quality Director and their supervisory management staff September 30, 2023	NCAL agency results were 94.3 Excellent performance achieved as a region, above target of 94.0 Goal met or exceeded in several agencies. Challenges impacting agencies not achieving target (NOV, OAK) include labor activity, lack of standardization of onboarding new staff to Care Experience, staffing challenges and new leadership. For 2024, the same question of Overall rating of agency was chosen to track. Continuity of goal focus will enable teams to continue efforts in place on this high-level question. Individual correlating questions driving to improve overall rating of agency has been analyzed and provided for each agency for performance improvement opportunities. Regional team will also support standardization of onboarding new staff for both Home Health and Hospice specific to Care Experience in 2024.
Metric-Overall Rating of Hospice Agency NCAL goal is 84.0 based on current work, baseline performance, expected likely continued challenges from COVID and average historical improvement. The purpose of this goal is to improve the overall experience that a Hospice	1. Develop and implement agency specific interventions based on driver related data analysis across all agencies 2. Leadership rounding via tracer visits will continue to assess real-time care experience, with any changes to the care experience	Each Home Health Agency Service Director and Quality Director and their management supervisory staff June 30, 2023	Performance was not achieved as a region, ending at 83.6, slightly below target of 84.0 Goal met or exceeded in some agencies. Challenges impacting agencies not achieving target (MTZ, OAK, SAC, SCL) include labor activity, lack of standardization of onboarding new staff to Care Experience, staffing challenges and new leadership.

Home Health and Hospice Member Experience

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
agency member receives. Acknowledging the ongoing impact of COVID-19 to care provision, the goal for 2023 will be to increase current performance levels with glidepath driving towards the 75TH percentile ranking nationally of 85% in PY 2025. Baseline: 83.7 2023 Target: 84.0	questions informed by data analysis. 3. Sharing of best practices at peer groups as a standing agenda item 4. Sharing of real-time care experience data and feedback with frontline staff 5. Report and analytics development, training and utilization for data captured within tracer tool will be incorporated to drive targeted efforts		For 2024, the same question of Overall rating of agency was chosen to track. Continuity of goal focus will enable teams to continue efforts in place on this high-level question. Individual correlating questions driving to improve overall rating of agency has been analyzed and provided for each agency for performance improvement opportunities. Additional actions moving forward will include targeted in-person site visits for lower performing agencies and those with new leadership staff to train inter-rater reliability for patient visit observations, data analysis standardization using SHP training for all leaders to be initially scheduled for Q1 2024. Regional team will also support standardization of onboarding new staff for both Home Health and Hospice specific to Care Experience in 2024.

Kidney Transplant Clinics

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps																																																																																																				
Transplant Wait Times To ensure members are referred in a timely manner for evaluation. Target Transplant Referral to Phone Evaluation (wait time in days): ≤ 21 calendar days.	Monitor the wait times from referral to evaluation. When wait time exceeds 21 days, review case to identify reason for the delay and share learning.	Renal Transplant / Kidney Transplant Clinics; Renal Quality and Performance Improvement Committee Quarterly	PARTIALLY MET. Analysis Met for the University of California San Francisco (UCSF); did not meet for the University of California Davis (UCD) The average wait time target of 21 days was met 87% of the time at UCSF, with an average wait time of 6.9 days, and 55% at UCD, with an average wait time of 22.1 days. UCSF met target in all 4 most recent reported quarters, while UCD met target in 2 of the 4 most recent reported quarters. Please see the tables below for details. Barriers UCD has two dedicated referral coordinators to outreach patients to schedule appointments and have converted their Education First class to a video offering to process new referrals in a timelier fashion. UCD has also introduced a new online based referral portal in Q2 of 2022 to improve transplant referral intake operations. KPNC transplant program will continue to monitor patient access to the initial phone appointment with the UCD transplant center to ensure that wait times are within target. <table><tr><th colspan="2" rowspan="2"></th><th colspan="5">UCSF</th></tr><tr><th>Median Wait Time</th><th colspan="2">RANGE</th><th>% of Patients within the Target</th><th>Included Patients</th><th>Excluded Patients</th></tr><tr><th colspan="2">Wait Time for Pre-Transplant (Measured in Calendar Days)</th><th></th><th>Min</th><th>Max</th><th></th><th></th><th></th></tr><tr><td rowspan="4">Referral to Triage Appointment Wait Time (Target: 21 calendar days)</td><td>2022 Q4</td><td>7.0</td><td>0</td><td>141</td><td>86%</td><td>71</td><td>8</td></tr><tr><td>2023 Q1</td><td>7.0</td><td>0</td><td>127</td><td>92%</td><td>71</td><td>21</td></tr><tr><td>2023 Q2</td><td>7.0</td><td>0</td><td>77</td><td>88%</td><td>93</td><td>15</td></tr><tr><td>2023 Q3</td><td>6.5</td><td>0</td><td>113</td><td>81%</td><td>54</td><td>4</td></tr></table> <table><tr><th colspan="2" rowspan="2"></th><th colspan="5">UCD</th></tr><tr><th>Median Wait Time</th><th colspan="2">RANGE</th><th>% of Patients within the Target</th><th>Included Patients</th><th>Excluded Patients</th></tr><tr><th colspan="2">Wait Time for Pre-Transplant (Measured in Calendar Days)</th><th></th><th>Min</th><th>Max</th><th></th><th></th><th></th></tr><tr><td rowspan="4">Referral to Triage Appointment Wait Time (Target: 21 calendar days)</td><td>2022 Q4</td><td>19.0</td><td>4</td><td>65</td><td>61%</td><td>44</td><td>35</td></tr><tr><td>2023 Q1</td><td>19.5</td><td>4</td><td>88</td><td>70%</td><td>30</td><td>40</td></tr><tr><td>2023 Q2</td><td>26.0</td><td>7</td><td>60</td><td>43%</td><td>35</td><td>43</td></tr><tr><td>2023 Q3</td><td>24.0</td><td>10</td><td>59</td><td>45%</td><td>40</td><td>31</td></tr></table>			UCSF					Median Wait Time	RANGE		% of Patients within the Target	Included Patients	Excluded Patients	Wait Time for Pre-Transplant (Measured in Calendar Days)			Min	Max				Referral to Triage Appointment Wait Time (Target: 21 calendar days)	2022 Q4	7.0	0	141	86%	71	8	2023 Q1	7.0	0	127	92%	71	21	2023 Q2	7.0	0	77	88%	93	15	2023 Q3	6.5	0	113	81%	54	4			UCD					Median Wait Time	RANGE		% of Patients within the Target	Included Patients	Excluded Patients	Wait Time for Pre-Transplant (Measured in Calendar Days)			Min	Max				Referral to Triage Appointment Wait Time (Target: 21 calendar days)	2022 Q4	19.0	4	65	61%	44	35	2023 Q1	19.5	4	88	70%	30	40	2023 Q2	26.0	7	60	43%	35	43	2023 Q3	24.0	10	59	45%	40	31
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Patient and Graft Survival Patient and Graft Survival target rates are within expected hazard ratios set by Scientific Registry of Transplant Recipients (SRTR).	Conduct quality review on 1- and 3-year patient and graft survival rates. Compare observed performance with expected and national data from the SRTR. Compare the same metrics as above for KP-specific population by reviewing NTS reports created with the help of UNOS	Renal Transplant / Kidney Transplant Clinics; Renal Quality and Performance Improvement Committee Annually	GOAL MET. One and three-year survival rates are calculated by organ, institution, and living versus deceased donor by the Scientific Registry of Transplant Recipients (SRTR). It includes all patients transplanted by the COEs. A hazard ratio above 1 indicates higher than expected graft failure rates (e.g., a hazard ratio of 1.5 would indicate 50% higher risk), and a ratio below 1 indicates lower than expected graft failure rates (e.g., a hazard ratio of 0.75 would indicate 25% lower risk). The observed hazard ratios for UCSF were at or below the expected ratios for both patient and graft survival and for living and deceased donor at one and three years (1-year graft survival: 1.09 deceased donor; 0.86 living donor. 1- year patient survival: 0.91 deceased donor; 0.64 living donor; 3- year graft survival: 0.90 deceased donor; 0.63 living donor. 3- year patient survival: 0.81 deceased donor; 0.43 living donor). The observed hazard ratios for UCD were below the expected ratios for both patient and graft survival for living and deceased donor transplants at one year and three years. (1- year graft survival: 0.92 deceased donor; 0.79 living donor. 1- year patient survival: 0.38 deceased donor; 1.03 living donor. 3- year graft survival: 1.06 deceased donor; 0.61 living donor. 3- year patient survival: 0.94y deceased donor; 0.65 living donor). Cedars Sinai transplant center specializes in transplanting patients who are highly sensitized and are more likely to encounter a rejection episode. Observed hazard ratios were at or below the expected hazard ratios for patient survival at both one and three years. KP National Transplant Services, in partnership with UNOS, has recently developed a dashboard using Kaiser Permanente patient records and UNOS data to compute risk-adjusted expected outcomes for transplanted patients. These risk-

Kidney Transplant Clinics

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
			adjusted outcome models compare outcomes of KP transplant recipients relative to national transplant recipients. The risk-adjusted expected outcomes are based on data as of October 25, 2021, and captures a different cohort of transplant recipients from the observed hazard ratio data presented above: The observed hazard ratio for UCSF for 1 and 3-year patient survival were below the expected ratio (0.95 and 0.87 respectively). The observed hazard ratio for UCD for 1 and 3-year patient survival was also below the expected ratio (0.97 and 0.94 respectively). The observed hazard ratio for UCSF for 1 and 3-year graft survival was above but near the expected ratio (1.06 and 1.11 respectively). The observed hazard ratio for UCD for 1-year graft survival was above the expected ratio, however the observed hazard ratio for 3-year graft survival was below the expected ratio (1.41 and 0.86 respectively). Next steps Continue to monitor annually.
Member Complaints and Grievances Complaints and grievances filed by KP members regarding the quality, services and care received at the Transplant COE are reviewed. Target ≤ 1% of patients who receive care at a Transplant COE submit a complaint or grievance.	Monitor and review complaints and grievances with the Transplant COEs during monthly conferences and biannual Oversight Joint Meetings.	Renal Transplant / Kidney Transplant Clinics Monthly	GOAL MET Analysis There were 3 complaints filed in 2023, which is below the 1% target. One complaint was filed by a KP member regarding their cost share for medication. The other two complaints were related to patient preference of brand medication. Next steps Ongoing monitoring of complaints and grievances for trends in the areas of renal transplant access, service, and quality.
Patient Satisfaction ≥ 75% favorable rating received from Transplanted Members.	Send patient satisfaction questionnaire to: members evaluated for a transplant 30-days after members are denied or listed for transplant	Renal Transplant / Kidney Transplant Clinics; Renal Quality and Performance	GOAL MET Patient satisfaction with the Center of Excellence ranged from a low of 92% and 84% (UCSF, UCD respectively) to a high of 97% and 92% (UCSF, UCD respectively) for post-transplant

Kidney Transplant Clinics

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps																																												
	transplanted members 90-days after receipt of transplant Analyze the results from the patient satisfaction questionnaire and review with the Transplant centers during biannual Oversight Joint Meetings.	Improvement Committee Quarterly	patients – meeting or exceeding target for each recorded quarter. Given the total number of transplants and the response rate, variability per quarter is expected. <table><tr><th colspan="5">Transplant Patient Survey</th></tr><tr><th rowspan="2"></th><th colspan="2">UCSF</th><th colspan="2">UCD</th></tr><tr><th>Response Rate</th><th>Favorable Rating</th><th>Response Rate</th><th>Favorable Rating</th></tr><tr><td>Target</td><td></td><td>75%</td><td></td><td>75%</td></tr><tr><td>2022 Q 4</td><td>21%</td><td>97%</td><td>29%</td><td>89%</td></tr><tr><td>2023 Q 1</td><td>15%</td><td>92%</td><td>25%</td><td>89%</td></tr><tr><td>2023 Q 2</td><td>24%</td><td>95%</td><td>32%</td><td>92%</td></tr><tr><td>2023 Q 3</td><td>23%</td><td>94%</td><td>27%</td><td>84%</td></tr><tr><td colspan="2">At or Above Target</td><td>Within 20% of Target</td><td colspan="2">20% From Target</td></tr></table> Patient satisfaction with the Center of Excellence ranged from a low of 75% (for both UCSF & UCD) to a high of 89% and 86% (UCSF, UCD respectively) for pre-transplant patients. Both UCSF and UCD met or exceed target in each recorded quarter.	Transplant Patient Survey						UCSF		UCD		Response Rate	Favorable Rating	Response Rate	Favorable Rating	Target		75%		75%	2022 Q 4	21%	97%	29%	89%	2023 Q 1	15%	92%	25%	89%	2023 Q 2	24%	95%	32%	92%	2023 Q 3	23%	94%	27%	84%	At or Above Target		Within 20% of Target	20% From Target	
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Quality Indicators and Sentinel Events (within 90-days of transplant) Ensure all complications within 90-day of transplant are captured. Compare data quarterly to ensure there are no fluctuations in the 90-day quality indicators.	Monitor quality indicators with Transplant centers at monthly conferences and biannual Oversight Joint Meetings. Address any reported fluctuations in quality indicators with Transplant centers. Report sentinel events to KP Regional Risk Management. Corrective measures will be taken with the transplant centers to address fluctuations in quarterly quality indicator data.	Renal Transplant / Kidney Transplant Clinics; Renal Quality and Performance Improvement Committee Quarterly	GOAL MET Analysis The Kidney Transplant Clinic monitors quarterly reports for the percent of transplant recipients with complications including delayed graft function and surgical complications. The results at each COE each quarter remain generally consistent, without major outliers. Next steps Continue to monitor trends for each Transplant COE. There are no published national benchmarks for this timeframe (within 90-days of transplant).																																												

Medi-Cal Geographic Managed Care (GMC)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
Population Needs Assessment 2022 – 2024 <u>Health Disparity</u> Focus on improving the health of African American women and their children. Goal: Improve Postpartum Visit rate among African American members in the Sacramento Valley. Metric: By September 30, 2024, increase Postpartum Visit rate among African American members in the Sacramento Valley from baseline of 67.6% (ECHO (Equitable Care Health Outcomes) Data end date Q3 2021) to 70% by ECHO Data end date Q3 2024. Baseline: 67.6% Target: 70% Process measure: Prenatal Depression Screening & Postpartum Depression Screening	Request necessary data to track both outcome and process measures. Develop Charter with established Stakeholder Group. Develop specific PDSAs (Plan Do Study Act) with the Stakeholder workgroup to address PPV (Postpartum Visits) disparity and process measures related to depression (prenatal and postpartum) Develop exhaustive list of supports for African American (AA) pregnant women, both in the community and internal KP (Kaiser Permanente) resources. Develop workflow, including talking points for both the Member Engagement Specialists (MESs) and the Health Care Coordinators (HCCs). Ensure HCCs are aware of the AA pregnant members on their panel to allow them to conduct necessary outreach, assessment and care plan when needed. Establish the necessary Memorandum of Understands (MOUs) with Community agencies serving this population in ways proven to be successful. Track and evaluate progress following various PDSAs.	▪ GMC Department ▪ GMC Managers ▪ GMC Consultant ▪ GMC Healthcare Coordinators ▪ Sacramento Valley TPMG Women's Health Chiefs and Staff December 31, 2024	Most recent available ECHO rates are through Q32023. Rates for PPV for African American members in Sacramento Valley have escalated to 76.5%, a significant difference from baseline of 67.6% in Q32021. The team has set up a data reporting schedule and receives monthly files that include information for all pregnant women in each of the three Service Areas. Obtained data sharing agreement for process measures, prenatal depression screening and follow-up and postpartum depression screening and follow-up. The Stakeholder Group identified follow-up for both prenatal and postpartum depression screening as area of opportunity for future PDSAs. PDSA #1 ran from May 2023 – November 2023. included outreach to share information about Black Infant Health and Nurse Family Partnership and to obtain consent to make a referral to one or both programs. Telephone encounter was documented in KPHC and OB was messaged through secure message. When speaking to members we also shared information about Doula benefits and made referrals for services when requested. Outreached 253 members, reached 178. Referred 50 to BIH and 15 were enrolled, 6 were referred to both BIH and NFP, 1 member enrolled in NFP. In 3Q2023, we explored a partnership with the Social Health Call Center to initiate calls to pregnant women to introduce the Social Health Hub and provide a link back to OBGYN and PCPs.

Medi-Cal Geographic Managed Care (GMC)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
			This project will be further discussed in 2024 as a PDSA.
Population Needs Assessment 2022-2024 and PDSA 2022-2023 <u>Child and Adolescent Health</u> Focus on improving the health of young Medi-Cal children in Sacramento Valley. Goal: Improve W30-2+ Metric: By December 31, 2024, increase Two Well Child Visits after 15 months through 30 months from the 2021 MCAS baseline of 54.35 to the Medi-Cal Benchmark of 70.67 in Sacramento Valley. Baseline: 54.35 Target: 70.67 Process measure; Well Child Visits between 18 and 24 months	Obtain necessary data agreements for outcome and process measures. Establish Stakeholder Group. Utilize multiple modalities for outreach to engage members with a scheduled visit to remind them of their well child visit appointment. The first PDSA cycle will address Medi-Cal members ages 17-20 months who do not have a well child visit scheduled, and who have a PCP in Sacramento Railyards (SRY) or Sacramento Point West (SAC). The priority barrier is lack of outreach and tracking of unscheduled WCC appointments. Denominator: 141 Medi-Cal children ages 17-20 months due for W30-2+ in SAC and SRY. Numerator: 48 Medi-Cal children ages 17-20 months without a WCC appointment scheduled in SAC and SRY. By 3/10/2023, the percent of booked appointments for W30-2+ measure will	▪ Sacramento Valley TPMG Pediatric Chief (Andrew McDaniel) and assigned Medical Assistant Staff ▪ Data Analytics Consultant: Andre Van Horn ▪ GMC Manager: Gina Anixter December 31, 2024	MCAS 2022 results for W30-2+ is 73.45%, an improvement from baseline 54.35% and far above 2022 MPL of 65.83%. This goal has been met. Obtained data sharing agreements to receive metrics: 2 age groups (17-20 months and 22-26 months) No recent WCC completed, and nothing scheduled PDSA #1- Met As of 3/10/2023 35 of the 48 (72.9%) members have been seen or have an appointment scheduled. Among the denominator of the 141 Medi-Cal children ages 17-20 months due for W30-2+ in SAC and SRY Clinics, 128 have had or were booked for an appointment (90.8%) and 13 still don't have an appointment scheduled. Following review of these 13 cases most don't appear to have a current address, phone number or email. PDSA #2 – Met By 7/7/2023, the number of booked appointments for W30-2+ (attended and booked combined) measure went from zero to 56 of 83 (67.5%) by conducting patient outreach to the 83 members between ages of 21-30 months, who are assigned to a pediatrician in either SAC or SRY Clinics and who do not have a second scheduled well child visit. PDSA #3 – Met

Medi-Cal Geographic Managed Care (GMC)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
	increase by 17% (from 66% to 83%) by conducting patient outreach to the 48 members between ages of 17-20 months, who are assigned to a pediatrician in either SAC or SRY and who do not have a scheduled well child visit. Track and evaluate progress following various PDSAs.		W30-2+: By 11/3/2023, the number of booked appointments for W30-2+ measure will go from zero to 7 children (25%) by conducting patient outreach to the 27 members between ages of 21-30 months, who are assigned to a pediatrician in either SAC or SRY Clinics and who do not have a second scheduled well child visit. W30-6+: By 11/3/2023, the number of booked appointments for W30-6+ measure will go from zero to 5 children (67.56%: NCQA 90% percentile) by conducting patient outreach to the 7 members under 6 months, who are assigned to a pediatrician in either SAC or SRY Clinics and who do not have a 6 month well child visit scheduled. The remaining members from PDSA#2 (9 out 27) (33%) attended their W30-2+ visits. Plus 5 out 7 (71.4%) outreached AA members for W30-6+ attended their well child visits. Two members without outreach both attended their visits. Among the 5 receiving outreach, two did not show and one has been escalated to management for no engagement at KP at all.
Population Needs Assessment 2022-2024 <u>Behavioral Health</u> Improve behavioral health for Medi-Cal members in the Sacramento Valley. Goal: By December 31, 2024, enroll at least 80% of Medi-Cal members (n=67) who are eligible (d=84) for Enhanced Care Management (ECM) who have Severe Mental Illness (SMI). Baseline: 84 eligible 53 enrolled November 2022 (63%).	Obtain necessary data agreements for outcome and process measures. Establish Stakeholder Group. Determine existing Member Outreach Specialist, KP Psychiatry, Medi-Cal Health Care Coordinator, and KP Emergency Room, County Behavioral Health workflows related to SMI. Conduct pilot with Placer County for SMI to establish best practices before spreading to all the surrounding counties.	▪ GMC Department ▪ GMC Managers ▪ GMC Care Coordination Team December 31, 2024	Obtained data sharing agreements. Implemented workflows for enrolling ECM eligible members with SMI/ SUD into the benefit. Of members identified as ECM eligible due to an SMI/ SUD diagnosis (2,474), 88% were enrolled in ECM (2,179). This excludes members identified but not reached after multiple attempts. This goal has been met.

Medi-Cal Geographic Managed Care (GMC)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
Target: 67% Process measure: FUM – Follow-up after emergency department visit for mental illness in 30 days.	Spread workflows and processes to all counties. Proactively promote ECM for SMI among Adult Med and Behavioral Health Clinics. Share monthly enrollment of ECM for SMI with Health Care Coordinators in GMC. Provide additional resources in English and Spanish from Health Education to HCCs: https://mydoctor.kaiserpermanente.org/ncal/video/caring-for-your-emotional-and-mental-health-1600063 https://mydoctor.kaiserpermanente.org/es/ncal/video/caring-for-your-emotional-and-mental-health-1600063 Enroll members in ECM who have SMI. Track and measure both outcome and process measures. Improve Behavioral Health access through Community Agency connections on Thrive Local.		
In the retrospective assessment of the preceding year's work plan, it is noteworthy that KP underwent a significant transition from the GMC to the Direct Contract with DHCS on January 1, 2024. During the autumn of 2023, DDHCS granted approval for the adoption of new clinical and non-clinical Performance Improvement Projects (PIPs) designed to be implemented from 2023 to 2026. Furthermore, the Patient Needs Assessment (PNA) process underwent a shift to CHA/CHIP participation at the county level, effectively commencing on January 1, 2024. As a result of these pivotal changes, all subsequent work plans will be revised to align with the updated framework, superseding the goals outlined in the aforementioned period.			

