2017 Quality Program Description

Kaiser Foundation Health Plan
Southern California Region
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Approved May 26, 2017 by Southern California Quality Committee (SCQC)
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*Final Charter pending*
1. MISSION AND VISION

Mission
Kaiser Foundation Health Plan’s mission is to provide high-quality, accessible and affordable health care services to improve the health status of the members and the communities we serve.

Vision
To be a leader in total health by making lives better.

Through internal performance:

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

Through external presence:

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

2. KAISER FOUNDATION HEALTH PLAN SOUTHERN CALIFORNIA

Overview of Organization Structure
KAISER PERMANENTE

An Integrated Healthcare System
Kaiser Foundation Health Plan, Inc. (KFHP) is a not-for-profit public benefit California Corporation that contracts with individuals and groups to provide, or arrange for, comprehensive health care benefits. KFHP is a health maintenance organization and a California-licensed Knox-Keene health care service plan serving approximately 4.2 million members.

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

**KFHP has an exclusive contract with Kaiser Foundation Hospitals (KFH),** a not-for-profit public benefit corporation that owns and operates hospitals that provide or arrange hospital services for KFHP members. Each KFH hospital and its professional staff, maintain a quality assurance program subject to extensive licensing and regulation by the California Department of Public Health (CDPH) under California Health & Safety Code Section 1250 et seq. and by the Centers for Medicare & Medicaid Services (CMS) under Title 42 of the Code of Federal Regulations, Section 482.21.

KFH hospitals are subject to compliance with The Joint Commission. The standards are designed to guide hospitals in the creation and monitoring of processes of patient care that are both safe and of high-quality.

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

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

**KFHP is responsible for the oversight and monitoring of quality improvement activities.** KFH and SCPMG collaborate with KFHP to ensure the provision and coordinate appropriate safe and effective care and medical management to the communities in which they serve KFHP members in accordance with professionally recognized standards. Together, these three entities operate the Kaiser Permanente Medical Care Program in Southern California.

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

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

**KFHP Southern California serves twelve Medical Centers.** Each Medical Center contains one or more KFH hospitals in the following counties:

- Orange County (Anaheim/Irvine)
- Los Angeles County (Antelope Valley/Panorama City, Baldwin Park, Downey, Los Angeles, South Bay, West Los Angeles, Woodland Hills)
- San Bernardino County (Fontana/Ontario)
- Kern County (Plan Hospital: San Joaquin Medical Center)
- Riverside County (Riverside/Moreno Valley)
- San Diego County (San Diego)

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

The Medical Director of Medicare Advantage and Part D Pharmacy Plans is responsible for ensuring the clinical accuracy of coverage determinations involving "medical necessity", for Medicare members. The Permanente Medical Group medical directors active in these areas are accountable to the Medical Director of Medicare Advantage and Part D pharmacy plans for:

- Ensuring clinical accuracy of coverage determinations involving "medical necessity", for Medicare members
- Providing oversight for Health Plan operations involving medical/utilization review for Medicare members
- Providing oversight for Health Plan's benefit, formulary and claims management activities affecting Medicare members
- Providing oversight for Health Plan's quality assurance activities affecting Medicare members

Membership and Membership Diversity
KFHP's Southern California Region serves members under several commercial and government product lines. As of January 2016, KFHP Southern California covers the following lives under the following product lines (including Marketplace products):

- 3,286,884 lives in the Commercial (including Marketplace) products
- 524,492 lives in the Medicare products
- 295,476 lives in the Medicaid product
- 32,378 lives in other products

KFHP Southern California also serves a diverse cultural and linguistic membership. Of the members*:
- 36.37 % identify as Caucasian/White
- 35.10 % identify as Hispanic/Latino
- 11.33 % identify as Asian or Pacific Islander/Native Hawaiian
- 9.00 % identify as African American/Black
- 7.85 % identify as Multiracial
- 0.35 % identify as Native American/Alaska Native

*Data Source is KP HealthConnect. (As of Quarter 1, 2017)
**Diversity and Nondiscrimination**

Commitment to Inclusion and Diversity

Kaiser Permanente is committed to diversity and inclusion as a key business strategy essential to maintain high-quality and affordable healthcare, best-in-class service, and our status as the best place to work and leverages its rich diversity of people and enduring commitment to inclusion in order to remain a leader in providing high quality care that is affordable, improves total health, and is designed to ensure that all medically necessary covered services are available and accessible to all members 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 community it serves.