Member Experience (ME 7)						
Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps			
Commercial, Medicare, and Marketplace Member Experience (ME 7 C-D)						
ME 7 C-D - Analyze and monitor Commercial, Medicare, and Marketplace complaints, grievances and appeals - Conduct a member experience survey - Identify opportunities for improvement	- Identify trends in Commercial, Medicare, and Marketplace complaint, grievance and appeal data which represent opportunities for improvement - Identify trends in member experience surveys which represent opportunities for improvement	TPMG Consulting Services Member Experience Standard Lead Member Concerns Committee Annual: October 2023				
			Q3'22 - Q2'23			
			Commercial	Total	% of Total	Per 10K
			Access	7,107	8%	22.57
			Attitude/Service	40,413	47%	128.32
			Billing/Financial	23,349	27%	74.14
			Quality of Care	14,205	17%	45.10
			Quality of Practitioner Office Site	619	1%	1.97
			Q3'22 - Q2'23			
			Covered CA	Total	% of Total	Per 10K
			Access	771	5%	21.92
			Attitude/Service	6,386	42%	181.58
			Billing/Financial	5,947	39%	169.09
			Quality of Care	2,045	13%	58.15
			Quality of Practitioner Office Site	62	0%	1.76

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			and surveys, the Commercial LOB has an opportunity to: 1. Improve the member experience with staff communication, ensuring that communication is timely, complete, and accurate. 2. Improve member experience with billing for services, through transparency and accuracy From analysis of member experience complaints, appeals, and surveys, the Exchange QHP LOB has an opportunity to: 1. Improve the member experience with staff communication, ensuring accuracy of information provided 2. Attitude and Service; incorrect information given Billing for Emergency Services Medicare Opportunity: From analysis of member experience complaints, appeals, and surveys, the Medicare LOB has an opportunity to: 1. Improve the member experience with staff communication, ensuring accuracy of information provided 2. Improve member experience with billing for services Next Steps: Continue to monitor

Member Experience (ME 7)						
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Behavioral Health Member Experience (ME 7 E-F)						
ME 7 E-F - Analyze and monitor Behavioral Health complaints, grievances and appeals - Conduct a behavioral health member experience survey - Identify opportunities for improvement - Implement at least two interventions	- Identify trends in behavioral health complaint, grievance and appeal data which represent opportunities for improvement - Identify trends in behavioral health member experience surveys of psychiatry and chemical dependency departments which represent opportunities for improvement.	TPMG Consulting Services Member Experience Standard Lead Behavioral Health Quality Oversight Committee Annual: October 2023				
			Commercial	Total	% of Total	Per 10K
			Access	1,798	30%	5.71
			Attitude/Service	2,040	34%	6.48
			Billing/Financial	116	2%	0.37
			Quality of Care	2,028	34%	6.44
			Quality of Practitioner Office Site	4	0%	0.01
			Total	5,986	100%	19.01

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			- There was a 17 percent increase in behavioral Medicare complaints between Q3'21 – Q2'22 and Q3'22 – Q2'23, attributed by a 7% increase in Access complaints, 20% increase in Attitude/Service complaints, 111% increase in Billing/Financial complaints, 19% increase in Quality of Care complaints, and a 50% decrease in Quality of Practitioner Office Site complaints.. - There was a 22 percent increase in behavioral Medi-Cal complaints between Q3'21– Q2'22 and Q3'22 – Q2'23, attributed by a 18% increase in Access complaints, 12% increase in Attitude/Service complaints, 100% increase in Billing/Financial complaints, 35% increase in Quality of Care complaints. Barriers: - Opportunities for Behavioral Health Improvement: Access, Billing/Financial, and Quality of Care Next Steps/Actions: - Implemented the following programs to increase return access and graduate patients through episodes of care. The goal

Member Experience (ME 7)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
			of these evidence-based care tracks is to get patients to remission faster. ○ Created regional pop care program (Virtual ADAPT) to treat mild to moderate depression and anxiety patients to remission ○ Created regional pop care program for SPMI patients, published in NEJM Catalyst (May 2022) and Journal of Clinical Psychiatry (Jan 2024) ○ Created and spread Depression treatment track at KPNC Medical Centers ○ Created and spread ADHD treatment track at KPNC Medical Centers ○ Creating Trauma treatment track to spread across KPNC Medical Centers • Regional rollout of e-visit for anxiety and depression. The program allows members to self-book their new appointment with Mental Health, reducing time spent on triage.

Member Relations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Complaint, Grievance & Appeals (CGAs) Reduction NCAL Region Metric: Achieve target for joint goal reduction in average number of cases per 1k member per month inclusive of all Complaints/Grievances 2023 - Target: 3% reduction from baseline period rate of 2.04 cases per 1k member	- Identify grievance trends by location/area/function - Help facilitate creation/execution of action plans to eliminate pain points to reduce complaint, grievance, and appeals volume Approach varies by service area, some examples include: - Sharing dashboards with leaders for visibility and review/discussion during Member Concern Committee meetings - Integration of care experience training (ECX) to improve service experience - Nurse leader rounding debriefs to improve communication on in-patient plan of care - Continuous coaching via observations/validations - Real-time escalation of dissatisfaction to department leadership for immediate resolution of concerns Partner with departments across the MCA to develop strategies and share best practices	Member Relations (Local Member Services, Grievance Ops, Data & Reporting and key stakeholders at medical offices / hospitals) 10/2023	At the beginning of 2023, Member Relations proposed and socialized a market level CGA reduction goal of 3% across health plan leadership. However, this was placed on hold because the goal required both Health Plan and TPMG approval. For 2024, NCAL joint leadership is working with each service area to implement a CGA reduction goal at the medical center level. Based on actual performance as of December 2023, NCAL finished at 2.70 issues per 1k members, which did not meet the proposed target. When comparing 2022 vs. 2023 year-end results, NCAL saw an increase in volume of 15.10%. Among some of the factors, lack of availability to schedule timely appointments had a significant impact on the increase in member complaints, grievances and appeals. We continue efforts to address CGA at the local level in partnership with medical center and MCC leaders by: - Engaging in regular discussions with local leaders to develop action plans and drive improvements - Monthly complaint and grievance dashboards sent to leaders/stakeholders for visibility and actions - Ongoing review of dashboards during MCC meetings
Medicare 5 Star A. Achieve CMS Medicare 5 Star targets per 2020 Stars Cut points	Enable clear line of sight into Health Plan appeals measure performance for Member Relations grievance	Member Relations (Grievance Ops, Data &	As of December 2023, Member Relations met target for both metrics.

Member Relations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
in: Part C Timeliness Target ≥97% B. Achieve CMS Medicare 5 Star per 2020 Stars Cut points in: Part C Upheld Target ≥97%	- Timely delivery of 5 Star report (based on Service Level Agreement (SLA) to create transparency and quickly identify opportunities and risks - Ensure action plans are tracked for status updates and mitigation efforts are in place to avoid risk / penalties	Reporting, and Quality & Regulatory Ops) 12/31/23	A. Part C Timeliness = 98% B. Part C Upheld = 98% Please note that for the 5-Star goal, cut point changes were unknown for the majority of the year; goals and performance expectations were based on cut points set at the beginning of the year.
Maintain timeliness results for processing claims member grievances at the required compliance targets. 95% of grievance cases are acknowledged within 5 calendar days 95% of grievance cases are resolved within the required compliance targets for each line of business	Continue ongoing monitoring and take actions as indicated to improve performance as needed. - Hiring plan of action being executed to address higher volumes than current staffing case support - Medical center goals to reduce CGAs will positively impact achievement of timeliness goals	CA Grievance Operations Monthly Average	As of December 2023, target was met for Acknowledgement, but missed for Resolution. - Acknowledgement is at 95% - Resolution is at 90% Year over year increase in complaint volume was more than the staffing allocation in the first half of the year; however, with leadership approval we were able to adjust and recover from a backlog with ongoing monthly improvements in timeliness performance as a result of staff hiring efforts. This effort will continue into 2024.

Member Service Contact Center

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps						
Monitor and track call quality metrics to objectives based on the MSCC’s Quality Assurance Call Standards & Expectations. - Threshold: 90% - Target: 92%	- The MSCC’s Quality Assurance department monitors phone calls utilizing the Quality Assurance Call Standards & Expectations. - The Quality Assurance analyst reviews the interaction and assesses the customer service representative’s service provided, accuracy of information provided, ability to follow all policies and procedures, and the interaction’s documentation in our tracking system. - The Call Quality Assurance program includes data collection, reporting, analysis, and identification of opportunities to improve overall performance through process improvements, staff training, coaching, and mentoring.	Member Service Contact Center Regulatory Operations 12/31/2023	1. Analysis of results including metrics<table><tr><th>Metric</th><th>Goal</th><th>2023 Results</th></tr><tr><td>Call Quality</td><td>Threshold: 90% Target: 92%</td><td>91.7%</td></tr></table> The MSCC in the California market met threshold goal in 2023, missing target by only .3%. 2. Barriers In 2023, the MSCCs experienced some staffing challenges that may have affected overall CSR performance. 3. Next steps Continue monitoring and analyzing results in a monthly basis to ensure goals are met.	Metric	Goal	2023 Results	Call Quality	Threshold: 90% Target: 92%	91.7%
Metric	Goal	2023 Results							
Call Quality	Threshold: 90% Target: 92%	91.7%							

Member Service Contact Center

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps						
Monitor and track email quality metrics to objectives based on the MSCC’s Email QA Standards & Expectations. - Threshold: 90% - Target: 92%	- The MSCC’s Quality Assurance department monitors member emails sent after logging into their kp.org account utilizing the Quality Assurance Email Standards & Expectations. - The Quality Assurance analyst reviews the interaction and assesses the customer service representative’s response to the member, the accuracy of information provided, ability to follow all policies and procedures, and the interaction’s documentation in our tracking system. - The Email Quality Assurance program includes data collection, reporting, analysis, and identification of opportunities to improve overall performance through process improvements, staff training, coaching, and mentoring.	Member Service Contact Center Regulatory Operations 12/31/2023	1. Analysis of results including metrics<table><tr><th>Metric</th><th>Goal</th><th>2023 Results</th></tr><tr><td>Email Quality</td><td>Threshold: 90% Target: 92%</td><td>93.4%</td></tr></table> The MSCC in the California market met target goal in 2023. 2. Barriers In 2023, the MSCCs experienced some staffing challenges that may have affected overall CSR performance. 3. Next steps Continue monitoring and analyzing results in a monthly basis to ensure goals are met.	Metric	Goal	2023 Results	Email Quality	Threshold: 90% Target: 92%	93.4%
Metric	Goal	2023 Results							
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Outside Utilization Review Services

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps																																												
Goal - Improve customer service for outbound calls. The % of times that the customer interactions for outbound calls included identification of the case manager by name, the name of the KP/department and that the call is on a recorded line. Methodology: number of compliant in the business telephone analysis program (NICE)/Total number recorded outbound calls monitored Baseline: 2022 was 68% Data Source: NICE business telephone analysis program Measurement Period: 2/01/23 - 12/31/23 Target: 70%	• Include goal in mandatory AB1203 training. • Dept results, progress to goal and reminders to staff during staff meetings. • ANM's to include individual call results during monthly one on one meetings.	OURS Quality and Management Teams Due: 12/31/2023	<table border="1"> <thead> <tr> <th>Sections/Questions</th><th>Y</th><th>N</th><th>%</th></tr> </thead> <tbody> <tr> <td>1. Identification Name & Department</td><td></td><td></td><td></td></tr> <tr> <td>1. Did CM Identify self to caller?</td><td>31</td><td>0</td><td>100%</td></tr> <tr> <td>2. Did CM identify they are from KP/department</td><td>29</td><td>1</td><td>3%</td></tr> <tr> <td>2. Recorded Line Statement</td><td></td><td></td><td></td></tr> <tr> <td>1. Did CM state they were calling from a recorded line?</td><td>17</td><td>9</td><td>53%</td></tr> <tr> <td>Department Average Score:</td><td>0.85</td><td></td><td></td></tr> <tr> <td>Department Average Proportional Score:</td><td>77/93</td><td></td><td></td></tr> <tr> <td>Department Average % Score:</td><td>83%</td><td></td><td></td></tr> </tbody> </table> Target: 70% Results: 83% Barriers: N/A Next steps: Continue to share our progress towards the goal and issue reminders during staff meetings. ANMs will continue to include results during monthly 1:1 meetings.	Sections/Questions	Y	N	%	1. Identification Name & Department				1. Did CM Identify self to caller?	31	0	100%	2. Did CM identify they are from KP/department	29	1	3%	2. Recorded Line Statement				1. Did CM state they were calling from a recorded line?	17	9	53%	Department Average Score:	0.85			Department Average Proportional Score:	77/93			Department Average % Score:	83%										
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Goal - Improve customer service for incoming calls. The % of times that the customer interactions for incoming calls included identification of the operations specialist by name, the name of the KP/department and caller name, and number was obtained prior to the end of the call. Methodology: number of compliant in the business telephone analysis program	• Include goal in mandatory AB1203 training. • Dept results, progress to goal and reminders to staff during staff meetings. • ANM's to include individual call results during monthly one on one meetings.	OURS Quality and Management Teams Due: 12/31/2023	<table border="1"> <thead> <tr> <th>Sections/Questions</th><th>Y</th><th>N</th><th>%</th></tr> </thead> <tbody> <tr> <td>1. Identification of Self and Department</td><td></td><td></td><td></td></tr> <tr> <td>1. Did staff identify self to caller?</td><td>30</td><td>0</td><td>100%</td></tr> <tr> <td>2. Did staff identify they are from KP/Department?</td><td>30</td><td>0</td><td>100%</td></tr> <tr> <td>2. Caller Information</td><td></td><td></td><td></td></tr> <tr> <td>1. Did staff get caller name?</td><td>30</td><td>0</td><td>100%</td></tr> <tr> <td>2. Did staff get where caller is calling from?</td><td>30</td><td>0</td><td>100%</td></tr> <tr> <td>3. Did staff get a call back number in case of disconnection? (within 1 min.)</td><td>30</td><td>0</td><td>100%</td></tr> <tr> <td>Department Average Score:</td><td>1</td><td></td><td></td></tr> <tr> <td>Department Average Proportional Score:</td><td>150/150</td><td></td><td></td></tr> <tr> <td>Department Average % Score:</td><td>100%</td><td></td><td></td></tr> </tbody> </table> Target: 82% Results: 100%	Sections/Questions	Y	N	%	1. Identification of Self and Department				1. Did staff identify self to caller?	30	0	100%	2. Did staff identify they are from KP/Department?	30	0	100%	2. Caller Information				1. Did staff get caller name?	30	0	100%	2. Did staff get where caller is calling from?	30	0	100%	3. Did staff get a call back number in case of disconnection? (within 1 min.)	30	0	100%	Department Average Score:	1			Department Average Proportional Score:	150/150			Department Average % Score:	100%		
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Outside Utilization Review Services

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
(NICE)/Total # recorded outbound calls monitored Baseline: 2022 was 82% Data Source: NICE business telephone analysis program Measurement Period: 2/01/23 - 12/31/23 Target: 84%			Barriers: N/A Next steps: Continue to share our progress towards the goal and issue reminders during staff meetings. ANMs will continue to include results during monthly 1:1 meetings.

Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps

Medicare STARS

Medication Therapy Management (MTM)

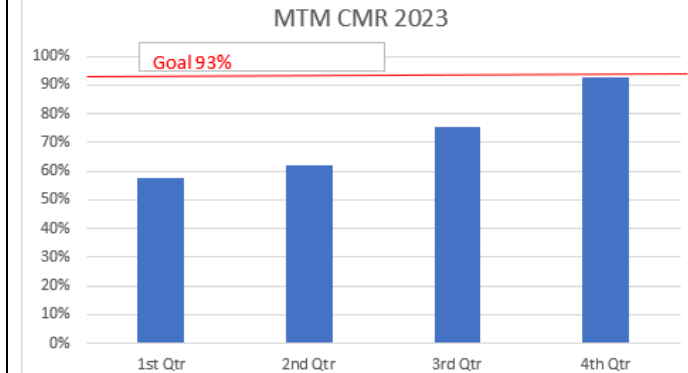
- CMS Medicare Star Rating measure on Comprehensive Medication Reviews (CMR) completion rate, with the goal to improve medication use by reducing adverse events and optimizing therapeutic outcomes.
- For star rating year 2025, (measurement year 2023), Program Office originally forecasted the 5-star cut point at 91% CMR completion rate. However, due to higher-than-expected STAR year 2024 (CY2022) cut points, the Program Office forecast 5-star cut point was increased to 93%.

- Review staffing model
- Incorporate technology to support operations through automated outreach and scheduling and allowing for patient in-reach
- Deploy KPHC Compass Rose for MTM in 2023
- Integrate diabetes deprescribing flag along with communication skills training
- Continue to leverage outpatient pharmacists to complete targeted medication reviews, specifically related to medication adherence
- Support data analytics to demonstrate ROI and impact on patient outcomes
- Continue to enhance the MTM Clinical Workup Tableau dashboard to assist with pharmacist work-up
- Refine non-responder outreach and target outreach within 60 days of enrollment
- Integrate predictive models for patient complexity and no-show for scheduled visits
- Panel management under collaborative practice agreements

Clinical Operations

12/31/2023

Analysis of results:



Evaluation: Target Achieved

- For measurement year 2023 (2025 Star rating year), NCAL achieved a 92.9% CMR completion rate which met Program Office's projected 5-star cut point of 93%. This equates to over 28,800 Medicare members receiving CMRs.
- Achieved 4 stars for 2024 Star rating (2022 performance) with final 5-star cut point at 92% CMR completion rate (+2% above Program Office's projection and +3% from previous calendar year).
- New technology implemented in 2023: KPHC Compass Rose module and text CMR offered
- Integrated diabetes deprescribing flag along with communication trainings
- Refined outreach resulted in most disenrollment occurring within 60 days of enrollment (therefore,

Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
			removed from the denominator). Compass Rose will further improve timely & multiple outreaches. - Improved collaborative practice agreement (i.e., pharmacist protocol) efficiencies with panel management Barriers: - Rising CMS 5-star cut point for MTM CMR completion rate with eligible population expansion proposal - Extensive documentation process for CMS reporting requirements makes it hard to leverage medication reconciliations completed by other programs Next steps: - Metric achieved and will continue to monitor in 2024 Trilogy plan. Continue applicable plans. - Work with inter-regional MTM programs to improve Compass Rose efficiency - Integrate outpatient pharmacy CMRs & targeted medication reviews using a simpler workflow - Integrate predictive models for patient complexity. - Support data analytics to demonstrate ROI and impact on patient outcomes
Med Adherence/SUPD CMS Medicare Star Rating measures on medication adherence to non-insulin diabetes, statin, or RAS agents to improve patient outcomes.	- Develop a staffing model to ensure an adequate number of weekly outreaches are completed - Move to a new patient list platform called the Member Outreach	Pharmacy Operations 12/31/2023	Analysis of results:

Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps																																										
2025 star rating year (2023 measurement year) medication adherence 5-star cut points internally projected from Program Office: - Non-Insulin Diabetes (DM) Agents: 91% (triple-weighted) - Renin-Angiotensin System (RAS) Agents: 91% (triple-weighted) - STATIN: 91% (triple weighted) - Statin Use in Persons with Diabetes (SUPD): 93% (single-weighted) Note: Given the unexpected shifts in the Star year 2024 Clinical Part D cut points, Program Office 2025 projected cut points were revised as listed above with Adherence cut-points decreased and SUPD increased. Health equity sub-scoring: to improve medication adherence in underserved ethnicities, namely African American patients. - Annual Incentive Plan (AIP)/Health Equity targets (based on a calculator from AIP) and may include more ethnicities in addition to African American patients: - Below Threshold: < 3.0 - Threshold: 3.0 - 11.9	Management (MOM) tool created by National Pharmacy Analytics - Maintain interactive texts, batch secure messages, and outreach telephone calls at 80+% reach rate - Continue to incorporate additional technology, e.g., IVR robocalls and Pharmacy Digital Transformation features - Continue targeted medication list clean-up, including 90 to 100 day supply conversions and deprescribing - Complete annual claims remediation - Further integrate social health with use of the Social Health Predictive Model and communication skills training - Panel management under collaborative practice agreements		<table><tr><td></td><td colspan="4">Data Source</td><td></td></tr><tr><td></td><td>National Pharmacy (Rolling 12 months)</td><td colspan="3">Program Office Forecasts (Acumen Reports available after Q2)</td><td></td></tr><tr><td></td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td><td>Goal</td></tr><tr><td>DM</td><td>88.6%</td><td>91.4%</td><td>90.9%</td><td>92.2%</td><td>91%</td></tr><tr><td>RAS</td><td>89.1%</td><td>91.3%</td><td>91.1%</td><td>92.5%</td><td>91%</td></tr><tr><td>STATIN</td><td>88.6%</td><td>91.4%</td><td>90.9%</td><td>92.9%</td><td>91%</td></tr><tr><td>SUPD</td><td>93.2%</td><td>91.5%</td><td>92.2%</td><td>92.2%</td><td>93%</td></tr></table> Evaluation: Target Achieved: DM, RAS, Statin Target NOT Achieved: SUPD - For 2023, based on Program Office projections (5-star cut points projections updated after final 2023 cut points released): - DM 92.1% (goal 91%) – 5 stars - RAS 92.4% (goal 91%) – 5 stars - STATIN 92.6% (goal 91%) – 5 stars - SUPD: 92.2% (goal 93%) – 4 stars - Annual Incentive Plan (AIP) health equity score at 9.2 (at threshold) - Implemented new patient list platform called the Member Outreach Management (MOM) tool - Implemented IVR to obtain authorizations to refill medications, saw 13% lift in refill rates at 7 days which saves the need for ~500 telephone touches in the following weeks - Phone outreach goal of 80% reach/review rate not met (average 66%).		Data Source						National Pharmacy (Rolling 12 months)	Program Office Forecasts (Acumen Reports available after Q2)					Q1	Q2	Q3	Q4	Goal	DM	88.6%	91.4%	90.9%	92.2%	91%	RAS	89.1%	91.3%	91.1%	92.5%	91%	STATIN	88.6%	91.4%	90.9%	92.9%	91%	SUPD	93.2%	91.5%	92.2%	92.2%	93%
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Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
○ Target: 12.0 - 20.9 ○ Max: 21.0			• 2-week refill rate goal of 70% not met (average 62%) • Worked with Regional TPMG leaders to coordinate SUPD exclusion coding that is applicable to HEDIS and CMS SUPD measure, rather than the code they were utilizing that only excluded from HEDIS • Created SUPD patient lists and started pharmacist outreach to refill (2x difference in statin fill, $p<0.001$) and initiate statin (5-6x difference in statin fill, $p<0.001$) • Integrated social health training in KP Learn • Journal of Managed Care Pharmacy validates social health predictive risk score • Residency poster highlights value in Spanish-speaking pharmacists screening social health risks with transportation and food access as the most common needs • Pharmacy & Therapeutics approved scripts with days supply <100 to be converted to 100 days supply to support adherence and maximize drug benefits • Improved collaborative practice agreement (i.e., pharmacist protocol) efficiencies with panel management Barriers: • High 5-star cut points • Patient alert-fatigue & fear of scams • Medication stockpiling with timely refills over time

Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps								
			Next steps: - Refine staffing model to support seasonal timeline to ensure outreach goals & effectiveness - Continue targeted medication list clean-up, including 100 day supply conversions and diabetes deprescribing - Continue SUPD coordination with TPMG, including pharmacist outreach - Coordinate with National Pharmacy refill campaigns - Continue monitoring on 2024 Trilogy plan								
Member Experience											
Improve Customer Service with Reduced Internal Turn Around Time (TAT) in Mail Order Pharmacy: Target: Internal TAT >70% prescriptions processed in 3 days	- Optimize staffing - Process improvement for optimization of automation - Installation of automation to reduce manual filling of medication	Centralized Service Team Q4 2023	Analysis of Results <table border="1"> <thead> <tr> <th>1Q23</th><th>2Q23</th><th>3Q23</th><th>4Q23</th></tr> </thead> <tbody> <tr> <td>68.3%</td><td>72.47%</td><td>75.36%</td><td>77.09%</td></tr> </tbody> </table> Evaluation: Target Achieved Barriers: Defect resolution in progress but can take time due to investigations and testing. Next Steps: Continue working with vendor in resolution of defects and reassess operational efficiencies. Transition off 2024 Trilogy plan. National and local Mail Order team will continue monitoring these results.	1Q23	2Q23	3Q23	4Q23	68.3%	72.47%	75.36%	77.09%
1Q23	2Q23	3Q23	4Q23								
68.3%	72.47%	75.36%	77.09%								
Improve JD Power Scores	Increase in staffing for clerks and technicians	Outpatient Pharmacy Team Q4 2023	Analysis of Results <table border="1"> <thead> <tr> <th>1Q23</th><th>2Q23</th><th>3Q23</th><th>4Q23</th></tr> </thead> <tbody> <tr> <td>841</td><td>878</td><td>890</td><td>882</td></tr> </tbody> </table>	1Q23	2Q23	3Q23	4Q23	841	878	890	882
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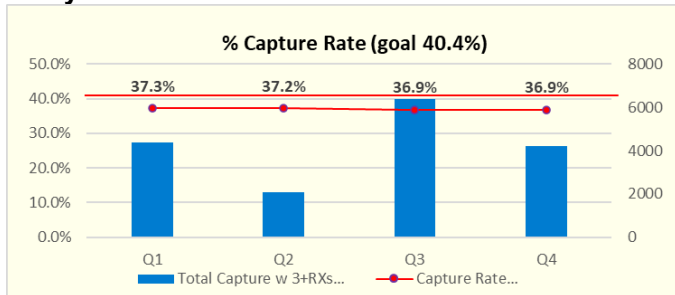
Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Improve overall satisfaction score to ≥ 900	- Operational best practices being followed - Reduce overall wait times		Evaluation: Target goal Not Achieved in 2023. Ended the year at 873 YTD. Positive improvement was demonstrated from Q1 to Q4 (41-point increase). Barriers: - Continued national drug shortages in key therapeutic classes - Recruitment challenge with ongoing national shortage of pharmacy technicians - OPIOID shortages/escalations - SEIU strike and post-strike challenges with volume. Next Steps: - Signage: leverage National Signage program to provide clear guidance to members - Manager Excellence Training: standardized training curriculum for front line managers - Scheduling: standardize to ensure consistent member experience - Continue to leverage technology to improve member experience - Continue to track metric on 2024 Trilogy Plan
Improving Customer Service and Self-Service Technology PCC dashboard targeted goals obtained and sustained as below:	- Leverage Nexedia AI to improve customer service, identify reason for calls, and barriers to self-service utilization - Retention Strategy	Centralized Service Team Digital Project Solution Team National Pharmacy Ops Team	Analysis of Results

Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps															
80% Calls answered within 30 secs (starting April 2023)	- Convert clerks to technician - Optimize PCC model. Consider decentralize and/ or annex hubs. - Push for remote work regulation with the BOP - Enhance IVR self-service - Natural Language - Rx Status - CC update - MFAP/Zero copay 1st fill - Spread Click to Chat NCal wide.	Contact Center Technology Team Q4 2023	Calls Answered and Service Levels 80% Answered in <table><thead><tr><th>Quarter</th><th>Calls Answered (Approx.)</th><th>Service Level (Approx. %)</th></tr></thead><tbody><tr><td>Q1 2023 *</td><td>380,000</td><td>65%</td></tr><tr><td>Q2 2023 *</td><td>450,000</td><td>80%</td></tr><tr><td>Q3 2023 *</td><td>480,000</td><td>70%</td></tr><tr><td>Q4 2023 *</td><td>470,000</td><td>70%</td></tr></tbody></table> Evaluation: - Target 80% Calls Answered in 30 Sec achieved Q2 2023 (new goal 80% Calls Answered in 30 sec effective April 2023) Goal not achieved in Q4 2023. Barriers: - Drivers to lower service levels - Backorders - Resource diverted to C2C go-live - Retention Next Steps: - Accelerated Hiring Process - Review retention opportunities - Systems enhancements - Chatbot technology - Natural Language Phone system - Continue to monitor metric via Operational teams and transition off the 2024 Trilogy Plan.	Quarter	Calls Answered (Approx.)	Service Level (Approx. %)	Q1 2023 *	380,000	65%	Q2 2023 *	450,000	80%	Q3 2023 *	480,000	70%	Q4 2023 *	470,000	70%
Quarter	Calls Answered (Approx.)	Service Level (Approx. %)																
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Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps															
			JD powers scores for Brick & Mortar and Mail Order will flex overall pharmacy service levels															
Optimize Centralized Pharmacy New Member Program Increase Capture rate to 3% increase over 2022 baseline of 37.4% for a target of 40.4% Background: Improving new member capture rate will improve new member onboarding experience with KP. Will provide a “Wow” experience for the member by transitioning prescription needs before the 1 st PCP appointment creating more time for provider and members to discuss medical needs. This also supports member retention.	- Pharmacy strategic staffing plan for 1st quarter of each year - Partner with TPMG and Management Strategy consultant to improve new member referrals to pharmacy	Centralized Service Team NCAL Local New Member Onboarding Team TPMG Q4 2023	Analysis of Results  <table><caption>% Capture Rate (goal 40.4%)</caption><thead><tr><th>Quarter</th><th>Capture Rate</th><th>Total Capture w 3+RXs...</th></tr></thead><tbody><tr><td>Q1</td><td>37.3%</td><td>~4500</td></tr><tr><td>Q2</td><td>37.2%</td><td>~2500</td></tr><tr><td>Q3</td><td>36.9%</td><td>~6500</td></tr><tr><td>Q4</td><td>36.9%</td><td>~4500</td></tr></tbody></table> Evaluation: 2023 Capture Rate = 36.9% - Target goal 40.4% not achieved Barriers: - Lost opportunity with timely transitions - Opportunity for higher referral rates Next Steps: - Member outreach (text message, secure message, cold calls) - Collaborate with TPMG by increasing new member referrals to Pharmacy's new member onboarding program. - Continue to monitor metric on 2024 Trilogy plan	Quarter	Capture Rate	Total Capture w 3+RXs...	Q1	37.3%	~4500	Q2	37.2%	~2500	Q3	36.9%	~6500	Q4	36.9%	~4500
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Q4	36.9%	~4500																
Electronic Prescribing Controlled Medications for patients discharging to SNF	Reach agreement with Regional HBS leadership and KPHC technical leads to establish e-	Pharmacy Continuum Team	Analysis of Results															

Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps								
Goal: - In an effort to adopt electronic prescribing as the primary method for prescribing control substances for patients discharging from hospital to SNF, we aim to improve the rate of e-prescribing to 10% above baseline for patients discharging from hospital to SNF on a controlled substance. - E-prescribing controlled substances for patients discharging to SNF will improve member experience, decrease delays in start of care therapy, reduce manual prescriber error and decrease calls made to after-hours advice program for missing hardcopies. Baseline: 4% - Target ≥ 14% by end of 2023 Background - Electronic prescribing is the gold standard method for prescribing controlled substances in many healthcare settings. - E-prescribing controlled substances for patients discharging to SNF will improve member experience, decrease delays in start of care therapy, reduce manual prescriber error and decrease calls made to after-hours Continuing Care Advice Program (CCAP) for missing hardcopies. Invalid prescription leads to delays in start of therapy for regimen's such as	prescribe workflow for HBS/ED physicians. - Communicate & implement e-prescribing workflow for controlled substances to transition of care teams in the medical center and SNF. - Function as subject matter expert for local medical centers interested in piloting e-prescribing for SNF discharges. - Assess e-prescribing utilization through data analysis of e-prescribing prescription volume to SNF's pharmacy	Q4 2023	SNF Electronic Prescribing Rate <table><tr><td>Q12023</td><td>Q22023</td><td>Q32023</td><td>Q42024</td></tr><tr><td>2%</td><td>5%</td><td>14%</td><td>26%</td></tr></table> Evaluation: Target Achieved - Target achieved to improve the rate of e-prescribing to 10% above baseline for patients discharging from hospital to SNF on a controlled substance. - Regional roll-out launched on September 22nd as part of KPHC Fall upgrade Barriers: - Availability of KPHC resources for technical build - SEIU strike impact on regional launch Next Steps: - Goal completed. Continue to track progress in Operational meeting. - Continual update of regional smart phrase. - Reassess e-prescribing launch with regional stakeholders - Re-evaluate e-prescribing non-controlled/OTC medications.	Q12023	Q22023	Q32023	Q42024	2%	5%	14%	26%
Q12023	Q22023	Q32023	Q42024								
2%	5%	14%	26%								

Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps

pain and/or anxiety. - E-Prescribing is available in KP HealthConnect (KPHC) via the Surescripts functionality. However, implementation of e-prescribing in the SNF setting has been delayed due to coordination and technical challenges. - The current process of prescribing controlled substance for patients discharging to SNF is to manually write a DEA tamper-resistant prescription. This manual process increases the risk of prescriber error and leads to delays in start of therapy and poor member experience for patients arriving to SNF with an invalid prescription.			

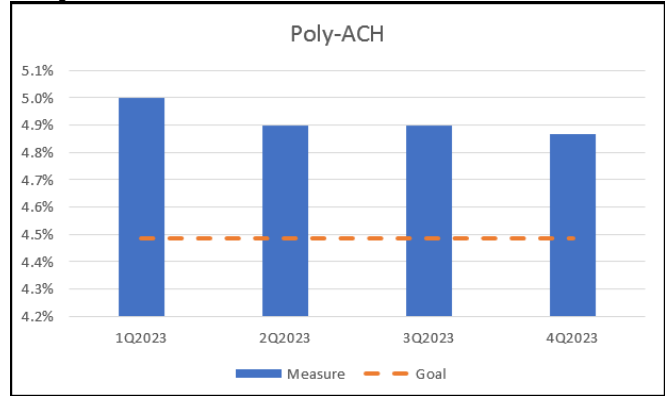
Medication Use / Deprescribing

High Risk Medications- Polypharmacy: Reduce use of multiple CNS-active and anticholinergic medications in members ≥ 65 years of age Achieve new Dual Goal targets effective 10/22: Polypharmacy CNS-active: Phase 1 (10/2023): 10% reduction from MC BL <u>OR</u> $\leq$ NCAL avg (8.4%) Phase 2 (10/2024): 15% reduction from MC BL <u>OR</u> $\leq$ NCAL avg (8%) Polypharmacy Anticholinergic:	- Continue to work with TPMG and pharmacy leaders to identify ways to promote deprescribing and continue to reduce polypharmacy. - Engage key prescribers: - AFM - Female Pelvic Medicine and Reconstructive Surgery - Neurology - Obstetrics and Gynecology - Psychiatry - Urology - MTM pharmacists - AmCare clinical pharmacists - TPMG quality team - Leverage KPHC support	Drug Use Management Team 12/31/2023	Polypharmacy CNS-Active ($\downarrow$ is better) Analysis of Results Evaluation: Target Achieved <table><caption>Poly- CNS Data</caption><thead><tr><th>Quarter</th><th>Measure (%)</th><th>Goal (%)</th></tr></thead><tbody><tr><td>1Q2023</td><td>9.2</td><td>8.4</td></tr><tr><td>2Q2023</td><td>8.9</td><td>8.4</td></tr><tr><td>3Q2023</td><td>8.3</td><td>8.4</td></tr><tr><td>4Q2023</td><td>7.9</td><td>8.4</td></tr></tbody></table>	Quarter	Measure (%)	Goal (%)	1Q2023	9.2	8.4	2Q2023	8.9	8.4	3Q2023	8.3	8.4	4Q2023	7.9	8.4
Quarter	Measure (%)	Goal (%)																
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3Q2023	8.3	8.4																
4Q2023	7.9	8.4																

Pharmacy Operations

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Phase 1 (10/2023): 5% reduction from MC BL <u>OR</u> ≤ NCAL avg (4.5%)	- o Best practice alerts - o SmartPhrases • Collaborate with Health Engagement Consulting Services (HECS)		Barriers: • Polypharmacy: Avoidance of Multiple Medications, focuses on the combinations of medications rather than a single agent, and the 2022 updates include high volume medication classes added to the metric. CNS-active medication classes added include SNRIs and antiepileptics commonly used to treat anxiety, depression, insomnia, pain, etc. The addition of these medication classes increases the numerator and denominator for the metric, which results in an overall increase of utilization of concurrent CNS-active agents. • Due to the backlog of COVID-19, many patients have returned to in-person appointments, minimizing extra time for deprescribing outreach efforts. • Challenging to see real-time progress as the impact of the completed work is reflected in 12 months due to the continuous data methodology determined by CMS. Next Steps: • Metric is achieved and will be carried into the 2024 plan. • Continue to disseminate initiative performance tracking through the monthly DRUM scorecard and Initiatives Report, which provides physician and pharmacy leadership tools to evaluate the medical center performance and identify areas of opportunity that exist for improving a medical center's performance. • Continue physician education and shared decision-making strategies for deprescribing.

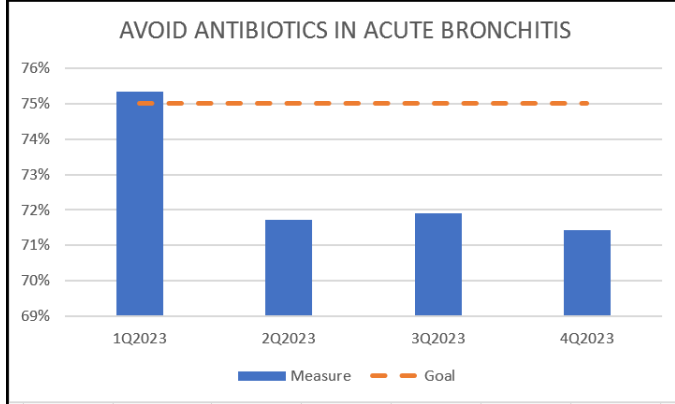
Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps															
			- Developed new standing agenda to be presented during the Bimonthly McDRUM webinar to focus on deprescribing presented by the Regional NCAL Eldercare Champion. Polypharmacy ACH (↓ is better) Analysis of Results Poly-ACH <table><thead><tr><th>Quarter</th><th>Measure (%)</th><th>Goal (%)</th></tr></thead><tbody><tr><td>1Q2023</td><td>5.0%</td><td>4.5%</td></tr><tr><td>2Q2023</td><td>4.9%</td><td>4.5%</td></tr><tr><td>3Q2023</td><td>4.9%</td><td>4.5%</td></tr><tr><td>4Q2023</td><td>4.8%</td><td>4.5%</td></tr></tbody></table> Evaluation: Target NOT Achieved Barriers: - Polypharmacy: Avoidance of Multiple Medications, focuses on the combinations of medications rather than a single agent, and the 2022 updates include the following anticholinergic medications to the metric methscopolamine and pyrilamine (minimal impact to performance). - Due to the backlog of COVID-19, many patients have returned to in-person appointments,	Quarter	Measure (%)	Goal (%)	1Q2023	5.0%	4.5%	2Q2023	4.9%	4.5%	3Q2023	4.9%	4.5%	4Q2023	4.8%	4.5%
Quarter	Measure (%)	Goal (%)																
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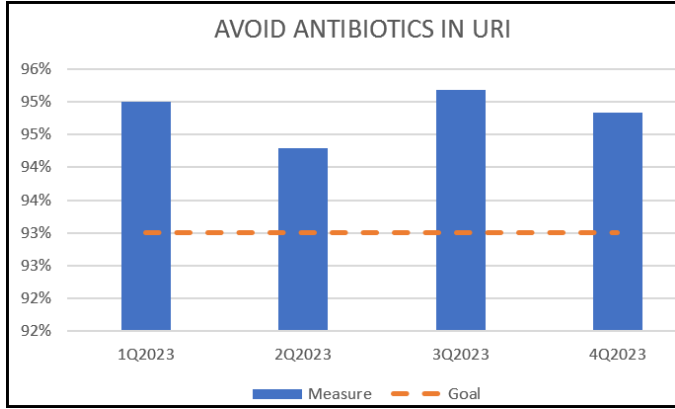
Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
			minimizing extra time for deprescribing outreach efforts. - Challenging to see real-time progress as the impact of the completed work is reflected in 12 months due to the continuous data methodology. Next Steps: - Metric is not achieved and will be added for the 2024 plan. - Continue to disseminate initiative performance tracking through the monthly DRUM scorecard and Initiatives Report, which provides physician and pharmacy leadership tools to evaluate the medical center performance and identify areas of opportunity that exist for improving a medical center's performance. - Continue physician education and shared decision-making strategies for deprescribing. - Developed new standing agenda to be presented during the Bimonthly McDRUM webinar to focus on deprescribing presented by the Regional NCAL Eldercare Champion.

Pharmacy Operations

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Appropriate Antibiotic Utilization – Expansion - POTENTIAL: Antibiotic Utilization for Respiratory Conditions - Avoid use of antibiotics in Acute Bronchitis ≥ 75% * - Avoid use of antibiotics in URI ≥ 93%* *External HEDIS quality measures. DrUM expanded the outpatient antimicrobial stewardship and expanded antibiotic avoidance in acute rhinosinusitis.	- Evaluate new HEDIS antibiotic metric- Antibiotic Utilization for Respiratory Conditions (AXR): The percentage of episodes for members 3 months of age and older with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event. - Evaluate performance of the existing antibiotic avoidance measures. - Continue partnership with TPMG Chair of Chiefs - Infectious Disease (ID) - Pediatrics - Adult and Family Medicine - Emergency Medicine - Pediatric Infectious Disease Regional Lead - Introduce new antibiotic measures with ID specialists and continue antibiotic avoidance best practice sharing during the Bimonthly McDRUM Webinars. - Outlier physician education as needed.	Drug Use Management Team 12/31/2023	Avoid use of antibiotics in Acute Bronchitis (↑ is better) Analysis of Results AVOID ANTIBIOTICS IN ACUTE BRONCHITIS <table border="1"><thead><tr><th>Quarter</th><th>Measure (%)</th><th>Goal (%)</th></tr></thead><tbody><tr><td>1Q2023</td><td>75.5</td><td>75.0</td></tr><tr><td>2Q2023</td><td>71.5</td><td>75.0</td></tr><tr><td>3Q2023</td><td>72.0</td><td>75.0</td></tr><tr><td>4Q2023</td><td>71.5</td><td>75.0</td></tr></tbody></table> Evaluation: Target NOT Achieved Barriers: - Avoiding antibiotic use during cough and cold season can be challenging, presenting a significant area of opportunity. Next Steps: - Metric is not achieved and will be added for the 2024 plan. - Continue to disseminate initiative performance tracking through the monthly DRUM monitored scorecard. - Continue physician education and shared decision-making strategies for deprescribing.	Quarter	Measure (%)	Goal (%)	1Q2023	75.5	75.0	2Q2023	71.5	75.0	3Q2023	72.0	75.0	4Q2023	71.5	75.0
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Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps															
			Avoid use of antibiotics in URI (↑ is better) Analysis of Results AVOID ANTIBIOTICS IN URI <table><caption>AVOID ANTIBIOTICS IN URI - Performance Data</caption><thead><tr><th>Quarter</th><th>Measure (%)</th><th>Goal (%)</th></tr></thead><tbody><tr><td>1Q2023</td><td>95.0</td><td>93.0</td></tr><tr><td>2Q2023</td><td>94.5</td><td>93.0</td></tr><tr><td>3Q2023</td><td>95.5</td><td>93.0</td></tr><tr><td>4Q2023</td><td>94.8</td><td>93.0</td></tr></tbody></table> Evaluation: Target Achieved Barriers: - Avoiding antibiotic use during cough and cold season can be challenging, presenting a significant area of opportunity. Next Steps: - Metric is achieved and will be added for the 2024 plan. - Continue to disseminate initiative performance tracking through the monthly DRUM monitored scorecard. - Continue physician education and shared decision-making strategies for deprescribing.	Quarter	Measure (%)	Goal (%)	1Q2023	95.0	93.0	2Q2023	94.5	93.0	3Q2023	95.5	93.0	4Q2023	94.8	93.0
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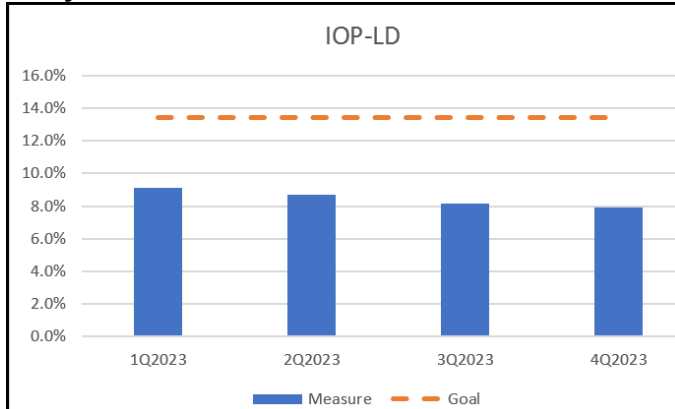
Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps																												
Controlled Substances Reduction																															
Opioid Red Flags Reduction Reduce the number of red flags in opioid prescribing and dispensing while maintaining or improving clinical quality. Goal: decrease in overall red flag percentage by 2% from the prior year by 12/31/2023 Baseline: November 2022 <u>** Note: Baseline subject to change with addition of new red flags</u>	- Outpatient pharmacists exercising their corresponding responsibility to screen all opioid and controlled substance prescriptions for safety concerns and red flags - Pharmacists escalating clinical interventions as appropriate for red flag prescriptions - Outpatient Pharmacy to complete new training for corresponding responsibility - Manager rounding for evidence of documentation of corresponding responsibility - Continue collaboration with Pharmacy and TPMG workgroup, Medical Director of Pharmacy & Regional Opioid Lead	OP Pharmacy Team, Controlled Substances Project Manager 12/31/2023	Analysis of Results December Performance: 48.0% (Note: Goal ≤ 50.7%) - NCAL had an overall -4.7% reduction in adjusted red flag percentage in December 2023 compared to baseline (November 2022). <table><tr><th>Location</th><th>Nov 2022 Baseline</th><th>Jan-23</th><th>Feb-23</th><th>Mar-23</th><th>Apr-23</th><th>May-23</th><th>Jun-23</th><th>Jul-23</th><th>Aug-23</th><th>Sep-23</th><th>Oct-23</th><th>Nov-23</th><th>Dec-23</th></tr><tr><td>NCAL</td><td>52.7%</td><td>49.1%</td><td>48.4%</td><td>48.2%</td><td>47.5%</td><td>47.5%</td><td>47.1%</td><td>47.4%</td><td>46.8%</td><td>47.0%</td><td>47.6%</td><td>47.0%</td><td>48.0%</td></tr></table> Evaluation: Target Achieved Barriers: - Operational impacts on Pharmacy and TPMG (tapering is resource intensive) Next Steps: - The metric has been achieved and will be carried onto the 2024 plan. - Alignment between regional and local review processes to reduce overall overdose events related to opioids. - Focus on different strategies for harm reduction by assessing the high-risk combination drugs with opioids and tapering effort where clinically appropriate. - Pilot sites for Hospital Opioid Honor Roll	Location	Nov 2022 Baseline	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	NCAL	52.7%	49.1%	48.4%	48.2%	47.5%	47.5%	47.1%	47.4%	46.8%	47.0%	47.6%	47.0%	48.0%
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NCAL	52.7%	49.1%	48.4%	48.2%	47.5%	47.5%	47.1%	47.4%	46.8%	47.0%	47.6%	47.0%	48.0%																		

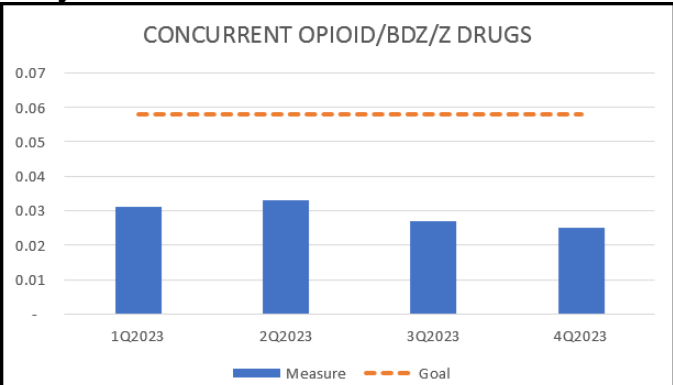
Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps																					
Opioid Measures <table><tr><td>IOP- Opioid High Dose (PQA)</td><td>Avoid prescribing ≥1 initial opioid prescription(s) with an average daily morphine milligram equivalent (MME) of ≥ 50 during the measurement year</td></tr><tr><td>IOP- Long Duration (PQA)</td><td>Avoid prescribing ≥1 initial opioid prescription(s) for >7 cumulative days’ supply during the measurement year</td></tr><tr><td>COB/Z Drugs</td><td>Avoid concurrent use of opioids and benzodiazepines/Z drugs (eszopiclone, zaleplon, zolpidem)</td></tr></table> Goal is the same for the 3 separate measure (lower is better) Phase 1: 5% reduction from NCAL baseline (BL) or 5% reduction from medical center (MC) BL Phase 2: 10% reduction from NCAL BL or 10% reduction from MC BL Phase 3: 15% reduction from NCAL BL or 15% reduction from MC BL	IOP- Opioid High Dose (PQA)	Avoid prescribing ≥1 initial opioid prescription(s) with an average daily morphine milligram equivalent (MME) of ≥ 50 during the measurement year	IOP- Long Duration (PQA)	Avoid prescribing ≥1 initial opioid prescription(s) for >7 cumulative days’ supply during the measurement year	COB/Z Drugs	Avoid concurrent use of opioids and benzodiazepines/Z drugs (eszopiclone, zaleplon, zolpidem)	- Modify 2023 goal setting to further reduce duration and high opioid MME, and concurrent use of opioid/bzd/z drugs. - Leverage support with the Regional Opioid Safety team and 13 Chiefs groups to promote opioid goal setting change. - DrUM to continue to support Regional Opioid Safety team as they lead specialty specific KPHC order sets and preference list changes to reduce opioid MME and dispense quantity.	Controlled Substances Project Manager 12/31/2023	IOP-Opioid High Dose (↓ is better) Analysis of Results <table><thead><tr><th>Quarter</th><th>Measure (%)</th><th>Goal (%)</th></tr></thead><tbody><tr><td>1Q2023</td><td>13.5</td><td>15.5</td></tr><tr><td>2Q2023</td><td>13.0</td><td>15.5</td></tr><tr><td>3Q2023</td><td>12.5</td><td>15.5</td></tr><tr><td>4Q2023</td><td>11.0</td><td>15.5</td></tr></tbody></table> Evaluation: Target Achieved Barriers: - KPHC order sets and preference lists are being worked on by the TPMG Regional Opioid Safety Team to promote lower quantities and MME of opioids. Next Steps: - Metric is achieved and will be added for the 2024 plan. - Plan to scope new goal setting for IOP measures in 2024. - Continue surgeon/prescriber, physician assistant, nursing, and pharmacist education regarding the initiative.	Quarter	Measure (%)	Goal (%)	1Q2023	13.5	15.5	2Q2023	13.0	15.5	3Q2023	12.5	15.5	4Q2023	11.0	15.5
IOP- Opioid High Dose (PQA)	Avoid prescribing ≥1 initial opioid prescription(s) with an average daily morphine milligram equivalent (MME) of ≥ 50 during the measurement year																							
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Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps															
			- Ongoing distribution of surgeon/prescriber level data to identify opportunities for focused education if needed. - Continue partnership with regional opioid safety team to enhancing KPHC content (order sets and preference list) to promote decrease quantity and MME. IOP-Long Duration (↓ is better) Analysis of Results IOP-LD <table><thead><tr><th>Quarter</th><th>Measure (%)</th><th>Goal (%)</th></tr></thead><tbody><tr><td>1Q2023</td><td>8.5</td><td>13.5</td></tr><tr><td>2Q2023</td><td>8.5</td><td>13.5</td></tr><tr><td>3Q2023</td><td>8.5</td><td>13.5</td></tr><tr><td>4Q2023</td><td>8.5</td><td>13.5</td></tr></tbody></table> Evaluation: Target Achieved Barriers: - KPHC order sets and preference lists are being worked on by the TPMG Regional Opioid Safety Team to promote lower quantities and MME of opioids.	Quarter	Measure (%)	Goal (%)	1Q2023	8.5	13.5	2Q2023	8.5	13.5	3Q2023	8.5	13.5	4Q2023	8.5	13.5
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Pharmacy Operations