Nondiscrimination

KFHP does not unlawfully discriminate in the delivery of healthcare services based on race/ethnicity, color, national origin, ancestry, religion, sex (including gender, gender identity, or gender related appearance/behavior whether or not stereotypically associated with the person’s assigned sex at birth), language (including members with limited English proficiency), marital status, veteran’s status, sexual orientation, age, genetic information, medical history, medical conditions, claims experience, evidence of insurability (including conditions arising out of acts of domestic violence), or source of payment to ensure that all covered services are provided in a culturally and linguistically appropriate manner. To ensure that all medically necessary covered services are available and accessible to all members and that they are delivered in a culturally competent and linguistically appropriate manner, KFHP provides cultural competency, sensitivity, and diversity training to staff, providers and sub-contractors.

**Quality Program Description**

The Quality Program is approved annually by SCQC and Quality & Healthcare Improvement Committee (QHIC), a subcommittee of the KFHP Board of Directors.

This includes a review of the Quality Program Description, the prior year's Quality Workplan, and the current year’s Quality Workplan to ensure ongoing performance improvement. The SCAL Trilogy Documents are also forwarded to the Medical Centers for implementation at the local level.

The Quality Program includes three levels of authority, accountability, and responsibility related to quality of care and services provided to members. These include the KFHP Governing Body, the SCQC, and the local Medical Center's quality structure. The Quality Management Program promotes positive patient outcomes and controls negative events by continually assessing and improving governance, managerial, clinical and support mechanisms that directly and indirectly impact outcomes.
3. QUALITY STRUCTURE AND SCOPE, AUTHORITY, ACCOUNTABILITY, AND RESPONSIBILITY

Governing Body

The Kaiser Foundation Health Plan (KFHP) Board of Directors

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

The Kaiser Foundation Health Plan, Inc. (KFHP) Board of Directors is comprised of 12 external Directors and two internal Directors, one of whom is the Chief Executive Officer (CEO) of Health Plan and serves as Chairman; and one is a senior officer of Health Plan designated by the CEO.

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

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

Quality and Health Improvement Committee (QHIC)

(Attachment D)

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

QHIC meets bimonthly and reports its decisions, actions, and recommendations to the KFHP Board of Directors. Annually, QHIC reviews and approve Regional quality program descriptions, work plans, and evaluations.

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

QHIC reviews and oversees:

- 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 services quality data)
• Integrity of systems related to the selection, credentialing, and competency of physicians and others practitioners
• Practitioner selection, credentialing, and competency
• Accreditation and Licensing results
• Quality goals, objectives, and measures
• Allegations of deficiencies in quality
• Internal standards and external surveys/audits and reports for Quality Improvement, Utilization Management, and Risk Management
• Health Improvement Metrics

**Southern California Repositories of Performance Data**

**Big Q Dashboard**

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

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

These domains are used to better understand and improve the overall performance of KFHP's care delivery system in the Southern California Region. The Dashboard provides a coherent, top-level view of clinical performance for senior leadership and governance, as well as an integrated, cascading measurement system for quality improvement and benchmarking throughout the organization. The Big Q dashboard information is available at the program office, Department of Care and Service Quality website: [http://kpnet.kp.org/qrrm/healthcare-analytics/big_q/bigq/index.htm](http://kpnet.kp.org/qrrm/healthcare-analytics/big_q/bigq/index.htm)
Big Q Performance Metrics Program

The Big Q Performance Metrics Program is used to report a comprehensive and integrated view of Kaiser Permanente Quality & Service performance to the QHIC. The Big Q is a repository of quality performance data over time and is used to better understand, track, and improve the performance of the entire healthcare system in six related domains of quality.

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

These domains are also used to improve the overall performance of KFHP's care delivery system in the Southern California Region by providing a coherent, top-level view of clinical performance for senior leadership and governance, as well as an integrated, cascading measurement system for quality improvement and benchmarking throughout the organization. The Big Q information is available at the program office, Department of Care and Service Quality website: http://kpnet.kp.org/qrrm/healthcare-analytics/big_q/bigq/index.htm

Clinical Analysis Department

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

The Southern California HEDIS and CSG performance metrics are also available on the Clinical Strategic Goals (CSG) website which contains 2016 Clinical Quality Key Measures and progress reports on CSG measures and Z-Scores. http://insidekp.kp.org:81/california/scpmg/csg/index.html

Management Information Systems

The Department of Management Information and Analysis (MIA), provides membership, utilization, and financial information to all levels of SCPMG, KFHP and KFH management. Major areas of MIA focus include:

- Operational reporting
- Performance reporting
- Regulatory compliance reporting
- Development of organizational information strategy
- Analytic support to processes such as:
  - Systems implementation
  - Development and maintenance of organizational analytic databases
Further information on MIA is available on the SAS information portal at

http:\NDC-APPS-CLUSTER-L.kp.org\KP\MIA\mialibra.nsf

Quality and Risk Management Department

Quality and Risk Management maintains databases reflecting professional quality review activities, quality profiles, claims experience and they provide analytical support for quality measurement, evaluation, and improvement.

**KFHP Southern California Southern California Quality Committee**
(Attachment E)

The primary KFHP and Regional Hospital oversight group, established by the President and Executive Medical Director, is the Southern California Quality Oversight Committee (SCQC).

**Purpose of SCQC**

- Evaluate the safety and quality of care and services provided to Kaiser Permanente members and patients in Southern California in all settings
- Support continuous improvement and recommend policy decisions in these areas
- Establish Quality Program direction by identifying and addressing strategic opportunities to establish and maintain the Southern California Region’s 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.

**Southern California Quality Committee (SCQC)**

SCQC Leadership

The SCQC is co-chaired by the Health Plan Vice President for Quality and Regulatory Services and the SCPMG Assistant Medical Director for Quality and Risk Management. These individuals are appointed by the President and Executive Medical Director as the key senior leaders administratively responsible for the leadership and direction of the quality program. The co-chairs of the SCQC, one practicing practitioner, have substantial involvement in the QI Program and are accountable to the KFHP President and the SCPMG Executive Medical Director who in turn hold them accountable to oversee the quality oversight processes and initiatives.
All KPHP Committees and Subcommittees have practicing practitioners, all have substantial involvement in the planning, design, implementation and review of the QI Program.

Reporting Structure

SCQC reports its activities and functions to the KFHP Boards of Directors.

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

Sub-Committees and functional reports are submitted on a quarterly and ad-hoc basis.
Additionally, the Kaiser Foundation Hospitals submit to the SCQC and to QHIC:

- Performance on standard program-wide quality/patient safety/utilization indicators.
- Summaries of significant events reports and follow-up actions.
- Summaries of accreditation, credentialing and licensing agencies' reports and findings.
- Summaries of other key quality/operational indicators including access metrics, member satisfaction, continuing care indicators.
- Annual quality program descriptions, quality work plans, and program evaluations.

The Quality Evaluation and Support Team (QuEST):

QuEST provides support to SCQC by serving as an expert body to provide consultation and recommendations to SCQC. QuEST reviews and makes recommendations, follow-up communications and activities prior to presentation to SCQC.

SCQC Membership: (Attachment E)

Confidentiality

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

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

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

SCQC Subcommittees (Overview)

Accountabilities

The SCQC assigns certain responsibilities to subcommittees that are required to report to SCQC at least quarterly, or more often as necessary. The Charters for each subcommittee are updated annually and include group composition, responsibilities, and activities. SCQC membership and subcommittee membership is reviewed annually. All KPHP Subcommittee have practicing practitioner participation
The subcommittees of the SCQC are:

- Access Committee
- Bariatric Surgical Steering Committee
- Clinical Information Systems Quality and Patient Safety Oversight
- Continuing Care Committee
- Hospital Clinical Improvement Team (HCIT)
- Medication Safety Oversight Committee (MSOC)
- Member Concerns Committee (MCC)
- Women and Children’s Health Leadership Team
- Procedure Outcomes Strategy Team (POST)
- Regional Bioethics Committee
- Regional Credentialing Committee (RCC)
- Regional Diversity Committee
- Regional Member Advisory Committee
- Regional Peer Review Oversight Committee (RPROC)
- Regional Pharmacy Nursing Committee
- Regional Radiation Safety Committee (RRSC)
- Regional Transplant Quality Committee (RTQC)/Renal Program
- National Transplant Services
- Utilization Management: Southern California Executive Resource Stewardship Committee (SCERC) and Utilization Management Steering Committee