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			Next Steps: • Metric is achieved and will be added for the 2024 plan. • Plan to scope new goal setting for IOP measures in 2024. • Continue surgeon/prescriber, physician assistant, nursing, and pharmacist education regarding the initiative. • Ongoing distribution of surgeon/prescriber level data to identify opportunities for focused education if needed. • Continue partnership with regional opioid safety team to enhancing KPHC content (order sets and preference list) to promote decrease quantity and MME. Concurrent Use of Opioids, Benzodiazepines and/or Z-Drugs (↓ is better) Analysis of Results CONCURRENT OPIOID/BDZ/Z DRUGS <table><thead><tr><th>Quarter</th><th>Measure</th><th>Goal</th></tr></thead><tbody><tr><td>1Q2023</td><td>0.031</td><td>0.058</td></tr><tr><td>2Q2023</td><td>0.033</td><td>0.058</td></tr><tr><td>3Q2023</td><td>0.027</td><td>0.058</td></tr><tr><td>4Q2023</td><td>0.025</td><td>0.058</td></tr></tbody></table>	Quarter	Measure	Goal	1Q2023	0.031	0.058	2Q2023	0.033	0.058	3Q2023	0.027	0.058	4Q2023	0.025	0.058
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Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
			Evaluation: Target Achieved Barriers: - Continued education to prescribers to avoid concurrent use of these medications (ex: when the concurrent medication is prescribed by a different specialty for a different indication). Next Steps: - Metric is achieved and will be added for the 2024 plan. - Plan to scope new goal setting for remaining opportunities. - Continue surgeon/prescriber, physician assistant, nursing, and pharmacist education regarding the initiative. - Ongoing distribution of prescriber level data to identify opportunities for focused education if needed.
Deprescribing Benzodiazepine (BZD) in Older Adults (HEDIS) Phase 1 (ETA July 2023): ≥ 27% of patients dispensed benzodiazepines that achieved a 20% decrease or greater in benzodiazepine dose (DME)	- Develop DrUM initiative to reinforce HEDIS quality measure - TPMG Chiefs of Addiction Medicine, Adult and Family Medicine, Pain Management, Psychiatry, Outpatient Quality and External Reporting Team, and the Regional Opioid Safety Team - Endorsement roadshow; Chiefs of AFM, Psychiatry, Regional	Controlled Substances Project Manager 12/31/2023	Deprescribing Benzodiazepine (BZD) in Older Adults (HEDIS) (↑ is better) Analysis of Results

Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps									
Background: - BZD should be avoided in older adults - Dose shall be tapered slowly and safely to minimize withdrawal symptoms and improve patient outcome - Higher is better: % of members >= 65 years of age who were dispensed BZD and achieve a >= 20% decrease in BZD dose during the measurement year	Pharmacy Meetings, TPMG Quality team - Develop initiative materials - Clinical presentation during Bimonthly McDRUM webinar with focus on benzodiazepine deprescribing		DEPREScribing BZD IN OLDER ADULTS <table><tr><th>Period</th><th>Measure (%)</th><th>Goal (%)</th></tr><tr><td>3Q2023</td><td>~30.2</td><td>27.0</td></tr><tr><td>4Q2023</td><td>~27.8</td><td>27.0</td></tr></table> Evaluation: Target Achieved Barriers: - Patient may be hesitant or resistant to discontinuing medications that have previously been prescribed. Deprescribing conversations take time and can result in multiple conversations for deprescribing considerations. Next Steps: - Metric is achieved and will be added for the 2024 plan. - Disseminate initiative performance tracking through the monthly DRUM scorecard and Initiatives Report, which provides physician and pharmacy leadership tools to evaluate the medical center performance and identify areas of opportunity that exist for improving a medical center's performance. - Physician education and shared decision-making strategies for deprescribing.	Period	Measure (%)	Goal (%)	3Q2023	~30.2	27.0	4Q2023	~27.8	27.0
Period	Measure (%)	Goal (%)										
3Q2023	~30.2	27.0										
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Pharmacy Operations

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Medication Safety

Improve Quality at Mail order Pharmacy by reducing the incidence of member receiving wrong meds due to mis-bagging: • Reduce by 25% compared to previous year • Goal ≤ 106 Events per year Baseline = 141 (2022)	• Improved training program for staff • Identification and resolution of barriers or defects resulting in mis-bagging	Centralized Service Team Q4 2023	Analysis of Results <table><tr><th>1Q23</th><th>2Q23</th><th>3Q23</th><th>4Q23</th></tr><tr><td>20</td><td>56</td><td>71</td><td>95</td></tr></table> Evaluation: Target Achieved Barriers: none Next Steps: Continue collaborating with IT/Ops to investigate and resolve root causes for misbagging errors in 2024. Monitor progress with the Operational team and close on the Trilogy plan.	1Q23	2Q23	3Q23	4Q23	20	56	71	95																																		
1Q23	2Q23	3Q23	4Q23																																										
20	56	71	95																																										
Naloxone Pick up Opportunity Goal: To reduce the Naloxone Opportunity rate by 10% from the baseline by December-2023. ▪ December-2023 Goal = 61.7% Background: ▪ To mitigate the risk of harm due to opioid related respiratory depression by increasing naloxone dispensing for patients receiving high dose opioid therapy. ▪ Naloxone is an effective reversal agent for potentially fatal respiratory depression associated with an opioid overdose.	▪ Criterion in the Northern California Opioid Escalation Practice Recommendation (OEPR) – includes a recommendation for outpatient pharmacists to consult patients receiving > 50 MME to encourage naloxone pick-up and to request a new order if previous prescription has expired or is no longer active. ▪ Develop toolkit with talking points for outpatient pharmacists – to emphasize the importance of having naloxone on hand for patients at higher risk.	PQMS in collaboration with TPMG – Regional Pharmacy Regional Opioid Safety Team and Outpatient Pharmacy Operations 12/31/2023	Analysis of Results December Performance: 57.4% (Note: Goal ≤ 61.7%) ▪ NCAL (NCAL=CN) % Naloxone opportunity % for Dec-2023 was 57.4%, which represents an overall 16.7% change (reduction) from the Dec-22 baseline (68.6%). <table><tr><th>REGION</th><th>Dec-22</th><th>Jan-23</th><th>Feb-23</th><th>Mar-23</th><th>Apr-23</th><th>May-23</th><th>Jun-23</th><th>Jul-23</th><th>Aug-23</th><th>Sep-23</th><th>Oct-23</th><th>Nov-23</th><th>Dec-23</th></tr><tr><td>KP</td><td>60.1%</td><td>58.4%</td><td>57.6%</td><td>56.7%</td><td>56.1%</td><td>57.2%</td><td>56.2%</td><td>56.1%</td><td>55.4%</td><td>54.8%</td><td>53.8%</td><td>53.3%</td><td>52.6%</td></tr><tr><td>CN</td><td>68.6%</td><td>65.8%</td><td>64.3%</td><td>62.2%</td><td>61.5%</td><td>62.4%</td><td>61.5%</td><td>61.2%</td><td>60.4%</td><td>59.2%</td><td>57.8%</td><td>58.1%</td><td>57.4%</td></tr></table> Evaluation: Target Achieved Barriers: The measure is based on prescription point-of-sale (POS) data. The accuracy of the POS data may be impacted by the following:	REGION	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	KP	60.1%	58.4%	57.6%	56.7%	56.1%	57.2%	56.2%	56.1%	55.4%	54.8%	53.8%	53.3%	52.6%	CN	68.6%	65.8%	64.3%	62.2%	61.5%	62.4%	61.5%	61.2%	60.4%	59.2%	57.8%	58.1%	57.4%
REGION	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23																																
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Pharmacy Operations

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- The CDC Clinical Practice Guideline for Prescribing Opioids for Pain (2022) recommends offering naloxone when prescribing opioids to patients at increased risk for overdose, including patients receiving ≥ 50 MME/day. - To expand naloxone access in California, Assembly Bill 2760 was signed into law, effective January 1, 2019. This law requires that "high-risk patients" are offered a naloxone prescription and provided education on overdose prevention and the use of naloxone. Comments: Baseline = 68.6% (Dec-2022) Numerator: Number of individuals from the denominator who were NOT dispensed naloxone in the last 24 months Denominator: Number of individuals receiving prescription opioid(s) with an average daily dose (over the past 3 months) > 50 morphine milligram equivalents (MME) per day.	- Distribute Medication Safety Moment Huddle message to re-emphasize the importance of this OEPR criterion. - Develop and distribute a monthly Naloxone Opportunity Report with a drilldown to the medical center level to allow local leaders to track progress and to identify potential bright spots and successful practices. - Consult with the Regional Pharmacy Member Advisory Committee to better understand potential patient barriers and seek recommendations to improve patient naloxone pick-up. - Assess reported external successful practices or recommendations (by the CDC and other KP regions) for implementation in Northern California.		- The FDA approved naloxone hydrochloride nasal spray for over the counter (OTC) sales in September 2023. - NCAL KP Emergency Departments (EDs) participate in the free Naloxone Distribution Project (NDP), which is funded federally by SAMHSA and administered by California's state Department of Healthcare Services (DHCS). True naloxone in hand numbers may be higher with service in place, but not captured. Next Steps: - The interregional Controlled Substances Stewardship Committee (CSSC) is currently assessing the impact of non-prescription naloxone on reporting measures and recommendations. - NCAL is conducting a crosswalk of the CSSC recommended standardized universal naloxone BPAs to assess for redundancies or potential retirement of existing naloxone BPAs. - In collaboration TPMG, develop a pharmacy process to renew and order naloxone to be placed on file for patients on > 50 MME. - Target achieved and close for 2023 Trilogy plan. Will define a new metric to monitor for 2024.

Special Needs Plan Program

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Improve Special Needs Plan (SNP) member access to essential services and affordable care: Ensure 90% of members had a health risk assessment completed	Monitoring: monthly and rolled up annually via the Regional Process Report measuring percent of members who had a health risk assessment completed - Enhance operational tools - Identify enhancements to performance reporting - Identify and share best practices from high-performing teams and provide additional support to lower-performing teams	Regional SNP Leadership and Local SNP Teams 12/31/2023	November 2023 YTD performance of 87% fell short of the 90% goal. Barriers: This may be attributed to members who refuse the service and/or those who cannot be reached. Significant, unexpected membership growth contributed to the shortfall. Next Steps: The implementation of Compass Rose should improve outreach practices and KP will continue to enhance those practices according to best practices. KP will also identify and share best practices from high-performing teams and provide additional support to lower-performing teams.
Improve coordination of care and appropriate delivery of services through the direct alignment of the HRAT (Health Risk Assessment Tool), ICP (Individualized Care Plan), and ICT (Interdisciplinary Care Team): Members answer “yes” to the phone survey question, “Do you think this Care Management program is helpful for you in achieving your goals?” The target is 95%.	Monitoring: Monthly and rolled up annually via the IVR phone survey that Care Managers are successfully providing care coordination for our members by making sure that our members feel that the SNP Care Management program is helping them coordinate their needs to help them achieve their goals.	Regional SNP Leadership and Local SNP Teams 12/31/2023	November 2023 YTD performance of 98% met the target of 95%. Next Steps: Continue to reinforce offering of the survey and encourage care managers to continue their high level of support for patients’ goals.
Provide seamless transitions for SNP members across healthcare settings, care providers, and health services: Appropriate transitions as evidenced in	Monitoring: Quarterly Transition Audit The regional SNP team will continue to audit transition management on a quarterly basis.	Regional SNP Leadership and Local SNP Teams 12/31/2023	November 2023 YTD performance of 88% met the target of 80%. NOTE: KP NCAL stopped performing chart reviews and now includes this metric on the monthly performance dashboard.

Special Needs Plan Program

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
internal chart review audits. The target is 80%.	- Emphasize Model of Care requirements - Continue to support medical center use of operational and performance reporting, including updated and enhanced transition reporting - Identify best practices in managing patients who are moving between healthcare settings.		Next Steps: Continue to emphasize Model of Care timing requirements for transitions and provide close consultation to medical center teams. Continue to support medical center use of the performance dashboard, performance reports, transition reports and outreach lists, . Identify best practices in managing patients who are moving between healthcare settings.
Ensure appropriate utilization of services for preventive health and chronic conditions: HEDIS Comprehensive Diabetes Control HbA1c < 8 metric. The target is the HEDIS Commercial 90th percentile; 69.33%	Monitoring: Yearly via HEDIS rates Work with care managers to utilize tools and resources that support the linking of members to appropriate preventative services.	Regional SNP Leadership and Local SNP Teams 12/31/2023	November 2023 performance of 71.78% met the target of the HEDIS 90th percentile, which was 69.33%. Next Steps: Continue current operations to meet or exceed HEDIS Medicare 90th percentile.
Ensure appropriate utilization of services for preventive health and chronic conditions: Percent of adults with a designated decision maker and/or Advanced Health Care Directive (AHCD) on file in medical record. The target is 85%.	Monitoring: Monthly Work with care managers to support them in having initial life care planning conversations with members and giving them the tools to have a designated decision maker and/or a AHCD on file in KPHC.	Regional SNP Leadership and Local SNP Teams 12/31/2023	November 2023 performance of 91% met the target of 85%. Next Steps: Continue to support medical center teams which may include regional or individual training sessions.

Utilization Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Leveraging technology: - Automate the production of: - daily Appeals update - quarterly KP Medicare Appeals performance reports (hospital, SNF, Home Health) - monthly CDSU productivity reports - universe pulls - Establish a direct line of communication between CDSU and DME Champions via Tapestry (eliminates the extra step of sending communications via the DME Hub RNs) Metric: the above listed reports will be automated by end of 4Q 2023. Metric: CDSU will be able to communicate directly with DME Champions via Tapestry by end of 4Q 2023.	- Regular meetings with data partners to confirm report specifications, resolve coding issues, and validate report output - Regular meetings with Tapestry Team, DME Champions, and DME Hub to build, test, and use the new line of direct communication from CDSU	CDSU and business partners (by end of 4Q 2023).	Automated report production: Met. - Appeals daily update completed July 2023 - Quarterly KP Medicare Appeals CDSU data updated daily. Integration with hospital and SNF data not fully automated as of yet since resource/contact person left the organization (new resource not yet identified) - Data that feeds productivity report is updated daily, completed July 2023 - Universe pull base queries that apply filtering are set up and work when needed (universe pull parameters change frequently from audit to audit so are as automated as they can be). DME Champion/CDSU communication: Met. Completed in May 2023.
CDSU Letter Template Improvement: - Improve overall readability of letters - Statewide effort to be in compliance about correct use of clinical criteria vs coverage	This will be achieved via: Meetings with SCAL partners to assure alignment between the two markets	CDSU and business partners (by end of 4Q 2023)	Letter Template Improvement: 95% Met. Medical necessities denials updated for all LOB and loaded into Tapestry by 3Q 2023. Benefit denials updates scheduled for completion by 1/15/2024, loaded into Tapestry by 1/30/2024, and taken to RMC at 2/27/2024 meeting. Collaboration with business partners and alignment with SCAL took place in 2023.

Utilization Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
criteria for medical necessity denials (MND) and benefit denials (BD) respectively. Metric: CDSU denial rationale in letters will be at a 6th grade reading level and in compliance using correct clinical criteria for medical necessity denials and correct coverage criteria for benefit denials as required by regulatory agencies (DHCS, DMHC, NCQA) and measured by letter content approval by Resource Management Committee by the end of Q4 2023.	- Proactively check grade reading level on all correspondence, including appeals - Meetings with our business partners (statewide DME, Regulatory Services) and presenting changes to the DME Formulary Committee - Partner with Tapestry and DMSS Teams to implement changes into production environment - Weekly random case review to assure denial letter accuracy of content for regulatory compliance		Barriers: Changing EOC and criteria make this an ongoing effort, requiring rework of already completed letter template updates. Competing work due to CMS 2024 Final Rule new DME criteria and UM requirements, effective 1/1/2024, took priority in 4Q 2023.
Working with APICs Process Improvement: - Transplant Appeal/Denial—decrease untimeliness for denials for liver transplant patients by aligning the Pre-Transplant referral workflow with other OMS referral type workflows. Metric: Transplant denials will meet or exceed 95% timeliness by 4Q 2023. - Early Periodic Screening. Diagnostic, and Treatment (EPSDT) Denial Letters/APIC denials – improve the content of	- Regular Meeting with business partners to check on implementation - Update HPPA, APICs, and Medicare Compliance on a regular basis - Update workflow with the new process into Tapestry system with the new build - Update the letters with clinical review/criteria/guidelines and EPSDT denial language	CDSU and business partners (by end of 4Q 2023)	Transplant Appeal/Denial: Not Met. Although workflow was aligned and approved mid-September (with appeals going from FRC to Transplant Board in a closed system for outpatient), this new process did not work well for transplant inpatient cases, and the decision to return to the previous process for transplant appeal/denial was made. EPSDT: Met. Letter content approved by HPPA in May 2023; loaded into Tapestry and validated in July 2023.. Staff education in 3Q 2023. Content accuracy measured via audit and productivity data (97.73% timeliness by end of 3Q 2023). --

Utilization Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation (to be completed in 2024) 1. Analysis of results including metrics 2. Barriers 3. Next steps
EPSDT denial letters to meet DHCS requirements. Metric: EPSDT letters will achieve or exceed 95% content accuracy by 4Q 2023.	• Obtain approval from Regulatory Services on the updated EPSDT language • Partner with SCAL UM partners to assure alignment. • Notify business partners (DME Hub, Outside Services, Tapestry) of changes • Provide training and education to staff		



**Kaiser Foundation Health Plan, Inc.
Northern California Region**

2024 Quality Program Workplan

Quality Oversight Committee Approval Date: April 16, 2024

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Accessibility of Services (NET 2)			
Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Primary & Specialty Care Access			
Access to Routine and Urgent Care <u>Routine & Regular Appointments</u> CAHPS Goal: 77% of members will report either usually or always (u/a) getting a routine appointment when needed	- Monitor CAHPS results and report findings to the Member Concerns Committee (MCC) - Monitor and report access to appointment complaint findings to the MCC. - Obtain action plans from facilities not meeting regional goal through local evaluations and work plans.	TPMG AED Annual: October 2024	
Access to Urgent Care <u>Urgent Care Appointments</u> CAHPS Goal: 84.29% of members will report either usually or always (u/a) getting urgent care as soon as needed	- Monitor CAHPS results and report findings to the Member Concerns Committee (MCC) - Monitor and report access to appointment complaint findings to the MCC. - Obtain action plans from facilities not meeting regional goal through local evaluations and work plans.	TPMG AED Annual: October 2024	
Access to After-Hours Care <u>After Hours Call Center (AACC)</u> <u>Annual Report</u> - Average Speed of Answer (ASA) is within 60 seconds - Less than 3% of calls will be abandoned	- Monitor and report after- hours access to care complaint findings to the MCC. - Monitor and report after-hours access metrics, and report to AOC. - Obtain action plans from facilities not meeting regional goal through local evaluations and work plans.	TPMG AED Annual: October 2024	

Accessibility of Services (NET 2)			
Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
BH Telephone Access <u>Psychiatry After Hours Call Center (PACC) Telephone Service Report</u> 85% or more of calls will be answered within 30 seconds - Less than 5% of calls will be abandoned	- Monitor PACC telephone service and report to IUS and BHQOC. - Within existing space constraints, actively recruit PACC staff to meet increasing call volume demands. - Provide PACC call abandonment trends to Chiefs of Psychiatry.	Regional Director of Inpatient Psychiatry and Continuing Care Quarterly: Jan 2024 April 2024 July 2024 October 2024	
Access to Care for Life-Threatening and Non-Life-Threatening Emergencies <u>Psychiatry After Hours Call Center (PACC) ED Referral and Emergent BH Drop In Clinic Audit Reports</u> <u>Goal:</u> - Behavioral health access to care for non-life-threatening emergencies is within 6 hours - PAAC is appropriately referring members to the closest ED for life threatening and non-life-threatening emergency situations	Monitor access to BH clinicians for life threatening and non-life-threatening emergencies	Chair, Chiefs of Psychiatry Annual: October 2024	
Access to Routine and Urgent Care Visits <u>Access standards:</u> - Urgent Mental Health Visits within 48 hours - Nonurgent Mental Health visits within 10 business days - Urgent Chemical Dependency visits within 48 hours	- Monitor quarterly results to determine if distribution to Non-Urgent Physician Services persists after the global public health emergency - As needed, recruit and hire BH clinicians. - Facility specific access action plans to be submitted and monitored by	Chair, Chiefs of Psychiatry Quarterly: Jan 2024 April 2024 July 2024 Oct 2024	

Accessibility of Services (NET 2)			
Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Nonurgent Chemical Dependency visits within 10 business days.	Chair of the Chiefs of Psychiatry when targets not met.		
Improve CAHPS Results: Monitor CAHPS results and report to regional and local quality committees and all staff (health plan rating, health care rating, PCP rating, specialist rating)	- Survey results reported to MCC - CAHPS and METEOR results are also presented to other regional and local quality committees.	TPMG AED Annual: October 2024	

Appointment and Advice Call Center

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Goal: To ensure that members receive service in a timely manner. Metric: Internal goal for ASA (Average Speed of Answer) for the Regional Tele Service Representatives (TSRs) is less than or equal to 1 minute; Abandonment Levels are less than 3%.	Monitor and report Average Speed of Answer and abandonment levels to improve member satisfaction. Ongoing 30-minute monitoring process for timeliness of service. Adjust staffing levels in response to call demand. Evaluate staffing monthly to determine new hire plan and adjust accordingly based on attrition levels. Implement technology solutions to mitigate any potential clinical or environmental call volume surges.	AACC Medical Director AACC Operations Director Annual – January to December 2024	
Goal: Ensure patient safety by focused review of Advice Registered Nurse (ARN) calls using symptomatic and/or high-risk protocols Metric 1: Maintain average clinical quality scores for all three AACC sites above 95% across all questions. Metric 2: Decrease serious clinical errors.	Focused monthly review of Advice Registered Nurses (ARNs) calls. Trends and learnings from serious clinical errors will be shared with staff and training to enhance clinical content for new hires.	AACC Medical Director AACC Operations Director Annual – January to December 2024	
Goal: If Sentinel Events occur, review, and analyze each event for trends and learning.	Monthly review of potential patient safety events by AACC Regional Quality Assurance Committee.	AACC Medical Director	

Appointment and Advice Call Center

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Metric 1: Achieve Sentinel Event error rates less than 3 clinical errors/1,000,000 calls Metric 2: Trends and learnings from Sentinel Events will be shared with staff.	Analysis of events to identify trends related to educational needs for AACC staff.	AACC Operations Director Annual – January to December 2024	

Assessment of Network Adequacy (NET 3)			
Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Non-Behavioral Health Network Adequacy			
To assess network adequacy using access and availability data; and complaint, appeal, and member experience data in order to prioritize access opportunities for KPNC (NET 1, NET 2).	- Conduct an assessment of network adequacy using member complaint and appeal data, and member experience surveys. - Identify opportunities to improve member experience with BH and non-BH network adequacy. - Implement at least one opportunity and measure effectiveness	TPMG Consulting Services Annual: December 2024	
Behavioral Health Network Adequacy			
To assess network adequacy using access and availability data; and complaint, appeal, and member experience data in order to prioritize access opportunities for KPNC (NET 1, NET 2).	- Conduct an assessment of network adequacy using member complaint and appeal data, and member experience surveys. - Identify opportunities to improve member experience with BH and non-BH network adequacy. - Implement at least one opportunity and measure effectiveness	TPMG Consulting Services Annual: December 2024	

Availability of Practitioners (NET 1, DMHC)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Primary Care Practitioners			
Ensure adequate availability of providers within target ratios and geoaccess standards <u>Geoaccess:</u> 95% of members will be within 15 miles OR 30 minutes of a PCP <u>Ratios:</u> • 1 PCP per 2,000 all members (MD head count) • 1 PCP per 2,000 adult members (MD head count) • 1 PCP per 2,000 pediatric members (MD head count) • 1 PCP FTE per 2,000 members • 1 pediatric practitioner per 2,000 members • 1 family medicine practitioner per 6,000 members • 1 internal medicine practitioner per 2,500 Members	• As needed and subject to changes in membership and staff turnover, increase physician staffing by hiring new primary care physicians. • Recruit bilingual PCPs as needed. • Expand and remodel facilities. • Report annual findings to MCC.	Annual: September 2024 TPMG AED of Adult & Family Medicine TPMG AED of Women's Health & Pediatrics	
Ensure that all members are linked to a primary care provider <u>PCP Member Linkage:</u> 85% of members will be linked with a PCP.	• Monitor the transition of young adults from pediatrics to adult medicine • Ensure process in place so that members are appropriately linked to a PCP • Monitor PCP Member Linkage reports	Annual: December 2024 TPMG AED of Adult & Family Medicine TPMG AED of Women's Health & Pediatrics	

Availability of Practitioners (NET 1, DMHC)			
Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Specialty Care Practitioners			
Ensure adequate availability of high volume and high impact SCP providers within target ratios and geoaccess standards High Volume SCPs: Dermatology, General Surgery, Head & Neck Surgery, OBGYN, Ophthalmology, Orthopedics High Impact SCPs: Oncology Geoaccess: 80% of members will be within 30 miles OR 60 minutes of a high-volume SCP High Volume SCP Ratios – • 1 Dermatology MD per 40,000 Members • 1 General Surgery MD per 35,000 Members • 1 Head & Neck MD per 40,000 Members • 1 OB/GYN MD per 10,000 Members • 1 Ophthalmology MD per 28,000 Members • 1 Orthopedic MD per 26,000 Members	• As needed and subject to membership change and staff turnover, increase physician staffing by hiring new specialty care physicians. • Recruitment of bilingual SCPs. • Expand and remodel facilities. • Report annual findings to MCC	September 2024 Access Committee Member Concerns Committee	
Behavioral Health Practitioners			
Ensure adequate availability of high volume and high impact SCP providers within target ratios and geoaccess standards	• As needed and subject to membership change and staff turnover, increase BH practitioner staffing.	September 2024	

Availability of Practitioners (NET 1, DMHC)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
- BHP FTE/Member Ratio: 1 BHP per 3,200 members, 1 CD specialist per 40,000 - Types of High-Volume BHP: 1 Psychiatrist per 20,000 members and 1 Psychologist per 20,000 members. Geographic distribution or driving time to BHP: 80% of members will be within 30 miles OR 60 minutes of a BHP.	Report annual findings to MCC and BHQOC.	Behavioral Health Quality Oversight Committee	

Facility Standards

Ensure adequate availability of facilities within target geoaccess standards Hospital/Emergency Room Geographic Distribution Standard: Geographic distribution or driving time to hospitals/emergency rooms: 100% of members will be within 15 miles OR 30 minutes of a KP or contracted hospital with an emergency department. Other Facility Standards: Geographic distribution or driving time to Skilled Nursing Facilities and Home Health Agencies: 100% of Members will be within 30 minutes of a KP or contracted facility. Psychiatric Inpatient Hospitals and Behavioral Health Residential Facility Standards:	Annual analysis and monitoring of Geoaccess and report findings to MCC.	Annual: September 2024 Access Committee	

Availability of Practitioners (NET 1, DMHC)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
80% of Members will be within 50 miles OR 75 minutes of a KP or contracted facility. • Ambulatory Surgical Centers, Mammography/Radiology clinics and other Ambulatory Clinics (including Behavioral Health): 80% of Members will be within 30 miles OR 60 minutes of a KP or contracted facility.			

Behavioral Health

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
<u>Youth Wrap Around Programs</u> Seneca Family of Agencies provides specialized, intensive support for youth encountering complex mental health challenges. The program includes a collaborative, strengths-focused approach, and multidisciplinary team to support youth's unique needs. This program offers targeted interventions to enhance well-being, prevent crises, and promote long-term stability, empowering youth to navigate challenges effectively. Seneca has been providing crisis stabilization and partial hospitalization services for our adolescent and child members at their contracted facilities in Concord, Fremont, Petaluma, and San Leandro. Wraparound services began being provided in 2020, which has been expanded to cover our Diablo, East Bay, Marin/Sonoma, and Napa/Solano Service Areas for adolescent psych patients who have experienced high utilization of inpatient psych and ED services. Partial hospitalization and wraparound services are being newly expanded into the South Bay. KP has been contracted with Seneca in the Bay Area since 2007, while providing psychiatric services for adolescent and child patients through their team of physicians, licensed nurses, and master's level therapists. These services have included operating 4	• Conduct analysis of current enrollment and compare with pediatric inpatient and ED hospitalization rates to determine where expansion is needed. • Analyze historical data to identify common reasons for ED visits among program participants and apply to selection criteria. • Develop a standardized process for tracking post-graduation healthcare utilization among program graduates, including hospital readmissions, specialist visits, and medication adherence. • Implement dashboard for tracking utilization and quality metrics.	Regional mental health administration Regional behavioral health & wellness Continuum of care	

Behavioral Health

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
STEP partial hospitalization programs, as well as their four wraparound programs located throughout the Bay Area. These wraparound programs reach out to young members who have difficulty remaining behaviorally stable by making contact with them 24/7 at their home, school, or other locations in the community. <u>Metrics:</u> 1. Increase program enrollment by 5-10% 2. Decrease ED visit utilization among program participants by 5-10% 3. Reduce post-graduation healthcare utilization for program graduates by 5% within 12 months by establishing a systematic process to track and link them to appropriate follow-up care.			

Behavioral Health

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
<u>Crisis Stabilization Unit (Fairfield) CSU</u> Crisis stabilization units provide urgent psychiatric services that include intervention, medication administration, therapeutic consultation and linkages to referral and follow-up care to outpatient services. Referrals to CSU are often from emergency departments. CSUs are designed to provide a safe, secure environment to allow patients to recover quickly and return to a lower level of care. Core Components: CSUs provide up to 23 hours and 59 minutes of care in a secure environment for patients 18 and older. Treatment emphasizes crisis intervention to stabilize the patient to a level of functioning that doesn't require hospitalization: • Psychological assessments • Substance abuse screening and assessment • Discharge plan with emphasis on crisis intervention and relapse prevention • Medical evaluation and management Coordination with outpatient and CD services An internalized KP CSU is scheduled to be opened in Fairfield, CA in October 2024 to provide 23 hour crisis services to the community. <u>Metrics:</u> 1. Reduce the rate of readmissions within	▪ Continuously monitor the effectiveness of interventions in reducing readmissions		

Behavioral Health

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
30 days of discharge. 2. Implement comprehensive discharge planning, enhance post-discharge support, and improve coordination with internal mental health services to facilitate successful transitions and reduce readmissions.			

Behavioral Health

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
<u>Member Journey Mapping</u> Conduct a thorough mapping of the member journey within our healthcare system, with a focus on behavioral health services. By closely examining each touchpoint and interaction, we seek to identify potential complications that members encounter when accessing these services. Through this process, we aim to gain valuable insights to improve the overall patient experience, ensuring it aligns with our commitment to delivering high-quality care. <u>Metrics</u> 1. Implement process improvements and streamline internal procedures to facilitate easy and convenient appointment scheduling and access to ongoing care. 2. Journey map is scheduled to be completed by end of Q2, 2024	• Conduct a comprehensive analysis of the current appointment scheduling process for behavioral health services to identify bottlenecks and inefficiencies. ▪ Collaborate with relevant stakeholders, including healthcare providers and administrative staff, to streamline the appointment scheduling process and implement necessary improvements. ▪ Continuously monitor and track key performance indicators related to appointment scheduling, such as average wait times and member satisfaction scores.		

Claims

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Maintain timeliness at the required compliance targets for each line of business. <u>Medicare:</u> 95% within 30 Calendar Day TAT (Non-Contracted Clean) 99% within 60 Calendar Day TAT (Non-Contracted Unclean) <u>Commercial:</u> DMHC Regulatory Metric 95% within 45 working days <u>Medi-Cal:</u> 95% within 45 working days 99% within 90 calendar days 90% within 30 calendar days	Continue to monitor monthly and remediate when/if needed.	National Claims Administration - California Region Annually	
Maintain industry standards for financial accuracy, payment accuracy and overall accuracy. <u>Turnaround Time Targets:</u> 30 Day Clean 95% <u>Accuracy Targets (for claims and encounters end-to-end):</u> Financial Accuracy 99.3% Payment Incident Accuracy 98.0% Overall Accuracy 95.0%	NCA has a robust QA process inclusive of configuration and claims processing audits. The audits are conducted daily, and feedback provided to claims operations for resolution. QA results are reported monthly to claims leadership.	National Claims Administration Monthly	

Continuity and Coordination between Behavioral Health and Medical Care (QI 4)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
Continuity and Coordination of Care – Med/BH 1. Exchange of Clinical Information NCQA standard requires a process goal. Goal: Annually collect data on opportunities to improve collaboration between medical care and behavioral healthcare related to exchange of information.	Continue to annually assess exchange of clinical information between medical care providers and behavioral healthcare practitioners.	TPMG Consulting Services Annually	
2. Appropriate Diagnosis, Treatment, and Referral for BH Disorders NCQA standard requires a process goal. Goal #1: Annually collect data on opportunities to improve collaboration between medical care and behavioral healthcare related to appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care. Goal #2: Measure members for >= 50% improvement over a 4-8 month period, based on PHQ-9 depression screening tool. Goal target: 17%	• Ongoing promotion of processes to improve the screening, diagnosis, and referral of depression in primary care through the KP Depression Monitoring and Depression Response initiatives. • In Adult Family Medicine: KP is continuing to pilot a PHQ-9 reminder alert system in four facilities that fires when a depression-related diagnosis is added to the patient's problem list. Consequently, if an elevated PHQ-9 score is entered with an encounter diagnosis present, another reminder alert triggers with the option to send a follow-up PHQ-9 series to the patient for 8 months. If successful, this reminder will be the first tool in	See above	

Continuity and Coordination between Behavioral Health and Medical Care (QI 4)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
	our technology suite strategy that the region is designing to support depression care management work. • In Adult and Child Psychiatry and Addiction Medicine: Increasing use of the Lucet assessment tool by our external contracted providers has been identified as an improvement opportunity over the next few years. We are now able to monitor the use of the tool by these external providers and receive alerts when members may need more intervention or are ready for discharge. All information obtained through external provider use of the Lucet tool goes into the member's medical record and is included in the "Depression Response" significant improvement reports – further enhancing continuity and coordination across the continuum of care. • KPNC also is working to continuously increase the number of internal KP providers using the Lucet assessment tool for completion of the PHQ-9, leveraging a variety of educational interventions.		

Continuity and Coordination between Behavioral Health and Medical Care (QI 4)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
3. Appropriate Use of Psychotropic Medications NCQA standard requires a process goal. Goal #1: Annually collect data on opportunities to improve collaboration between medical care and behavioral healthcare related to appropriate use of psychotropic medications. Goal #2: Achieve 2024 NCQA HEDIS 90th percentile targets for: ADHD Meds Initiation ADHD Meds Continuation	- Continue collaborative efforts between psychiatry and pediatrics, leveraging inreach and outreach strategies to make sure patients are scheduling follow-up visits by phone and video within the HEDIS specified timeline. - Continue to monitor HEDIS ADHD measure.	See above	
4. Treatment Access for Coexisting Medical and Behavioral Disorders NCQA standard requires a process goal. Goal: Annually collect data on opportunities to improve collaboration between medical care and behavioral healthcare related to management of treatment access and follow-up for members with coexisting medical and behavioral disorders.	Continue programs to ensure access to members with co-existing medical and behavioral disorders Monitor toxicology screening rate for Early Start program	See above	

Continuity and Coordination between Behavioral Health and Medical Care (QI 4)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
5. Primary and Secondary Prevention Programs NCQA standard requires a process goal. Goal: Annually collect data on opportunities to improve collaboration between medical care and behavioral healthcare related to primary or secondary preventive behavioral healthcare program implementation.	Continue to monitor access to the behavioral health education programs to understand impact.	See above	
6. Special Needs of Members with Severe and Persistent Mental Illness NCQA standard requires a process goal. Goal: Annually collect data on opportunities to improve collaboration between medical care and behavioral healthcare related to special needs of members with severe and persistent mental illness.	- Continue to assess the effectiveness of the ICT program throughout the region. - Monitor the percentage of members with SMI/SED diagnosis in the ICT program who had a primary care appointment within 30 days of hospital discharge, and who had a primary care follow-up appointment made on discharge.	See above	

Care Coordination Readmissions

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Reduce overall HEDIS readmissions from a baseline of 0.92 to 0.91 Observed/Expected (O/E) through improving SNF readmissions and expanding post discharge support to currently unsupported discharge patient populations.	In partnership with the DOR, Regional Continuum Pharmacy, and Supportive Care Services leverage the SNF Readmission workgroup to implement 3 initiatives to reduce readmissions in SNF. 1. Add clinical pharmacist support during SNF admission & discharge. 2. Develop mechanism to flag SNF high-risk patients flagging them at Admission for improved care. 3. Improve End of Life and Hospice education between skilled SNF patients, families, and physicians by increasing goals of care/Vital Talks conversations within SNF-custodial population	Pharmacy / SNF: 05/2024 Overall Initiative sustained deployment 12/2024	
	Expand post discharge support and outreach leveraging Cipher Health Automated Post Discharge Call Back Survey, decreasing low risk readmissions for patients currently not supported at hospital discharge. 1. Expanded team through approval of business case. 2. Phased roll out to all 21 medical center discharge populations will provide care	Leadership: Business case approval pending Guided Care Leadership: Hire and implement expansion workflows within 6 months of business case approval Target full implementation of 12/2024 if business case approved prior to 3/1/2024	

Care Coordination Readmissions

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
	coordination support for currently unsupported low-risk patients demonstrating higher than expected readmission and ED return rates.		
	Implementation go live of bi-directional integration of Cipher Health outreach data into KPHC for patients meeting criteria for the Excellent Transitions Program	Excellent Transitions, KPHC Date 2/17/2024	

Continuity and Coordination of Medical Care (QI 3)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Continuity and Coordination of Medical Care NCQA standard requires a process goal, to ensure members receive coordination of care across the continuum. Metric: - Identify four opportunities for improvement of coordination of medical care by collecting data on movement of members across settings of care, and conducting quantitative and causal analysis - Act on at least three opportunities - Measure the effectiveness of at least three improvement actions The following opportunities and actions were identified for 2024, based on results of the 2023 Physician Satisfaction Survey: <i>2024 Opportunity and Action 1:</i> Although there was +2% change in practitioner satisfaction compared to 2023, there is a need for additional improvement in ease of access to DME information. Satisfaction remains low relative to ease of access to other types of clinical information. Planned 2023 efforts to optimize DME orders in	- Administer 2024 Provider Satisfaction Survey to TPMG network and contracted physicians to identify opportunities to improve coordination of care across the continuum - Collaborate with Continuum leadership to identify actions to improve coordination of care - Measure effectiveness of action taken on three opportunities	TPMG Consulting Services Annually	

Continuity and Coordination of Medical Care (QI 3)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
KP HealthConnect were put on hold in order to support broader and more far-reaching DME optimization on the national level. It is anticipated that national DME order optimization will begin implementation in Northern California in mid-2024. These optimization efforts are expected to improve ease of access to DME information, including ensuring relevant clinical information is available from the order. In addition, comprehensive DME education for non-physician ordering clinicians is in its final stages of development. There are plans to include this education in training materials for regional rollout of a care management program. Transitioning DME order transmission to non-physician team members, within their scope of practice, is key to improving physician ease in approving DME orders as it builds expertise in ordering and presents information to clinicians for easy approval. Additional opportunities for dissemination and delivery are being explored. <i>2024 Opportunity and Action 2:</i> Practitioner satisfaction with the transition process for their patients to and from contracted home health agencies increased only slightly in			

Continuity and Coordination of Medical Care (QI 3)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
2023. Providers continue to express that they have little insight into a patient's care during the home health episode of care. The planned 2023 pilot to investigate the feasibility of communication from contracted Home Health agencies to physicians via KP HealthConnect in basket messaging rather than the current use of faxes went live in two service areas, and physicians who participated in the pilot and responded to the survey were very satisfied with the process. However, this process is currently only available in the GSAA and East Bay. There is an opportunity to spread the above technology enhancement, known as the External Home Health Order Signature solution, to other facilities in 2024. In addition to the electronic orders, KP NCAL is piloting a streamlined process to address change of condition for patients on Home Health service. Home Health agency staff can call into a centralized team of KP nurses who will clearly and consistently document the reason for the call and current patient status. This patient summary is forwarded to a HH Virtual hub physician on-call who will address the patient's needs. All communication is clearly documented in our EMR, which will improve the			

Continuity and Coordination of Medical Care (QI 3)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
transition of care between KP and Home Health. <i>2024 Opportunity and Action 3:</i> Efforts in 2023 to raise physician awareness of tools and technical improvements to improve ease of access to Advance Health Care Directives (AHCD) in KP HealthConnect led to a 3% increase in physician satisfaction compared to 2022. However, some clinicians still express a lack of familiarity with information and tools to support advance care planning. In order to continue the progress, there is a need for a broader communication strategy as well as updated job aids and support documents to raise provider awareness and knowledge of AHCD information and tools. There is additional opportunity for improvement with AHCD in 2024. Our AHCD document has gone through extensive revision and is planned to roll out in 2024. This rollout will include a broader communication strategy as well as updated job aids and support documents. The implementation and socialization of the document is anticipated to increase awareness, knowledge, and understanding of advance care			

Continuity and Coordination of Medical Care (QI 3)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
planning related information like the AHCD and other documented goals of care. <i>2024 Opportunity and Action 4:</i> When asked their level of satisfaction with ease of access to clinical information on Assessments, Care Plans, or Communication from Case Management teams, 79% of physicians said that they were satisfied, a 2% improvement from 2022. As this is a relatively new question on the Practitioner Satisfaction Survey and targeted improvement efforts have not previously been carried out, there is an opportunity to further increase physician satisfaction in this area. KP is implementing “Compass Rose”, an enhanced case management module in our EMR. Numerous Case Management / Care Coordination programs have moved to using this revised suite of tools which include standard assessment and consistent encounter structure and location within the EMR. Implementation of Compass Rose in 2024 is expected to increase physician satisfaction with ease of access to clinical information on Assessments, Care Plans, or			

Continuity and Coordination of Medical Care (QI 3)			
Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Communication from Case Management teams.			

Credentialing and Privileging

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Oversight of Delegated Credentialing through Teams Metric: By Q4, move to Teams for all oversight functions related to delegation of credentialing. Secure channels will house agreements, monitoring reports, and auditing materials. Shared documents will be accessible in real time.	- Build secure Teams Channel(s) and folders. - Assign internal owners and permissions for external stakeholders. - Upload active/current documents for sharing. - Go live with data exchange, pre-delegation assessments, and annual audits. - Upload historic documents to Teams folders.	Health Plan Quality Credentialing and Privileging December 2024	
Peer Group Meetings- MSO Leads Metric: Implementation of KFH/P MSO lead peer group meetings by Q2 for sharing best practices related to credentialing/privileging and education on accreditation standards, regulatory requirements, and KP credentialing policies.	- Survey MSO leads. - Establish structure and cadence based on survey results.	Health Plan Quality Credentialing and Privileging December 2024	
Credentials Staff Education Metric: Assess CP Coordinator education and training needs and develop a plan for targeted training for 2025 based on the assessment.	- Partner with RCPC Chair leads and Counsel to guide an assessment of educational opportunities. - Based on the assessment, draft a proposal for education for RCPC by December 19, 2024.	Health Plan Quality and Regional Credentialing and Privileging December 2024	

Cultural & Linguistic Diversity

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
Cultural & Linguistic Trainings - Increase the capacity of KP staff to address the language and cultural variations of our members and patients. Enhance the delivery of high quality cultural and linguistic care and services to all members and patients. 1) Ensure training completion of annual KP Staff Interpreter in-service by at least 90% KP staff interpreters by October 31, 2024. 2) Rollout the 2024 Providing Culturally & Linguistically Appropriate Services Training in KP Learn to NCAL and California statewide Health Plan staff by December 31, 2024.	1) Administer at least 4 sessions of 8 hours each of the annual KP Staff Interpreter in-service classroom training. The training is designed to reinforce, support, and further develop skills and proficiencies of the KP staff interpreters. 2) Update training content and rollout the Providing Culturally & Linguistically Appropriate Services training in KP Learn to NCAL and California statewide Health Plan staff with verbal contact by December 31, 2024. The training supports regulatory requirements designed to improve access to health care services for Limited English Proficient (LEP) population and persons with disabilities and to increase our capacity to address the language and cultural variations of our members and patients.	Regional Language Access Program, Manager, and staff December 31, 2024	
Address language needs of inpatients by expanding access to on-demand video interpreters in NCAL hospitals for	To expand availability of qualified Language Assistance tools and resources in NCAL hospitals, to demonstrate compliance with Language Assistance operational and regulatory requirements	Regional Language Access Program, Manager	

Cultural & Linguistic Diversity

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
Limited English Proficient and deaf and hard of hearing members/patients. KP LanguageConnect (KPLC) Video Remote Interpreting (VRI) Dual Supplier Services will improve and expand interpreter access for Limited English Proficient and Deaf and Hard of Hearing members and patients at clinical touchpoints, ensure long term service sustainability and mitigate risks previously identified related to interpreter resources availability, scalability and challenges securing just in time language assistance services when needed - Validate the KP LanguageConnect VRI dual supplier service expansion plan with a KP LanguageConnect VRI pilot in 2 hospitals by September 30, 2024. - Gather front line staff feedback from KPLC VRI pilot to validate end user experience and dual supplier service reliability. - Plan next steps for KPLC VRI services based on pilot outcome and results.	and to meet the non-English and Sign language needs of KP NCAL's diverse membership - 1) Deploy a KP LanguageConnect Video Remote Interpreting (VRI) Services Dual Supplier Model in the Hospitals. The Dual supplier model will expand the pool of external contracted qualified video interpreters to be accessible 24/7 for the hospital staff and providers and assist in mitigating risks previously identified related to interpreter resources availability, scalability and challenges securing just in time language assistance services when needed, along with an opportunity to expand language accessibility with addition of new video languages for our diverse members.	and staff December 31, 2024	

Cultural & Linguistic Diversity

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
Language Assistance Service Delivery and compliance Monitoring to ensure timely access, adequacy, and availability of Qualified Language Assistance Services to Limited English Proficient members at administrative and clinical touchpoints. Perform Quality Oversight audit & Monitoring of external contracted vendor resources to ensure the following service level expectations are met. 1) A 90% or better fill rate connecting to a phone interpreter within 30 seconds for Spanish 2) Maintaining a 90% or better fill rate connecting to a phone interpreter within 60 seconds for other languages 3) Maintaining a 95% or better fill rate for in-person non-emergent interpreter requests 4) Maintaining a 90% or better fill rate connecting within 30 seconds for Spanish, ASL, Mandarin, Cantonese, Russian, and Vietnamese Video interpreter.	To ensure consistent quality, adequacy, and availability of qualified Language Assistance services at administrative and clinical touchpoints, perform annual quality oversight monitoring audits of external contracted vendor resources for provision of language interpretation (Spoken and Sign language) services. Performance Measures include their capacity to successfully meet language needs of NCAL members and patients based on time required to connect to an interpreter for phone/video interpreter services metrics and % of interpreter requests successfully fulfilled for in-person interpreters services.	Regional Language Access Program Manager and staff December 31, 2024	

Cultural & Linguistic Diversity

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2023 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
5) Maintaining a 95% or better fill rate connecting to video interpreter within 60 seconds for other languages Compile audit findings and any applicable corrective action plans in the audit report to share and discuss with vendors to ensure timely resolution of issues and service gaps related to contracted resources.			