**Access Committee**  
(Attachment F: Access Charter)

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

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

- Understanding and executing the access requirements by regulatory and accrediting organizations.
- Reviewing access performance data for all areas to identify and understand trends, distributions and outliers in wait times at the regional, medical center and department levels.
- Reviewing access complaints, trends and patterns and recommend areas of focus based on those data.
- Requesting and overseeing implementation of corrective action plans to address gaps in access.
- Escalating concerns and report resolution of CAPs to the SCQC.
- Providing oversight for submission of area-specific and regional Rate of Compliance (ROC) data for annual Timely Access Report submitted to DMHC
Bariatric Surgical Steering Committee (BSSC)
(Attachment G: BSSC Charter)

The Kaiser Permanente Southern California Region (KPSC) provides a comprehensive bariatric surgical program for its membership. The Bariatric Surgery Steering Committee, a sub-committee of the Southern California Quality Committee (SCQC) provides coordination and oversight of bariatric surgery related services such as:

- Development of regional bariatric surgery services program description and workplan/goals.
- Assessment and evaluation of pre-surgical preparation program (Options)
- Analysis of quality data from all surgical centers, including contracted sites, with annual reporting to SCQC
- Monitoring of access to services
- Analysis of member complaints with routine reporting to the Member Concerns Committee
- Evaluation of new requests for expansion of network
- Evaluation of new technology and procedures
- Periodic review/revision of clinical practice and referral guidelines
- Development of educational programs for members and providers
- Development of enhancements to program, such as bariatric surgery registry and post-op management program.
- Monitoring of status of center of excellence accreditation status for surgical programs, including contracted sites.

Behavioral Health Program Quality Council (BHPQC)
(Attachment H: BHPQC Charter)

The Kaiser Permanente Southern California Region (KPSC) provides a comprehensive Behavioral Health Program for its membership. The Behavioral Health Program Quality Council is designed to ensure that Health Plan and Medical Group leaders have an established infrastructure for joint decision making process on the execution of quality and regulatory activities for our behavioral health members. The Council also is structured to provide a joint venue for Health Plan and Medical Group coordinated approach in responding to growing member/consumer expectations of behavioral health care.

Through the Behavioral Health Program Quality Council, the Health Plan and Medical Group Behavioral Health leaders will jointly:

- Identify, prioritize care delivery activities in relation to the external and internal needs and demands.
- To coordinate and ensure alignment between Health Plan and SCPMG.
- Oversight process of BH quality and regulatory activities.
- Review quality, patient safety and other performance improvement outcomes.
- Jointly address gaps in care and recommend actions to improve care delivery process.
- Provide oversight for the submission of evidence of compliance with regulatory and consumer driven activities.
Clinical Information Systems Quality and Patient Safety Oversight
(Attachment I: CISQPS Charter)

The electronic medical record offers unique opportunities for Kaiser Permanente to improve quality of care and patient safety to its members. The vision of the SCAL Clinical Information Systems Quality and Patient Safety Oversight Committee is to continually improve the care and safety of our patients, workflows for our clinical providers and ensure regulatory compliance via the use of clinical information systems.

- The SCAL KP Clinical Information Systems Quality and Patient Safety committee provides quality of care and patient safety oversight in the context of an electronic medical record and other Clinical Information Systems. The committee regularly meets and reports semi-annually to SCQC. The primary goals are to:
  - Identify, prioritize, track and trend quality and safety issues regarding clinical information systems that are being reported from Medical Centers, Regional Departments and SSD through resolution
  - Promote consistency, continuity, and accuracy of electronic medical information as it relates the quality and patient safety
  - Provide the forum to refine SCAL quality of care and patient safety needs from KP HealthConnect and create a communication path to the national level
  - Provide recommendations to any relevant groups and individuals related to the quality of care and patient safety aspects associated with Clinical Information Systems
  - Act as a liaison between local and regional stakeholder leaders and committees with recommendations for operations.

Continuing Care Quality Committee

The overall purpose of the Home Health Quality Management, Hospice and Long-term Care Facility Program is to:

- Improve home health services provided to the members
- Ensure members receive appropriate care as it relates to the continuum of care, and
- Link home health quality management efforts with related services and with the strategic
- Quality direction of Kaiser Permanente.

Home Health Agencies use the concepts of Quality Management (QM) in the development of a systematic Quality Management practice model. Organizational and clinical functions are designed, measured, assessed and improved on an ongoing basis to meet professional, regulatory and accreditation standards.
The scope of Quality Management includes the following areas:

- Standards development
- Continuing education
- Professional credentialing, assessment for competency and ongoing performance appraisal
- Patient and family perception surveys and complaint monitoring
- Regular periodic concurrent and retrospective monitoring
- Utilization management
- Risk management, including incident tracking, safety and infection control monitoring, monitoring and evaluation for medication-related errors and adverse drug events
- Active problem identification
- Compliance to applicable laws and regulations
- Monitoring of contracted services.