Cultural Diversity Needs Assessment (NET 1)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
- On an annual basis, assess the cultural, ethnic and linguistic needs of KPNC membership. - As needed and subject to changes in membership and staff turnover, make adjustments to provider network	- Complete Cultural Needs Assessment by March 2023. - Review cultural and linguistic complaints related to provider network to ensure that members are being linked to practitioners per their expressed preferences. - Monitor mechanisms used for diversity outreach and recruitment to ensure KPNC is able to provide TPMG Medical Center leaders with the broadest cross section of excellent physicians and that placement of minority physicians is meeting the needs of the membership.	March 2024 Sr. Manager for Regulatory, Accreditation and Provider Network Reporting, TPMG Consulting Services	

DMHC Timeliness Initiated to Seen (ITS) Average Days Wait (ADW) Appointment Access Report

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Monitor compliance with DMHC California State timely access standards through the KPNC Access Committee ITS per Average Days Wait standards: • Urgent care within 48 hours • Nonurgent primary care within 10 business days • Nonurgent specialty care within 10 business days • Nonurgent ancillary services within 15 business days • Nonurgent Nonphysician mental health care within 10 business days • Nonurgent physician mental health care within 15 business days	• Implement action plans when departments/s service areas exceed the standard.	KFHP Vice President of Quality and Co-Chair of Quality Oversight Committee TPMG Operational AEDs and Co-Chair of Quality Oversight Committee Quarterly: February 2024 May 2024 August 2024 November 2024	

Durable Medical Equipment

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Standardize DME Dept. Inquiry Intake Goal is to consolidate and standardize inquiries sent to DME Dept. By KP staff and clinical teams that will ensure all needed information is provided to answer inquiry, when applicable direct to self help processes, and allow the DME Department to track request through to resolution.	1. Create application to standardize digital communications to DME Department from KP Staff. 2. Create workflow to review, prioritize, assign, escalate and resolve incoming request 3. Develop reports to track and categorize incoming requests	1. Roll out to NCAL Region by end of Q1 2024 2. End of Q1 2024 3. By end of Q2 2024	
DME Department Staffing Rebalance Review current business staffing needs. Draft a schedule that meets business needs for all operational hours and ensures timely processing of all DME referrals.	1. 90 percent of DME Authorization referrals process within 1 day of receipt	1. Review incoming referral volume by hour and calculate staffing needs throughout the day by end of Q1 2024 2. Draft proposed rebalanced department staffing model by end of Q1 2024 3. Communicate and collaborate with labor relations and labor union on proposed schedule change by end of Q2 2024 4. Implement schedule change to meet operational needs by 930/2024	
DME Timeliness Monitoring Objective: Improve the timeliness of	Baseline Data Analysis and Monitoring Process:	CDSU	

Durable Medical Equipment

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
the late denial process to achieve a performance metric of greater or equal to 95% timely by the end of the 4th Quarter of 2024. Metric: Performance will be measured using the "DME Dashboard Timeliness Report". We will reduce late referrals to <=5%, eliminate the Too Late To Deny (TLTD) process, and ensure >= 95% timely processing by DME RNs, DME Champions, and CDSU staff of all DME referrals by end of 4Q 2024.	- Establish baseline timeliness as of 1/1/2024. - Each team (DME Hub and CDSU) to conduct weekly timeliness monitoring using the DME Dashboard Timeliness Report. - DME and CDSU managers to review decision and notification timeliness respectively. - Bi-weekly group discussions to review findings. Audit and RCA Review (Monthly): - Assign nurses for RCA in each service area. - Systematic review of service areas for timeliness. - Combine DME/CDSU teams for a joint audit group focusing on the causes of lateness. Training and Methodology (Post-Staff Assignment):	DME Hub Achieve performance by 1/31/2024, and issue final report by 1/31/2025	

Durable Medical Equipment

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
	- Conduct training for RCA (focusing on returns and causes). - Develop a systematic investigation template, utilizing the "5 Whys" methodology (keep asking why it was late, then back up with why did THAT happened, and why did THIS happen, until you reach the root cause for the untimely referral/return to DME). Mitigation and Improvement Plan (If Timeliness < 95%): - Develop a contingency plan based on RCA outcomes. - Implement documented coaching, counseling, and refresher training to address issues of untimeliness. Reporting and Accountability		

Durable Medical Equipment

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
	• Incorporate quarterly reporting to the RMC with detailed analysis. • Annual detailed report including timeliness numbers, RCA results, and corrective action plans by 1/31/2025 Feedback Loop and Adjustment (Ongoing): • Regularly review the effectiveness of the action plan and adjust as needed. • Ensure continuous communication with all stakeholders for transparency and accountability. This action plan focuses on systematic investigation, continuous monitoring, training, and a robust reporting mechanism to achieve and maintain the goal of 95% or greater timeliness in the late denial process.		

Emergency Prospective Review Program (EPRP)

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Improve the non-KP experience by improving the intake speed to answer. 2023 (Source annual Call Volume Report: SL = 78.8% of calls answered within 60 seconds Abandonment rate = 5.4% • Measurement Period: July – December 2024 • Improve SL to 85% of calls answered within 60 seconds • Reduce abandoned calls to under 5%.	Monitor the Service Level (SL) monthly. -Implement set break times -Monitor performance real time through “Pulse”. -Hire an additional supervisor to monitor and coach -Weekly follow-up and coaching for staff with high not ready. -Weekly follow-up and coaching for staff with low calls productivity.	EPRP leaders will use the call volume report to monitor and report on results. 12/31/2024	

ESRD

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Dialysis Unit Quality Monitor dialysis unit quality: 1. BSI rate < 0.29 2. Peritonitis rates ≤ 0.33	Quarterly review of clinical quality indicators and corrective action or performance improvement plans during Renal QuPI Committee meetings. Review metrics with Large Dialysis Organizations (LDO) during Joint Operations Committee (JOC) meetings. Root-cause analysis of all BSI's and Peritonitis incidents.	Renal Quality and Performance Improvement (QuPI) Committee Chiefs of Nephrology Continuum Administrators By Dec. 31, 2024	
Home Dialysis [Peritoneal Dialysis (PD) + Home Hemodialysis (HHD) incidence - Initiate peritoneal dialysis and home hemodialysis for all eligible patients (i.e., patients who complete Options class, can independently or with assistance of caregiver perform PD/HHD). - Share best practices from high performing medical centers. Target: ≥ 36%	Utilize the Renal Dashboard and Reporting Workbench Queries to identify patients who would benefit from PD/HHD based on eGFR<25. Partner with Surgery and Interventional Radiology Champions to enhance workflows and guidelines to support consistent peritoneal dialysis catheter placement and repair.	Chiefs of Nephrology, Surgery, and IR Managers/Directors of Nephrology Home Dialysis Workgroup Home Health Administrators By Dec. 31, 2024	
Hemodialysis central venous catheter (CVC) prevalence	Create and leverage weekly reports to proactively monitor patients to obtain vascular access (i.e., AVF or graft).	Chiefs and Managers/Directors of Nephrology	

ESRD

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Continue to monitor hemodialysis patients with a CVC in place for more than 90-days Target: (new goal starting in 2024) ≤ 18% of Hemodialysis patients have a CVC in use for more than 90-days	Monitor timeliness of appointment for vein mapping, and OR access for Vascular Surgery for placement of CVC, AVF, or AVG as clinically indicated.	Chiefs of General and Vascular Surgery TPMG Regional Nephrology Medical Directors of Quality and Quality Directors By Dec. 31, 2024	
Optimal Starts Target: ≥ 68% % Pre-emptive Kidney Transplants- National Benchmark= 3.1%	Encourage consistent workflows from regional playbook, and utilization of reporting tools in KPHC. Share and monitor trends for Optimal Starts at monthly Renal QuPI committee meetings. Partner with Vascular, General Surgery and Interventional Radiology champions to share data and escalate concerns with timely access. Leverage dialysis vendors' "Options Education" resources.	Managers/Directors of Nephrology Chiefs of Nephrology Medical Director and Director of Kidney Transplant Center Chiefs of General and Vascular Surgery Renal QuPI Committee	

ESRD

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
		Medical Directors of Quality and Quality Directors By Dec. 31, 2024	
Complaints and Grievances To ensure the overall contracted providers are providing adequate care. Target: ≤ 1% of KP members who receive care at a contracted dialysis provider submit a complaint or grievance during the year.	Monitor complaints & grievances filed by KP members about service, quality, and care received at contracted dialysis providers. Complaints and grievances shared at JOC meetings with the LDOs to discuss areas of improvement and/or include in action plans. Standard resolution process to occur at the local medical centers, and followed up by the Continuum Administrators. Complaints and grievances reviewed monthly during Renal QuPI committee meetings to identify trends.	Renal Quality and Performance Improvement Committee Chiefs and Managers/Directors of Nephrology Continuum Administrators By Dec. 31, 2024	

Health Engagement Consulting Services

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Local Health Ed Services support: Health Engagement Consulting Services supports medical center infrastructure to provide a standard set of services and ensure fidelity to the model of care and the highest quality and care experience for members.	• Support Motivational Interviewing Excellence with training and skill building for Health Educators. • Manage regional model for online classes in Health Education to support availability of online classes across the region. • Launch single session online Healthy Weight class.	Health Engagement Consulting Services 12/31/24	
Patient Communication Consulting for Quality Goals: Continue outstanding consulting for patient messaging around chronic health conditions including: • Asthma • Diabetes • Depression • Colorectal Cancer Screening • Cervical Cancer Screening • Hypertension	Asthma • Redesign Asthma Action Plans for traditional therapy applying American Academy of Pediatrics recommendations.	Health Engagement Consulting Services 12/31/24	
	Diabetes • Continue to personalize the diabetes Care Guide on My Doctor Online by providing RGM status. • Launch Spanish diabetes curricula.	Health Engagement Consulting Services 12/31/24	

Health Engagement Consulting Services

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
	Review and launch 1:1 topic guide.		
	Depression - Review and update Managing Your Depression class. - Monitor utilization of evisit (interactive electronic visit) and online depression screening and adjust messaging as needed.	Health Engagement Consulting Services 12/31/24	
	Colorectal Cancer Screening - Revise screening kit outreach materials. - Evaluate screening kit video.	Health Engagement Consulting Services 12/31/24	
	Cervical Cancer Screening Pilot home HPV screening outreach.	Health Engagement Consulting Services 12/31/24	
	Hypertension Via the electronic medical record, integrate updated hypertension	Health Engagement Consulting Services	

Health Engagement Consulting Services

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
	patient education tools in English and Spanish into care delivery. • Implement outreach campaigns for patients with hypertension to encourage screening. • Scope patient education opportunities for hypertension education for people with diabetes.	12/31/24	
Communications Consulting on Patient Facing Tech Tools: Continue outstanding consulting support for TPMG technology strategy to support patients with online engagement as defined by AED Sponsors	• Consultants will work with TPMG Technology leadership, clinical leaders and IT consultants to develop new content on the My Doctor Online web site to support patient care paths, with a focus on virtual care resources. • We will further enhance these digital products with new outreach channels and personalized, relevant information.	Health Engagement Consulting Services 12/31/24	

Regional Health Plan Quality

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
To meet NCQA requirements, the NCAL 2024 Quality Program's workplans will be evaluated at the end of the year. Metric: meet the NCQA standard for identifying the review of the 2024 workplans in the 2025 workplan and then evaluating the documents at the end of the year and early in the following year. Submit completed Health Plan Quality Program Description and supporting documents, including workplans and evaluations, to Kaiser Permanente Board of Directors by April 2025.	Facilitate and provide consultation to care delivery subject matter experts for the development of the current year's workplan and the evaluation of the previous year's workplan. Present the evaluations and workplans to the Regional Quality Oversight Committee (QOC) during its routine review of the current year workplans and for the KFHP Board of Directors Quality and Health Improvement Committee.	Regional Hospital Health Plan Quality team April 2025 – QOC September 2025 – QHIC	
NCQA Accreditations / Programs: 1. Successfully achieve renewed Health Plan Accreditation (HPA) for the Commercial, Exchange, and Medicaid business lines 2. Complete a gap analysis specific to the HPA Medicaid business line by December 31, 2024 3. By December 31, 2024, Close 75% of identified gaps for HPA Medicaid business line in preparation for 2025 survey	Key actions in 2024: • Identify gaps in stakeholders and key evidence for HPA Medicaid business line • Work with standard leads to prepare for and complete HPA survey, anticipated March 2024 • Work with standard leads to prepare for Medicaid Add-On survey, anticipated in September 2025 • Maintain Health Equity Accreditation and Patient-Centered Medical Home Recognitions	Regional Hospital Health Plan Quality team December 2024 for key actions	

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
HEDIS Measures			
The organizational goals for reporting year 2024 for all HEDIS Measures 1. Exceed or maintain the 75th or 90th percentile for all measures. • Internal targets per individual measure are based on a number of factors including past performance trends and comparison to national benchmarks such as HEDIS percentiles 2. Link HEDIS measures to quality goal activities. 3. Identify areas for improvement which link to strategic goals.	Planned Activities for all HEDIS Measures: Report: • HEDIS results to the Quality Oversight Committee Annually • Exceed or maintain the national percentile for HEDIS measures • Distribute the “Crossing the Quality Chasm” performance indicator report to medical centers monthly (some HEDIS measures are also CQC measures) Data: • All clinical leads to work with HealthConnect staff to ensure data collection remains consistent Outreach: • Provide member outreach through appointment reminder mailings, invitations to health classes, and phone calls. Inreach: • Refer to the CQC and PHM sections attached below for additional interventions for select measures • Clinical Practice Guidelines (CPGs) are developed to assist clinicians by providing an evidence-based analytic framework for the evaluation and treatment of selected common problems in patients, and to support clinical decisions by practitioners at the point of care in the provision of acute, chronic,	Regional Medical Director Outpatient Quality Annual June 2024	

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
	preventive care, and behavioral health services. The use of CPGs by practitioners assists KFHP by ensuring that the care provided to members is evidence-based and consistent with professionally recognized standards of care. Development of CPGs is prioritized based on established criteria, which include: number of patients affected by a particular condition/need, quality of care concerns and/or excessive variation in clinical practice, regulatory issues, payor interests, cost, operational needs, leadership priorities and prerogatives. CPGs are not used to make utilization management determinations regarding the medical necessity of a member's care. Reducing Variation: The regional team is assessing common practices among top five NCAL performers; spreading these techniques to achieve more standardization.		

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Crossing the Quality Chasm			
Breast Cancer • 2024 target 84%	- Share best practices from top performing facilities - Prepare for potential USPSTF changes in screening start age - Monitor screening for the 40-49 age group in the CQC backpage - Update PROMPT and all inreach and outreach content with new screening start age	Medical Director for Quality Monthly	
Cervical Cancer Screening • 2024 target 84%	- Share best practices from top performing facilities - PROMPT updates to support 2024 demand smoothing - Focus on presweep and inreach efforts in 2024 - Home HPV self-collection pilot in NVL	Medical Director for Quality Monthly	
Colorectal Cancer Screening • 2024 target 78% (for 45-75-year-olds)	- Participation in the American Medical Group Association (AMGA) Colorectal Cancer Best Practices Learning Collaborative to gather innovative ideas from outside organizations - Development of a robust 'back-to-basics for Inreach' campaign that will launch during CRC Awareness Month (Mar) - Investigate the appropriateness of replicating and spreading the	Medical Director for Quality Monthly	

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
	Midreach plan developed by the Diablo Service Area • Circulate new FIT instruction video (launched Jan 2024) • Expanding the Cologuard program to a wider and targeted audience • Support lab initiative to streamline processing efficiency to improve Test Not Done (TND) rates		
Cardiovascular Health			
Diabetes A1C ≤ 9 • 2024 target 83%	• Improve use of remote glucose monitoring devices. • Encourage expanded lab access and after hours outreach. • Encourage treatment intensification for patients who are in and out of control. • Encourage use of health education support; encourage patient direct-booking of online HED classes. • Routine communication about best practices and promoting the use of performance dashboards. • Expanding creative outreach channels such as texting • Utilize THRIVE local to address SDOH.	Medical Director for Population Care Monthly	
Diabetes A1C < 8 • 2024 target 75%	• Improve use of remote glucose monitoring devices • Encourage expanded lab access and after hours outreach	See above	

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
	• Encourage treatment intensification for patients who are in and out of control • Encourage use of health education support; encourage patient direct-booking of online HED classes • Routine communication about best practices and promoting the use of performance dashboards • Expanding creative outreach channels such as texting • Utilize THRIVE local to address SDOH		
Diabetes Latino A1C < 8 • 2024 target 75%	• Improve use of remote glucose monitoring devices • Encourage expanded lab access and after hours outreach • Focus on culturally appropriate outreach • Encourage treatment intensification for patients who are in and out of control. • Encourage use of health education support; encourage patient direct-booking of online HED classes • Routine communication about best practices and promoting the use of performance dashboards • Expanding creative outreach channels such as texting	See above	

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
	Utilize THRIVE local to address SDOH		
Diabetic Retinopathy/DM Eye Screening • 2024 target 79%	- Transition to new modes of regional outreach and track impact to booking/screening rates - Explore opportunities to expand the regional outreach reminder population - Assess effectiveness of current camera resources and new locations with need - Continue to support local medical centers through best practice dissemination	Medical Director for Quality Monthly	
Hypertension (HTN) control all population • 2024 target 83%	- Continue with semi-annual HTN reminders to patients due for BP check - Evaluate opportunities to enhance performance reports - Encourage after hours outreach and access for BP checks. - Utilize THRIVE local to address SDOH	Medical Director for Population Care Monthly	
HTN in Black/African-American • 2024 target: 83%	- Follow up with high performances in AA HTN to learn of best practices for spread - Continue with semi-annual HTN reminders to patients overdue for a BP check	See above	

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
	- Encourage after hours outreach and access for BP checks. - Utilize THRIVE local to address SDOH		
Diabetes Blood Pressure • 2024 target 83%	- Follow up with high performers to learn of best practices for spread - Include DM on the monthly performance reports - Utilize THRIVE local to address SDOH	See above	
Statin Appropriate Fill/Adherence Combined Fill • 2024 targets: Statin Fill ASCVD: 92% Statin fill DM: 80%	- Technology enhancements to provide efficiency and organization in Statin outreach - Provide high-yield lists for targeted outreach and exclusion clean up - Training opportunities to adjust medication instructions to reflect correct statin usage - Utilize THRIVE local to address SDOH	Medical Director for Population Care Monthly	
ASCVD Adherence • See above • 2024 target 92%	- Technology enhancements to provide efficiency and organization in Statin outreach - Provide high-yield lists for targeted outreach and exclusion clean up - Training opportunities to adjust medication instructions to reflect correct statin usage	See above	

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
	Utilize THRIVE local to address SDOH		
DM Adherence • See above • 2024 target 87%	- Technology enhancements to provide efficiency and organization in Statin outreach - Provide high-yield lists for targeted outreach and exclusion clean up - Training opportunities to adjust medication instructions to reflect correct statin usage - Utilize THRIVE local to address SDOH	See above	
Tobacco Quit Rate • 2024 target 90%	- Design targeted outreach efforts to focus on high risks groups. - Continue bulk secure messaging (BSM)/Robo calls. - Collaborate with pediatrics on prevention rather than cessation. - Remind physicians and staff to utilize the updated NCAL Tobacco Cessation Clinical Practice Guidelines, and SmartRx – prescribing Varenicline (Chantix) as first-line therapy. - Continue to hardwire previous efforts: - Ensure ongoing training -- MAs: Accurately document tobacco use in the social hx and alert physicians about current smoker status. Physicians: Trained in effective conversations, uses SmartRx for NRT Rx and referrals to wellness coaching. - Sustain communication structure to ensure tobacco performance data is shared with providers and	Medical Director for Quality Monthly	

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
	staff (i.e., posted on huddle boards & shared during dept meetings).		
ESRD			
Optimal Start 2024 Targets: • Optimal Starts ≥ 68% • Home Dialysis [Peritoneal Dialysis (PD) + Home Hemodialysis (HHD)] incidence ≥ 36% • Pre-emptive kidney transplantation benchmark is 3.1%	- For hemodialysis vascular access improvements: Nephrology departments to partner with IR and Vascular Surgery to develop local agreements for timely vein mapping and access to surgery for access placement. - For Home Dialysis: Home Workgroup to meet and develop strategies to encourage Home PD/HHD. DSA to partner with Home Health to expand Home PD Assist program at all internal Home dialysis sites. Continuum to evaluate options to develop Home PD assisted programs with our external PD organizations for the rest of the medical centers. - For pre-emptive transplantation: HealthConnect trigger for early referral for transplant evaluation. Work with transplant programs to improve living donor identification and engagement. Expand out- of-California kidney transplant options.	Medical Director for Quality Monthly	
Hemodialysis patients with Central Venous Catheter (CVC) in use for ≥ 90 days • 2024 target =<18%	Local adoption of regionally approved Vascular e-consult. OR Schedulers to adhere to booking guidelines as set forth in e-consult.	Medical Director for Quality Monthly	

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management			
Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
	Partner with POM to create clinical guidelines to mitigate patient delay, surgery cancellations and denial for surgery.		
Asthma Care			
Asthma Med Ratio • 2024 target 92%	- Adjustment of CQC Population to be more focused to match HEDIS specifications. - Adding PMT priority fields to allow for more focused data pulls.	Medical Director for Quality Monthly	
Behavioral Health			
Depression Monitoring • 2024 target: 65% Depression Response • 2024 target: 18%	Depression Monitoring: - Continued refinement of workflows with the integration of inreach tool (PROMPT) - Release of additional tools to aid in identification of patients requiring a PHQ-9 Depression Response: - Additional outreach support tools scheduled to be released in 2024 - Best practices to be more widely collated and shared across the region	Medical Director for Quality Monthly	
Alcohol and Other Drugs – Initiation and Engagement in Treatment (AOD IET) • 2024 target 48%	Adjust current IET daily outreach lists to match new specifications and distribute to all medical centers early 2024	Medical Director for Quality Monthly	

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
(Note: AOD measure is now referred to as IET (Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment [IET]. 2023 target changed to 48% due to IET spec changes – utilized national benchmarks to finalize new target)			
Immunization			
Childhood Immunization – COMBO 10 • 2024 target 73%	Please see below for Childhood Immunization – Flu next steps	Medical Director for Quality Monthly	
Childhood Immunization – Flu • 2024 target 79%	Engaging and training MD Pediatric Immunization Consultants to train front-line MD colleagues and clinic support staff on patient-facing flu persuasion and communication techniques; convening Regional Pediatric Immunization Strategies peer group meeting (virtual + in-person) with MD Pediatric Immunization Consultants – AND – Pediatric Directors/Managers to highlight/share best practices for flu #1 & #2 outreach/inreach workflows, promote performance improvement tools and strategies to support tests of change for improving flu #1 & #2 patient communication and inreach	Medical Director for Quality Monthly	

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management			
Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Adolescent Immunization – Adol. COMBO 2 (replacing Adol. Combo 1) • 2024 target 62%	Pediatric clinics will continue meeting internal regional target	Medical Director for Quality Monthly	
Fracture Prevention: Treat or Scan			
Fracture Prevention: Treat or Scan • 2024 target 82%	- Leverage collaboration between participating departments (RAD, ORTHO, ED/HBS) - Add Virtual class for fracture pts - Educational efforts with AFM docs (Steal this Talk)	Medical Director for Quality Monthly	
Population Health Management			
Kaiser Permanente medical centers across Northern California maintain a C. diff standardized infection ratio (SIR) of 0.55 or below.	- Members targeted for the C. diff program care bundle receive close monitoring of any loose stools to determine cause and identify cases of C. diff infection (vs. carriers) - Members with confirmed cases of C. diff infection are acted upon quickly, including isolation and treatment with antibiotics.	TPMG Consulting Services and PHM/Quality Director 12/31/2024	

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Over 95% of members in the Special Needs Plan program and over 90% of patients in the Complex Chronic Conditions program affirm through a feedback survey that the interdisciplinary care team successfully assists them in achieving their goals.	Complex Chronic Conditions - Intensive case management conducted by nurses and social workers consisting of face-to-face clinic visits, telephone appointments, family conferences, and home visits if indicated. - During these visits, nurse/social worker teams develop a personalized care plan designed to be completed in the limited time span intended for the program (no more than 6 months) - Nurse/social worker teams assess the member's needs, provide education and self-care skill building, and link the member to appropriate internal and external resources. Special Needs Plan - Members in the Special Needs Plan program receive a comprehensive health assessment upon enrollment and annually thereafter, as well as during a transition in care venue - Members jointly develop a care plan customized to their specific health needs and preferences with the assistance of a nurse - Members' progress against the individualized care plan is tracked closely by Special Needs Plan teams at each of the medical centers, including nurses and social workers.	TPMG Consulting Services and Complex Needs Director 12/31/2024	
Receive no complaints or grievances related to the Complex Chronic Conditions (CCC) program	Continue to provide service according to the CCC program description	TPMG Consulting Services and Complex Needs Director	

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
		12/31/2024	
Appropriate members are informed about eligibility to participate, how to use program services, and how to opt in or out for the following programs: • Asthma • Diabetes • Special Needs Plan • Complex Chronic Conditions	Utilize print and secure electronic communications to reach members who are identified for program participation through registry inclusion, insurance coverage, or referral	TPMG Consulting Services, PHM/Quality Director, and Complex Needs Director 12/31/2024	
Complete population assessment report detailing demographics and disease burden of KPNC member population.	• KP will assess our member population to inform appropriate PHM strategies • KP will plan for the programs/services, goals and metrics that will address the identified strategies. • The assessment and the Strategy Program will be reviewed by the Quality Oversight Committee. • Strategies will be implemented. • Measure the impact of our population management program and identify opportunities for improvement.	TPMG Consulting Services, PHM/Quality Director, and Complex Needs Director 12/31/2024	
Conduct annual analysis of program effectiveness, including the following metrics: • Childhood Immunization Status Combo 10 • Well Child visits in the first 15 months of life • Interactive Voice Response Satisfaction Survey for SNP and CCC programs • CCC complaints and	Complete narrative report and analysis for quality leadership	TPMG Consulting Services, PHM/Quality Director, and Complex Needs Director 12/31/2024	

HEDIS Measures, Crossing the Quality Chasm, and Population Health Management			
Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
grievances			

Home Health and Hospice Member Experience

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Metric-Overall Rating of Home Health Agency NCAL Goal is 94.3 based on current work, baseline performance, expected likely continued challenges from COVID and average historical improvement. The purpose of this goal is to improve the overall experience that a Home Health agency member receives. Acknowledging the ongoing impact of COVID-19 to care provision, the goal for 2024 will be to increase current performance levels with a glidepath driving towards a 4-star rating of 94.5 in PY 2025. Baseline: 94.1 2024 Target: 94.3	National Care Experience Analytics performed an analysis on Rate Agency, examining National and KP Program-wide trends in performance to inform target setting. This question encompasses major focuses of Home Health which include the following projects: 1. Develop and implement agency specific interventions based on driver related data analysis across all agencies. 2. Leadership rounding via tracer visits will continue to assess real-time care experience, with any changes to the care experience questions informed by data analysis. 3. Sharing of best practices at peer groups as a standing agenda item 4. Sharing of real-time care experience data and feedback with frontline staff 5. Report and analytics development, training and utilization for data captured within tracer tool will be incorporated for all leaders	Each Home Health Agency Service Director and Quality Director and their management supervisory staff September 30, 2024	

Home Health and Hospice Member Experience

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
	(Q1 2024) to drive targeted efforts. 6. Regional team will support standardization of onboarding new staff for both Home Health and Hospice specific to Care Experience.		
Metric-Overall Rating of Hospice Agency NCAL goal is 84.5 based on current work, baseline performance, expected likely continued challenges from COVID and average historical improvement. The purpose of this goal is to improve the overall experience that a Hospice agency member receives. Acknowledging the ongoing impact of COVID-19 to care provision, the goal for 2024 will be to increase current performance levels with glidepath driving towards the 75TH percentile ranking nationally of 86% in PY 2026. Baseline: 84.2 2024 Target: 84.5	National Care Experience Analytics performed an analysis on Rate Agency, examining National and KP Program-wide trends in performance to inform target setting. This question encompasses major focuses of Hospice which include the following projects: 1. Develop and implement agency specific interventions based on driver related data analysis across all agencies. 2. Leadership rounding via tracer visits will continue to assess real-time care experience, with any changes to the care experience questions informed by data analysis. 3. Sharing of best practices at peer groups as a standing agenda item	Each Hospice Agency Service Director and Quality Director and their management supervisory staff June 30, 2024	

Home Health and Hospice Member Experience

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
	4. Sharing of real-time care experience data and feedback with frontline staff. 5. Report and analytics training needs for SHP and data captured within the JCR tracer tool will be assessed with subsequent education provided for all leaders (Q1 2024) to support and drive targeted PI efforts. 6. Regional team will support standardization of onboarding new staff for both Home Health and Hospice specific to Care Experience. 7. Regional team will perform targeted in-person site visits for lower performing agencies and those with new leadership staff including performing patient tracer visits, to train inter-rater reliability on visit observations, data analysis validation by leaders and educational training provided as indicated.		

Kidney Transplant Clinics

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Transplant Wait Times To ensure members are referred in a timely manner for evaluation. Target Transplant Referral to Phone Evaluation (wait time in days): ≤ 21 calendar days.	Monitor the wait times from referral to evaluation. When wait time exceeds 21 days, review case to identify reason for the delay and share learning.	Renal Transplant / Kidney Transplant Clinics; Renal Quality and Performance Improvement Committee Quarterly	
Patient and Graft Survival Patient and Graft Survival target rates are within expected hazard ratios set by Scientific Registry of Transplant Recipients (SRTR).	Conduct quality review on 1- and 3-year patient and graft survival rates. Compare observed performance with expected and national data from the SRTR. Compare the same metrics as above for KP-specific population by reviewing NTS reports created with the help of UNOS	Renal Transplant / Kidney Transplant Clinics; Renal Quality and Performance Improvement Committee Annually	
Member Complaints and Grievances Complaints and grievances filed by KP members regarding the quality, services and care received at the Transplant COE are reviewed. Target ≤ 1% of patients who receive care at a Transplant COE submit a complaint or grievance.	Monitor and review complaints and grievances with the Transplant COEs during monthly conferences and biannual Oversight Joint Meetings.	Renal Transplant / Kidney Transplant Clinics Monthly	
Patient Satisfaction Patient feedback on kidney transplant services received by transplant center and their experience in transitioning care back to KP. Target ≥ 75% favorable rating received from Transplanted Members	≥ 75% favorable rating received from Transplanted Members	Renal Transplant / Kidney Transplant Clinics; Renal Quality and Performance Improvement Committee Quarterly	

Kidney Transplant Clinics

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
grievance.			
Quality Indicators and Sentinel Events (within 90-days of transplant) Ensure all complications within 90-day of transplant are captured. Compare data quarterly to ensure there are no fluctuations in the 90-day quality indicators.	Monitor quality indicators with Transplant centers at monthly conferences and biannual Oversight Joint Meetings. Address any reported fluctuations in quality indicators with Transplant centers. Report sentinel events to KP Regional Risk Management. Corrective measures will be taken with the transplant centers to address fluctuations in quarterly quality indicator data.	Renal Transplant / Kidney Transplant Clinics; Renal Quality and Performance Improvement Committee Quarterly	

Medi-Cal QIHETP Workplan 2024

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team & Due Date	2024 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
<u>1. DHCS Managed Care Accountability Set (MCAS)</u> <u>Measure Performance: Child and Adolescent Well Care Visits (WCV)</u> Improve Child and Adolescent Well-Care Visit rates among Medi-Cal members in Kaiser Permanente Northern California Region. Improve Child and Adolescent Well-Care Visit rates among Medi-Cal members in Kaiser Permanente Southern California Region. <u>Goal:</u> Meet or exceed the 2024 Minimum Performance Level (MPL) for Child and Adolescent Well-Care Visits. <u>Metric:</u> Increase the percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. <u>Baseline:</u> MY 2022 48.03% MY 2023 55.93% (Preliminary) <u>Target:</u> 2024 MPL 2022 MPL was 48.93% 2023 MPL was 48.07% <u>Stretch Goal:</u> 50% <u>Outcome Measures:</u> WCV rate <u>Process Measures:</u>	Conduct applicable DHCS required Accountability Project (e.g., A3, DHCS Child Health Sprint). Establish Stakeholder group. Request and validate necessary data to track both outcome and process measures. Capacity building - Conduct feasibility study to build capacity for interactive data dashboard for industry wide quality metrics for entire NCAL population all lines of business for 4.6 million patients. Currently, there's no capacity to break data down by service area and county. Validate the data and break down by service area and county. Conduct a needs assessment to identify additional barriers. Develop specific PDSAs (Plan Do Study Act) with the Stakeholder workgroup to address Well-Care Visit disparity among young Medi-Cal Members in northern California. Track and evaluate progress following various PDSAs.	▪ Primary Care Chiefs ▪ Medi-Cal Medical Directors ▪ Data Consultants ▪ NCAL & SCAL Medi-Cal Quality ▪ Pediatric Departments ▪ Outpatient Quality ▪ TPMG & SCPMG Pediatric and Adult Primary Care Chiefs and Staff ▪ Adult and OBGYN Chiefs and Departments MY 2024 ending December 31, 2024 RY 2025	

Medi-Cal QIHETP Workplan 2024

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team & Due Date	2024 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
Pediatrics, Adult & Family Medicine and OB/GYN Access to care.	Report progress and goal status to stakeholders and committees for review, support, recommendations, and approval.		
<u>2. DHCS MCAS Measure Lead Screening in Children (LSC)</u> Improve lead screening rates among Kaiser Permanente Medi-Cal Members by their second birthday. <u>Goal:</u> Meet or exceed the 2024 Minimum Performance Level (MPL) for Lead Screening in Children. <u>Metric:</u> Increase the percentage of children who turn 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday. (HEDIS) Baseline: MY 2022 45.09% (NCAL) MY 2023 49.61% (SCAL) Target: 2024 MPL 2022 MPL was 63.99% 2023 MPL was 62.79% Stretch Goal: 65%	Establish Stakeholder group. Request necessary data to track both outcome and process measures. Capacity building - Conduct feasibility study to build capacity for interactive data dashboard for industry wide quality metrics for entire NCAL population all lines of business for 4.6 million patients. Currently, there's no capacity to break data down by service area and county. Validate the data and break down by service area and county. Develop specific PDSAs (Plan Do Study Act) with the Stakeholder workgroup to address lead screening rates among Medi-Cal Members between 6-months to 72-months of age during Periodic Health Assessment (PHA). Educate Pediatric department leadership staff on importance of lead screenings and requirements for Members 6-month to 72-months of age. Initiate follow-up plan of care for missed lead screenings and blood tests.	▪ Medi-Cal Medical Directors ▪ Data Consultants ▪ NCAL & SCAL Medi-Cal-Quality ▪ Pediatric Departments ▪ Outpatient Quality ▪ TPMG & SCPMG Pediatric Chiefs and Staff ▪ Lab Departments ▪ Information Technology MY 2024 ending December 31, 2024/RV 2025	

Medi-Cal QIHETP Workplan 2024

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team & Due Date	2024 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
<u>Outcome measures:</u> Lead Screening in Children (LSC) rate <u>Process measures:</u> Lab orders for lead screening in children between 6-months to 12-months of age. Completed lab draws for lead screening for children between 6-months to 12-months of age.	Engage Laboratories to streamline the patient experience to obtain a lead screening. Add lead screening prompts in the medical records. Track and evaluate progress following various PDSAs. Report progress and goal status to stakeholders and committees for review, support, recommendations, and approval.		
<u>3. 2023-2026 Kaiser Permanente Statewide DHCS Clinical Performance Improvement Project (PIP): W30-6</u> Improve Well Child Visits in the First 30 Months of Life - Well Child Visits in the First 15 Months of Life - Six or More Well-Child Visits (W30-6) measure among Black/African American Medi-Cal Members in Kaiser Permanente. <u>Health Disparity</u> Improve the health of Black/African American Medi-Cal Members 0-30 months of age. <u>Goal:</u> Conduct required PIP in accordance with DHCS contract and HSAG guidelines <u>HSAG/DHCS Deliverable Timeline:</u> 2024 – Submit baseline data to HSAG/DHCS for CY 2023 for Well Care Visits in the first 30-months of Life 0-15 months: 6 or more well child visits (W30-6). Update Steps 1-6, if needed, complete Step 7 with	Submit 2024 deliverables to HSAG and DHCS within required timeframes and achieve validation requirements. Establish Stakeholder group. Request necessary data to track both outcome and process measures. Capacity building - Conduct feasibility study to build capacity for interactive data dashboard for industry wide quality metrics for the Medi-Cal population. Currently, there's no capacity to break data down by service area and county. Validate the data and break down by service area and county. Develop specific PDSAs (Plan Do Study Act) with the Stakeholder workgroup to	▪ Medi-Cal Medical Directors ▪ Chief Health Equity Officer ▪ Data Consultants ▪ NCAL& SCAL Medi-Cal-Quality ▪ Pediatric Departments ▪ Outpatient Quality ▪ TPMG & SCPMG Pediatric Health Chiefs and Staff	

Medi-Cal QIHETP Workplan 2024

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team & Due Date	2024 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
baseline data, and Step 8 with QI activities completed to date. 2025 – Submit baseline remeasurement data for CY2024 and narrative to HSAG/ DHCS, complete Step 8 with QI activities completed to date. 2026 – Meet the target established in 2024. Submit final baseline remeasurement data for CY2025, narrative and PIP report to HSAG/DHCS. Metrics: HSAG/DHCS Submission timeline met and achieve validation requirements. Increase W30-6 rate among Black/African American from the MY2023 baseline. Baseline: MY2023 TBD MY2022: 69.08%. Target: TBD based on MY2023 baseline, but to exceed MY2022 and MY2023 performance. Outcome measure: W30-6 rate among Black/African American Medi-Cal members. Process measure: Pediatrics access to care.	address Well-Care Visit disparity among Black/African American Medi-Cal Members 0-30 months of age. Track and evaluate progress following various PDSAs. Report progress and goal status to stakeholders and committees for review, support, recommendations, and approval.	MY 2024 ending December 31, 2024/RY 2025	

Medi-Cal QIHETP Workplan 2024

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team & Due Date	2024 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
4. 2023-2026 Kaiser Permanente Statewide DHCS Non-Clinical PIP Improve % of provider notifications for Members with Substance Use Disorder (SUD) and Specialty Mental Health (SMH) diagnoses following or within 7-days of E.D. visit. Goal: Conduct required PIP in accordance with DHCS contract and HSAG guidelines. <u>HSAG/DHCS Deliverable Timeline:</u> Goal: 2024 – Submit to DHCS baseline data to HSAG/DHCS for CY2023 for % of provider notifications care for Members with SUD/SMH following or within 7-days of Emergency Department (ED) visit. Update Steps 1-6, if needed, complete Step 7 with baseline data, and Step 8 with QI activities completed to date. 2025 – Submit baseline to remeasurement data for CY2024 and narrative to HSAG/ DHCS, complete Step 8 with QI activities completed to date. 2026 – Meet the target established in 2024. Submit final baseline to remeasurement data for CY2025, narrative and PIP report to HSAG/ DHCS. Metrics: HSAG/DHCS Submission timeline met and validation requirements achieved. Improve % of provider notifications care for Members with SUD/SMH following or within 7-days of Emergency Department (ED) visit from the MY 2023 baseline to the target established in 2024.	Submit 2024 deliverables to HSAG and DHCS within required timeframes and achieve validation requirements. Establish Stakeholder group. Request and validate necessary data. Develop specific PDSAs (Plan Do Study Act) with the Stakeholder workgroup to improve % of provider notifications for Members with Substance Use Disorder (SUD) and Specialty Mental Health (SMH) diagnoses following or within 7-days of E.D. visit. Identify and implement IT solution for notification of KP PCPs about qualifying encounters at non-KP and KP facilities. Report progress and goal status to stakeholders and committees for review, support, recommendations, and approval.	▪ Medi-Cal Medical Directors ▪ Data Consultants ▪ NCAL & SCAL Medi-Cal-Quality ▪ ED Departments ▪ Outpatient Quality ▪ Information Technology ▪ Pediatric and Adult Primary Care/Adult & Family Medicine Chiefs and Departments ▪ Psychiatry/Addiction Medicine Chiefs and Departments (potentially) ▪ Revenue Cycle (potentially) MY 2024 ending December 31, 2024/RY 2025	

Medi-Cal QIHETP Workplan 2024

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team & Due Date	2024 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
Baseline: SMH - CY2023 TBD (SMH – CY2022 54.62%) SUD - CY2023 TBD (SUD – CY2022 37.69%) TOTAL – CY2023 TBD CY2022 47.78% Target: TBD in 2024 based on MY2023 baseline, but to exceed MY2022 and MY2023 performance. Process measure: N/A			
<u>5. DHCS Comprehensive Quality Strategy Bold Goals 50 x 2025 Initiative</u> <u>2024 Goal:</u> Complete gap analysis and create a comprehensive improvement plan to be implemented in 2025. <u>2025 Goal:</u> Close the gap in baseline MY2021 performance for Bold Goal Specific Measures to exceed the MPL by 2025 to help achieve DHCS' vision of eliminating health care disparities. Bold Goals: <u>Bold Goal 1:</u> Close racial and ethnic disparities in well-child visits and immunizations by 50% <u>Bold Goal 2:</u> Close maternity care disparity for Black and Native American persons by 50% <u>Bold Goal 3:</u> Improve maternal and adolescent depression by 50%	2024 Establish Stakeholder group. Identify baseline performance data (MY 2021 performance). Identify current performance data (MY 2024 YTD). Complete gap analysis. Create a roadmap from current state to meeting or exceeding targets by December 2025. 2025 Implement focused initiatives around children's health, preventive care, behavioral health integration, and maternity care, focusing on health equity to improve applicable measure	▪ Medi-Cal Medical Directors ▪ Chief Health Equity Officer ▪ Data Consultants ▪ NCAL/SCAL Medi-Cal-Quality ▪ Primary Care and Behavioral Health Departments ▪ Outpatient Quality ▪ TPMG/SCPMG Primary Care and Behavioral	

Medi-Cal QIHETP Workplan 2024

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team & Due Date	2024 Evaluation 1. Analysis of results including metrics 2. Barriers 3. Next steps
Bold Goal 4: Improve follow-up for mental health and substance use disorder by 50% Bold Goal 5: Ensure Kaiser Permanente NCAL exceeds the 50th percentile for all children's preventive care measures. Baseline: MY2021 performance Target by MY2025 ending on December 31, 2025: Goals 1-4 50% improvement from baseline Goal 5 exceed the 50th percentile	performance. Report progress and goal status to stakeholders and committees for review, support, recommendations, and approval.	Health Chiefs and Staff MY2024 ending December 31, 2024/RY 2025	

Member Experience (ME 7)			
Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Commercial, Medicare, and Marketplace Member Experience (ME 7 C-D)			
ME 7 C-D - Analyze and monitor Commercial, Medicare, and Marketplace complaints, grievances and appeals - Conduct a member experience survey - Identify opportunities for improvement	- Identify trends in Commercial, Medicare, and Marketplace complaint, grievance and appeal data which represent opportunities for improvement - Identify trends in member experience surveys which represent opportunities for improvement	TPMG Consulting Services Member Experience Standard Lead Member Concerns Committee Annual: October 2024	
Behavioral Health Member Experience (ME 7 E-F)			
ME 7 E-F - Analyze and monitor Behavioral Health complaints, grievances and appeals - Conduct a behavioral health member experience survey - Identify opportunities for improvement - Implement at least two interventions	- Identify trends in behavioral health complaint, grievance and appeal data which represent opportunities for improvement - Identify trends in behavioral health member experience surveys of psychiatry and chemical dependency departments which represent opportunities for improvement.	TPMG Consulting Services Member Experience Standard Lead Behavioral Health Quality Oversight Committee Annual: October 2024	

Member Relations			
Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Complaint, Grievance & Appeals (CGAs) Reduction NCAL Market Metric: Implement a CGA reduction goal at each Northern California medical center	• NCAL joint leadership is working with each service area to implement a CGA reduction goal at the medical center level – TBD. • I Identify trend in departments to improve member outcomes • Partner with departments across the MCA to develop strategies and share best practices to improve / reduce CGAs • Lead Member Concerns Committee (MCC) efforts for market complaint improvement by sharing and providing visibility to data; help facilitate discussion, creation and execution of action plans to eliminate member pain points, and reduce complaint, grievance and appeals volume	Key stakeholders at medical offices / hospitals) NCAL Local Member Services Member Relations Grievance Operations Data & Reporting Due date - 12/31/24	
Achieve timeliness results for processing member grievances at the required compliance targets. • 95% of grievance cases are acknowledged within 5 calendar days • 95% of grievance cases are resolved within the required compliance targets for each line of business	Continue ongoing monitoring and take actions as indicated to improve performance as needed. • Meet regulatory timeframes for grievance case processing • Medical center goals to reduce CGAs will positively impact achievement of timeliness goals	Member Relations Grievance Operations Monthly average Due date – 12/31/24	

Member Service Contact Center

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Monitor and track call quality metrics to objectives based on the MSCC's Quality Assurance Call Standards & Expectations. - Threshold: 90% - Target: 92%	- The MSCC's Quality Assurance department monitors phone calls utilizing the Quality Assurance Call Standards & Expectations. - The Quality Assurance analyst reviews the interaction and assesses the customer service representative's service provided, accuracy of information provided, ability to follow all policies and procedures, and the interaction's documentation in our tracking system. - The Call Quality Assurance program includes data collection, reporting, analysis, and identification of opportunities to improve overall performance through process improvements, staff training, coaching, and mentoring.	Member Service Contact Center Regulatory Operations 12/31/2024	

Member Service Contact Center

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Monitor and track email quality metrics to objectives based on the MSCC's Email QA Standards & Expectations. - Threshold: 90% - Target: 92%	- The MSCC's Quality Assurance department monitors member emails sent after logging into their kp.org account utilizing the Quality Assurance Email Standards & Expectations. - The Quality Assurance analyst reviews the interaction and assesses the customer service representative's response to the member, the accuracy of information provided, ability to follow all policies and procedures, and the interaction's documentation in our tracking system. - The Email Quality Assurance program includes data collection, reporting, analysis, and identification of opportunities to improve overall performance through process improvements, staff training, coaching, and mentoring.	Member Service Contact Center Regulatory Operations 12/31/2024	

Outside Utilization Services

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Goal: Improve customer service by ensuring calls are accepted by OURS when received. When a call is made to OURS and it clears the automatic switchboard, it is sent to one of several waiting staff. At this point, the call is accepted, and the caller can speak with the OURS staff. Methodology: number of calls answered divided by number of incoming calls as measured in the NICE business telephone analysis program. Base line in 2023 was 96% Data Source: NICE business telephone analysis program Measurement Period: 2/5/24 - 12/31/24 Target: Greater than 96 %	Monthly analysis of statistics to determine progress toward goal. Reminders to staff during staff meetings about the goal and progress towards it. ANM's to include individual call results during monthly one on one meetings.	OURS Quality and Management Teams Due: 12/31/2024	
Goal: Improve customer experience by ensuring they are contacted by OURS	Weekly analysis of statistics to determine progress toward goal.	OURS Quality and Management Teams Due: 12/31/2024	

Outside Utilization Services

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
when hospitalized in a non-plan hospital. When a member is hospitalized at a non-plan hospital, OURS will contact that member, or their family, or their designee, within 48 hours from when OURS starts managing the case (as when assigned to a case manager) is known as a first call. Methodology: Number of members first calls documented in RENO divided by total number of cases for a given period. Baseline in 2023 was 87% Measurement period 2/5/24 – 12/31/24 Target: greater than 90 %	Emails to staff and supervising ANMs each time a fallout is noted. Reminders to staff during staff meetings about the goal and progress towards it. ANM's to include individual call results during monthly one on one meetings.		

Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results, including metrics 2. Barriers 3. Next steps
CMS Medicare Part D: STARS Rating			
Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Reviews (CMR) CMS Medicare Star Rating measures the Comprehensive Medication Reviews (CMR) completion rate, with the goal of improving medication use by reducing adverse events and optimizing therapeutic outcomes. • 2024 measurement year (2026 Star year), Program Office projected 5-star cut point 93% CMR completion rate. • Based on 2024 MTM eligibility criteria, the eligible population will expand to 41-42k members. • 2023 forecasted 5-star cut point = 93%	• Incorporate technology to support automated outreach and scheduling, including patient in-reach • Support data analytics to demonstrate ROI and impact on patient outcomes • Review staffing model to ensure CMR completion for expanding population and high cut points • Integrate medication reconciliations completed by other programs • Refine non-responder outreach and target outreach within 60 days of enrollment • Engage with inter-regional MTM programs to improve CMR efficiency • Integrate predictive models to design patient panels	Clinical Operations 12/31/2024	
Medication Adherence for Diabetes (DM) CMS Medicare Star Rating measures on medication adherence to non-insulin diabetes agents to improve patient outcomes.	• Work with National Pharmacy Analytics on assessing various outreach methods vs AI/ML predictive modeling techniques • Continue work with Enterprise Automation Service (EASe) to	Pharmacy Operations 12/31/2024	

Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results, including metrics 2. Barriers 3. Next steps
2024 measurement year (2026 Star year), medication adherence Program Office projected 5-star cut point: - DM: 91% (triple-weighted) 2023 measurement year (2025 Star year) medication adherence Program Office projected 5-star cut point: - DM: 91% (triple-weighted)	implement Intelligent Automation (IA) robotic process to send secure messaging for medication adherence - Integrate targeted prescription clean-up in the Member Outreach management tool (MOM) (half dose, sig clarifications, dose consolidations, etc.) - Collaborate with Outpatient Clinical Medication Care Team to balance the seasonal volume of outreach telephone calls		
Medication Adherence for Hypertension (RAS Antagonists) CMS Medicare Star Rating measures on medication adherence to RAS agents to improve patient outcomes. 2024 measurement year (2026 Star year) medication adherence Program Office projected 5-star cut point: - RAS: 91% (triple-weighted) 2023 measurement year (2025 Star year) medication adherence Program Office projected 5-star cut point: - RAS: 91% (triple-weighted)	Same action plan as outlined above for diabetes medications.		

Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results, including metrics 2. Barriers 3. Next steps
Medication Adherence for Cholesterol (Statins) CMS Medicare Star Rating measures on medication adherence to statin agents to improve patient outcomes. 2024 measurement year (2026 Star year), medication adherence Program Office projected 5-star cut point: - Statin: 91% (triple-weighted) 2023 measurement year (2025 Star year) medication adherence Program Office projected 5-star cut point: - Statin: 91% (triple-weighted)	Same action plan as outlined above for diabetes medications.		
Statin Use in Persons with Diabetes (SUPD) 2024 measurement year (2026 Star year), Statin Use in Persons with Diabetes Program Office projected 5-star cut point: - SUPD: 93% (single-weighted) 2023 measurement year (2025 Star year) Statin Use in Persons with Diabetes Program Office projected 5-star cut point: - SUPD: 93% (single-weighted)	- Continue partnership and align with TPMG on ICD codes eligible for excluding patients for both Medicare and HEDIS - Monthly dashboard reporting and continued education. - Continue to generate an actionable patient list in Q3-Q4 for pharmacists to reach and assess statin eligibility and initiation/restart if appropriate. - Share/receive best practices from other regions		

Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results, including metrics 2. Barriers 3. Next steps
Member Experience			
JD Power Scores for Brick & Mortar Pharmacies - Improve overall satisfaction score to ≥ 900 - Surrogate marker for Medicare Advantage Consumer Assessment of Healthcare Providers & Systems (MCAHPS) rating of drug plan and getting needed prescription drugs.	- Continue to leverage technology and digital transformation to improve member experience - Signage: leverage National Signage program to provide clear guidance to members - Manager Excellence Training: standardized training curriculum for front-line managers - Scheduling: standardize to ensure consistent member experience	Outpatient Pharmacy Team Q4 2024	
Optimize Centralized Pharmacy New Member Program Increase Capture rate to 3% increase over 2023 baseline of 36.9% for a target of 39.9% Background: Improving new member capture rate will improve new member onboarding experience with KP. Will provide a “Wow” experience for the member by transitioning prescription needs before the 1st PCP appointment, creating more time for providers and members to discuss medical needs. This also supports member retention.	- Partner with TPMG and Management Strategy consultant improve new member referrals to pharmacy - Improve New Member referrals to pharmacy - TPMG collaboration - Outreach opportunities - Proactive staffing and training prior to new member winter surge. - Improve Rx Transfer workflows	Centralized Service Team NCAL Local New Member Onboarding Team TPMG Q4 2024	

Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results, including metrics 2. Barriers 3. Next steps
Medication Use			
High Risk Medications-Polypharmacy: <u>Polypharmacy CNS-active</u> Reduce use of multiple CNS-active medications in members ≥ 65 years of age Polypharmacy CNS-active Goal: Phase 1 (10/2023): 10% reduction from MC BL OR $\leq$ NCAL avg (8.4%) Phase 2 (10/2024): 15% reduction from MC BL OR $\leq$ NCAL avg (8%)	2023 AGS Beers Criteria updated to include smooth muscle relaxants (SMR) to the list of CNS-active medications to avoid in the elderly. As of 2024, no changes have been made to measurement specs for PQA or CMS yet to include SMRs. - Plan to add SMR medication class to polypharmacy CNS-active medication initiative. - Continue to work with TPMG and pharmacy leaders to identify ways to promote deprescribing and continue to reduce polypharmacy. - Continue clinical presentations during the Bimonthly McDRUM webinar to focus on deprescribing presented by the Regional NCAL Eldercare Champion. - Engage key prescribers groups - AFM, Female Pelvic Medicine and Reconstructive Surgery, Neurology, Obstetrics and Gynecology, Psychiatry, Urology, MTM pharmacists, AmCare clinical	Drug Use Management Team 12/31/2024	

Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results, including metrics 2. Barriers 3. Next steps
	pharmacists, TPMG quality team • Leverage KPHC support ○ Best practice alerts ○ SmartPhrases • Collaborate with Health Engagement Consulting Services (HECS) and develop materials for My Doctor Online, which will serve as an additional patient facing tool.		
High Risk Medications- Polypharmacy: Polypharmacy anticholinergic (ACH) • Reduce use of multiple anticholinergic medications in members ≥ 65 years of age Polypharmacy Anticholinergic Goal: Phase 1 (10/2023): 5% reduction from MC BL <u>OR</u> $\leq$ NCAL avg (4.5%)	• No changes to the 2023 AGS Beers Criteria list of anticholinergic medications to avoid, no changes to the DrUM metric. • Continue to work with TPMG and pharmacy leaders to identify ways to promote deprescribing and continue to reduce polypharmacy. • Continue clinical presentations during the Bimonthly McDRUM webinar to focus on deprescribing presented by the Regional NCAL Eldercare Champion. • Engage key prescribers groups ○ AFM, Female Pelvic Medicine and Reconstructive Surgery, Neurology, Obstetrics and Gynecology, Psychiatry, Urology, MTM	Drug Use Management Team 12/31/2024	

Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results, including metrics 2. Barriers 3. Next steps
	pharmacists, AmCare clinical pharmacists, TPMG quality team • Leverage KPHC support - o Best practice alerts - o SmartPhrases • Collaborate with Health Engagement Consulting Services (HECS) and develop materials for My Doctor Online, which will serve as an additional patient facing tool.		
Appropriate Antibiotic Utilization – Expansion • <i>POTENTIAL FUTURE METRIC FOR DRUM: Antibiotic Utilization for Respiratory Conditions</i>	• Scope out potential of HEDIS antibiotic metric to determine if there is opportunity for another antimicrobial stewardship DrUM initiative: Antibiotic Utilization for Respiratory Conditions (AXR): The percentage of episodes for members 3 months of age and older with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event.	Drug Use Management Team 12/31/2024	

Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results, including metrics 2. Barriers 3. Next steps
Appropriate Antibiotic Utilization – Avoid Antibiotics (HEDIS) Avoid use of antibiotics in Acute Bronchitis > 75%	- Continue to evaluate the performance of the existing antibiotic avoidance measures. - Continue partnership with TPMG Chair of Chiefs - Infectious Disease (ID) - Pediatrics - Adult and Family Medicine - Emergency Medicine - Pediatric Infectious Disease Regional Lead - Continue outlier physician education as needed.	Drug Use Management Team 12/31/2024	
Appropriate Antibiotic Utilization – Avoid Antibiotics (HEDIS) Avoid use of antibiotics in URI > 93%	Same planned actions as above	Drug Use Management Team 12/31/2024	
Controlled Substances Stewardship			
Opioid Red Flags Reduction Reduce the number of red flags in opioid prescribing and dispensing while maintaining or improving clinical quality.	- Outpatient pharmacists exercising their corresponding responsibility to screen all opioid and controlled substance prescriptions for safety concerns and red flags - Pharmacists escalating clinical interventions as appropriate for red flag prescriptions	OP Pharmacy Team, Controlled Substances Project Manager 12/31/2024	

Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results, including metrics 2. Barriers 3. Next steps
<u>Dual goal: decrease in overall red flags by 2% AND total Rx MME by 3% from baseline.</u> Baseline: December 2023 <u>** Note: Baseline subject to change with the addition of new red flags</u>	• Outpatient Pharmacy to complete annual training for corresponding responsibility • Evidence of documentation of corresponding responsibility through BPA • Continue collaboration with Pharmacy and TPMG workgroup, Medical Director of Pharmacy & Regional Opioid Lead • Alignment between regional and local review processes to reduce overall overdose events related to opioids. • Focus on different strategies for harm reduction by assessing the high-risk combination drugs with opioids and tapering effort where clinically appropriate. • Pilot sites for Hospital Opioid Honor Roll		
Initial Opioid Prescribing- Long Duration (PQA) IOP-Long Duration Avoid prescribing ≥1 initial opioid prescription(s) for >7 cumulative days' supply during the measurement year Goal (<u>lower is better</u>)	• Modify goal setting to further reduce initial opioid duration. • Leverage support with the Regional Opioid Safety team and TPMG Chiefs groups to promote opioid goal setting change. • DrUM to continue to support Regional Opioid Safety team as they lead specialty specific KPHC	Drug Use Management 12/31/2024	

Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results, including metrics 2. Barriers 3. Next steps		
Phase 1: 5% reduction from NCAL baseline (BL) or 5% reduction from medical center (MC) BL Phase 2: 10% reduction from NCAL BL or 10% reduction from MC BL Phase 3: 15% reduction from NCAL BL or 15% reduction from MC BL	order sets and preference list changes to reduce opioid MME and dispense quantity.				
Initial Opioid Prescribing- High Dose (PQA) <table><tr><td>IOP-Opioid High Dose</td><td>Avoid prescribing ≥1 initial opioid prescription(s) with an average daily morphine milligram equivalent (MME) of ≥ 50 during the measurement year</td></tr></table> Goal (lower is better) Phase 1: 5% reduction from NCAL baseline (BL) or 5% reduction from medical center (MC) BL Phase 2: 10% reduction from NCAL BL or 10% reduction from MC BL Phase 3: 15% reduction from NCAL BL or 15% reduction from MC BL	IOP-Opioid High Dose	Avoid prescribing ≥1 initial opioid prescription(s) with an average daily morphine milligram equivalent (MME) of ≥ 50 during the measurement year	- PQA IOP-HD has been retired, however, CMS is interested in adding the IOP-LD measure in the future to the Medicare Star Ratings based on the 2025 Advance Notice. Awaiting additional guidance from Program Office. For now, continue to keep initiative active. - Consider if there is opportunity to modify goal setting to further reduce high opioid MME. - Leverage support with the Regional Opioid Safety team and TPMG Chiefs groups to promote opioid goal setting change. - DrUM to continue to support Regional Opioid Safety team as they lead specialty specific KPHC order sets and preference list changes to reduce opioid MME and dispense quantity.		
IOP-Opioid High Dose	Avoid prescribing ≥1 initial opioid prescription(s) with an average daily morphine milligram equivalent (MME) of ≥ 50 during the measurement year				

Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results, including metrics 2. Barriers 3. Next steps		
Concurrent Opioid/BZD/Z Drugs <table><tr><td>COB/Z Drugs</td><td>Avoid concurrent use of opioids and benzodiazepines/Z drugs (eszopiclone, zaleplon, zolpidem)</td></tr></table> Goal (lower is better) Phase 1: 5% reduction from NCAL baseline (BL) or 5% reduction from medical center (MC) BL Phase 2: 10% reduction from NCAL BL or 10% reduction from MC BL Phase 3: 15% reduction from NCAL BL or 15% reduction from MC BL	COB/Z Drugs	Avoid concurrent use of opioids and benzodiazepines/Z drugs (eszopiclone, zaleplon, zolpidem)	- Determine if additional opportunity remains to adjust the goal setting to further reduce concurrent use of opioid/bzd/z drugs. - Leverage support with the Regional Opioid Safety team and TPMG Chiefs groups to promote goal setting change. - DrUM to continue to support Regional Opioid Safety team as they lead specialty specific KPHC order sets and preference list changes to reduce opioid MME and dispense quantity.	Drug Use Management 12/31/2024	
COB/Z Drugs	Avoid concurrent use of opioids and benzodiazepines/Z drugs (eszopiclone, zaleplon, zolpidem)				
Deprescribing Benzodiazepine (BZD) in Older Adults (HEDIS) - Phase 1 (July 2023): ≥ 27% of patients dispensed benzodiazepines that achieved a 20% decrease or greater in benzodiazepine dose (DME) - Phase 2: TBD 2024 **Goal- Higher is better: % of members >= 65 years of age who were dispensed BZD and achieve a >= 20% decrease in BZD dose during the measurement year	DrUM will develop goal setting for phase 2 in 2024 and continue to work with TPMG and Pharmacy leaders for this work. Continue to disseminate initiative performance tracking through the monthly DRUM scorecard and Initiatives Report, which provides physician and pharmacy leadership tools to evaluate the medical center performance and identify areas of opportunity that exist for improving a medical center's performance.	Drug Use Management 12/31/2024			

Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results, including metrics 2. Barriers 3. Next steps

	Continue physician education and shared decision-making strategies for deprescribing.		

Medication Safety

Naloxone Order Rate Purpose: To mitigate the risk of harm due to opioid related respiratory depression and comply with AB 2760 by increasing naloxone orders for patients receiving high risk opioid therapy. Background: - Naloxone is an effective reversal agent for potentially fatal respiratory depression associated with an opioid overdose. - Assembly Bill 2760 was signed into law, effective January 1, 2019. This law requires that “high-risk patients” are offered a naloxone prescription and provided education on overdose prevention and the use of naloxone. Measure: Naloxone Order Rate = % of individuals at risk for overdose* with an active naloxone ordered within past 24 months	- National “Zero Overdose” workgroup developed Naloxone training: - Physician Education – to be released in the Clinical Library for all Permanente Education Portals. (Jan-2024) - Pharmacist Education – to be released in KP Learn with associated CE credit (Feb/Mar-2024) - The interregional Controlled Substances Stewardship Committee (CSSC) is currently assessing the impact of non-prescription naloxone on dispense rate measures and recommendations. - NCAL to conduct a crosswalk of the CSSC recommended standardized universal naloxone BPAs to assess for redundancies or potential retirement of existing naloxone BPAs. - Develop and distribute the Opioid Harm Reduction Dashboard (including Naloxone Order and Dispense Rate) with a drilldown to the medical center level to allow local medical centers to	PQMS TPMG Regional Opioid Safety Team Outpatient Pharmacy Operations 12/31/2024	

Pharmacy Operations

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results, including metrics 2. Barriers 3. Next steps
Goal: To increase the Naloxone Order rate by 10% from the baseline by December-2024. - December-2024 Goal = 56.08% (58.63% if increase by 15%) (61.18% if increase by 20%) Comments: - Baseline (Dec-2023) = 50.98% (4026 out of 7897 at-risk members have a naloxone order) *At-Risk Population includes > 50 morphine milligram equivalents (MME) per day, new or current diagnosis of OUD with opioid, history of opioid overdose, concurrent use of benzodiazepine/Z-drug)	track performance and identify successful practices. Collaboration between TPMG and Pharmacy to increase Naloxone awareness, access, and patient education to improve ordering and dispensing rate of Naloxone for high-risk patients (e.g., MME $\geq$ 50).		

Special Needs Plan Program

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Improve Special Needs Plan (SNP) member access to essential services and affordable care: Ensure 90% of members had a health risk assessment completed	Monitoring: monthly and rolled up annually via the Regional Process Report measuring percent of members who had a health risk assessment completed - Enhance operational tools - Identify enhancements to performance reporting - Identify and share best practices from high-performing teams and provide additional support to lower-performing teams	Regional SNP Leadership and Local SNP Teams 12/31/2024	
Improve coordination of care and appropriate delivery of services through the direct alignment of the HRAT (Health Risk Assessment Tool), ICP (Individualized Care Plan), and ICT (Interdisciplinary Care Team): Members answer “yes” to the phone survey question, “Do you think this Care Management program is helpful for you in achieving your goals?” The target is 95%.	Monitoring: Monthly and rolled up annually via the IVR phone survey that Care Managers are successfully providing care coordination for our members by making sure that our members feel that the SNP Care Management program is helping them coordinate their needs to help them achieve their goals.	Regional SNP Leadership and Local SNP Teams 12/31/2024	
Provide seamless transitions for SNP members across healthcare settings, care providers, and health services:	Monitoring: Monthly and rolled up annually on the performance dashboard will continue to:	Regional SNP Leadership and Local SNP Teams 12/31/2024	

Special Needs Plan Program

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Percent of patients who transition from the Hospital, SNF, or Home Health to home with self-care who receive a transitions assessment. The target is 80%.	- Emphasize Model of Care requirements - Support medical center use of operational and performance reporting, identify best practices in managing patients who are moving between healthcare settings.		
Ensure appropriate utilization of services for preventive health and chronic conditions: HEDIS Comprehensive Diabetes Control HbA1c < 8 metric. The target is the HEDIS Commercial 90 th percentile;	Monitoring: Yearly via HEDIS rates Work with care managers to utilize tools and resources that support the linking of members to appropriate preventative services.	Regional SNP Leadership and Local SNP Teams 12/31/2024	
Ensure appropriate utilization of services for preventive health and chronic conditions: Percent of adults with a designated decision maker and/or Advanced Health Care Directive (AHCD) on file in medical record. The target is 85%.	Monitoring: Monthly Work with care managers to support them in having initial life care planning conversations with members and giving them the tools to have a designated decision maker and/or a AHCD on file in KPHC.	Regional SNP Leadership and Local SNP Teams 12/31/2024	

Utilization Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Ensure the appropriate, effective, and efficient utilization of resources/services to kp members across the continuum in compliance with requirements of state/federal and accrediting entities.	Evaluation of KFHP UM Processes to ensure appropriateness and relevancy: • Evaluate and update UM program (UM1 B) • Annual update to UM policies • Annual update to UM criteria (UM 2 A5) • Quarterly appeals report related to UM initial denials • Review and revision of KFHP UM Program Description (UM 1B) • Timeliness of UM Decisions (UM 5D) • Review of Pharmaceutical Management policy (UM11) • Distribution of required KFHP UM communication to providers, practitioners, members as required (UM 3A, ME 2A) • Inter-rater Reliability Testing (IRR) (UM 2C1) • UM denial system controls oversight (UM 12A) • Oversight of all delegated UM functions for the following services: (UM 13C) ➤ American Specialty Health (ASH) ➤ Delta Dental ➤ Cigna	HPUM Year End 2024	
CMS 2024 Final Rule DME denial inserts with updated criteria Objective: To revise and implement Medicare medical necessity denial inserts in accordance with traditional Medicare Utilization Management (UM) criteria, ensuring alignment with 2024 CMS Final Rule.	Review and Understand Priorities/ 3 Phases (Immediate): • Identify and understand the specific DME items prioritized in Lists 1 and 2. • There will be a 3rd and final list that will encompass all remaining DME MN inserts. Review existing medical necessity denial inserts for these items and update as needed. Revision of Denial Inserts (Ongoing to End of mid-March 2024):	CDSU/RUC/SCAL DME/DME Hub Tapestry Team	

Utilization Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
Metrics: Revision and Compliance: Complete Priority Lists 1 and 2 by 2/15/2024, followed by continued revisions for remaining DME items by 3/15/2024. Integration Success: All DME MN denial inserts successfully integrated into the Tapestry system by 3/29/2024. Staff Understanding and Compliance: All staff will understand the correct use of the updated inserts by 3rd quarter of 2024.	- Revise the medical necessity denial inserts to align with traditional Medicare UM criteria. - Confirm with Tapestry when they will need inserts for Phase 2 and Phase 3 to meet the go-live due dates (time for build, validation in WITS, and push to production). - Consult with legal and compliance teams for accuracy and adherence. Collaboration with Relevant Workgroups (Regular Meetings): - Regularly meet with the 2024 Medicare Final Rule workgroup and the CMS DME Formulary Denial Inserts/Letters Workgroup to stay aligned and on track. - Share updates, insights, and feedback during these meetings. Integration with Tapestry System (Post-Revision): - Coordinate with the Tapestry (Epic) team to integrate revised denial inserts. - Test and confirm successful implementation in the system. Training and Socialization (Post-Integration): - Conduct training sessions for DME hub, CDSU, and HPUM staff on revised denial inserts. - Socialize the changes to ensure understanding and compliance. - Provide resources and documentation for reference. - Collect feedback to identify areas for improvement. Monitor Letters for correct use of updated inserts - Review 7 random letters weekly beginning 3Q 2024 for accuracy and report quarterly results to RMC. - Document all revisions, meetings, and feedback for audits and future reference.	TPMG DME Champions Phase 1 inserts live in Tapestry in January 2024. Phase 2 inserts live in Tapestry by 2/29/2024. Phase 3 inserts live in Tapestry by 3/29/2024.	

Utilization Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
DME Timeliness Monitoring Objective: Improve the timeliness of the late denial process to achieve a performance metric of greater or equal to 95% timely by the end of the 4th Quarter of 2024. Metric: Performance will be measured using the "DME Dashboard Timeliness Report". We will reduce late referrals to <=5%, eliminate the Too Late To Deny (TLTD) process, and ensure >= 95% timely processing by DME RNs, DME Champions, and CDSU staff of all DME referrals by end of 4Q 2024.	Baseline Data Analysis and Monitoring Process: - Establish baseline timeliness as of 1/1/2024. - Each team (DME Hub and CDSU) to conduct weekly timeliness monitoring using the DME Dashboard Timeliness Report. - DME and CDSU managers to review decision and notification timeliness respectively. - Bi-weekly group discussions to review findings. Audit and RCA Review (Monthly): - Assign nurses for RCA in each service area. - Systematic review of service areas for timeliness. - Combine DME/CDSU teams for a joint audit group focusing on the causes of lateness. Training and Methodology (Post-Staff Assignment): - Conduct training for RCA (focusing on returns and causes). - Develop a systematic investigation template, utilizing the "5 Whys" methodology (keep asking why it was late, then back up with why did THAT happened, and why did THIS happen, until you reach the root cause for the untimely referral/return to DME). Mitigation and Improvement Plan (If Timeliness < 95%): - Develop a contingency plan based on RCA outcomes. - Implement documented coaching, counseling, and refresher training to address issues of untimeliness. Reporting and Accountability - Incorporate quarterly reporting to the RMC with detailed analysis.	CDSU DME Hub Achieve performance by 1/31/2024, and issue final report by 1/31/2025	

Utilization Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
	- Annual detailed report including timeliness numbers, RCA results, and corrective action plans by 1/31/2025 Feedback Loop and Adjustment (Ongoing): - Regularly review the effectiveness of the action plan and adjust as needed. - Ensure continuous communication with all stakeholders for transparency and accountability. This action plan focuses on systematic investigation, continuous monitoring, training, and a robust reporting mechanism to achieve and maintain the goal of 95% or greater timeliness in the late denial process.		
DME Benefit Denial Inserts and Revision Objective: To ensure that the DME benefit denial inserts are consistently in compliance with the requirements of regulatory agencies (DHCS, DMHC, NCQA), meeting all relevant utilization management criteria, evidence of coverage guidelines, and readability standards. Metrics: Revision Timeline: Each line of business Benefit Denial Inserts will be revised on the following timeline:	Regulatory Requirements Assessment (Ongoing): - Regularly review and assess regulatory requirements related to DME benefit denial inserts. - Keep track of changes in utilization management criteria, evidence of coverage, and other UM guidelines. DME Denial Inserts Evaluation and Revision (Quarterly): - Establish a schedule for the periodic evaluation of current DME benefit denial inserts. - Revise denial inserts to align with the latest regulatory requirements and readability standards. - Involve legal and compliance teams for accuracy and adherence. Collaboration with Southern California Team (Monthly Meetings): - Schedule regular meetings with the Southern California team for alignment and consistency across regions. - Share updates, insights, and feedback during these meetings. Integration with Tapestry (Epic) System (As Needed):	CDSU/R UC/SCAL DME/DM E Hub Tapestry Team Inserts updated by end of 2Q 2024 and live in Tapestry by 3Q 2024.	

Utilization Management

Goal (including Metric)	Planned Actions to Meet Goal	Accountable Team and Due Date	2024 Evaluation (to be completed in 2025) 1. Analysis of results including metrics 2. Barriers 3. Next steps
- MediCal – End of January 2024 - MediCare – End of 1st Quarter 2024 - Commercial/Federal /Self-funded – End of Second Quarter 2024 2. Readability Score: Achieve specific readability grade for DME benefit denial inserts per line of business requirement by end of 2Q 2024. 3. Staff Compliance: All staff to achieve 98% compliance with using the updated denial inserts by end of 4Q 2024.	• Coordinate with the Tapestry (Epic) team for the integration of new or revised DME benefit denial inserts. • Ensure that updates are loaded into the system for automated use. Training and Socialization (Post-Update): • Conduct training sessions for DME hub, CDSU, and HPUM staff on new or revised denial inserts. • Socialize the changes to ensure understanding and compliance. • Provide resources and documentation for reference. Monitoring and Feedback: • Implement a monitoring system to track the usage and effectiveness of the updated DME benefit denial inserts and report quarterly results to RMC. Continuous Improvement (Ongoing): • Regularly revisit and refine the process based on regulatory changes, staff feedback. • Stay agile to adapt to changing regulatory landscapes and internal feedback loops.		