**Hospital Clinical Improvement Team (HCIT)**
(Attachment J: HCIT Charter)

The Hospital Clinical Improvement Team will drive clinical care improvement through improved diagnosis and treatment strategy selection for patients within KPSC hospitals and in the peri-hospitalization period. The team will consist of a group of practicing clinicians and administrators with proven hospital leadership ability. The team will serve both governance and development functions, which include managing the regional portfolio of hospital related goals, measures, process improvement ideas, and clinical decision support tools. The team focuses on patients in the hospital environment (including care delivered immediately prior to or after the hospital encounter), all clinical services pertaining to the delivery of patient care in the hospital environment, and oversight of inpatient KPHC predictive analytics and clinical decision support tools (including selection, functional evaluation, and persistent quality evaluation).

For more information, go to [https://wiki.kp.org/wiki/display/hcit/HCIT](https://wiki.kp.org/wiki/display/hcit/HCIT)

**Medication Safety Oversight Committee (MSOC)**
(Attachment K: MSOC Charter)

There is strong leadership commitment to eliminate medication errors that cause harm or potential harm to the patients, while simultaneously advancing a sustainable just reporting culture. MSOC is an integrated, multidisciplinary committee that works in collaboration with the ambulatory and in-patient medical centers to reduce medication errors that cause harm or potential harm to members. MSOC reports directly to the Southern California Quality Committee (SCQC).

The MSOC is responsible for:

- Identifying sources of medication error data.
- Identifying methodology measurement strategies that will produce actionable methods to medication management.
- Overseeing High Alert Medication (HAMP) program.
• Overseeing medical center compliance with JCAHO National Patient Safety Goals related to medication safety.
• Providing input to Health Connect related to medication safety and computerized physician-order entry (CPOE).
• Developing reporting strategy to review medication error data for trends and including but not limited to: Unusual Reports, Sentinel events, Medication malpractice data, Walk-around data, Pharmacy reports, Health Connect reports, Risk Management reports, Patient complaints, HCAHPS scores
• Developing strategies and action plans to address internally and externally identified issues
• Disseminating and spreading enhanced practices and key learning’s.
• Identifying educational opportunities related to the causes of medication errors and the implemented prevention strategies.
• Communicating medication safety strategies and structures to decrease work redundancy while ensuring that gaps in work are recognized and eliminated.
• Making recommendations to foster safe medication systems, processes and practices.

**Member Concerns Committee (MCC)**
(Attachment L: MCC Charter)

The Member Concerns Committee (MCC) is a subcommittee of the Southern California Quality Committee (SCQC). The MCSS meets six times a year and reports to the SCQC twice a year. Its function is to oversee compliance of member complaint, grievance and appeal initiatives/priorities identified by Southern California Region.

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

• Conducting analysis of data related to complaints, grievances, and appeals regarding patient care, access, service and quality referrals. Present summarized findings and recommendations to the SCQC for review, revision, and approval.
• Reviewing and analyzing member satisfaction data regarding patient care, access and service and integrate with complaint, grievance and appeal data.
• Monitoring and overseeing compliance with timely access standards
• Recommending solutions to recurring themes or trends identified resulting in case escalation.
• Identifying areas of potential risk and develop recommendation
• Requesting local analysis and corrective action plans from those facilities/regional departments that meet the established criteria for responding to complaint, grievance, and appeal trends, as formally defined by SCQC and evaluate the effectiveness of corrective actions.
• Providing relevant complaint-related data and findings to other committee and peer groups as appropriate.
• Following-up with facilities and/or relevant peer groups regarding identified issues and opportunities for improvement.
• Providing oversight of a standardized Southern California complaint reporting process.
• Reviewing and analyze monthly/quarterly member complaint, grievance and appeals reports
• Recommending consistent implementation of best practices throughout Southern California
• Monitoring and understanding relevant regulatory standards (DMHC, DHCS, CMS) and accreditation standards (TJC and NCQA) for member complaints, grievance, and appeals for compliance.

**Procedure Outcomes Strategy Team (POST)**  
(Attachment M: POST Charter)

The purpose of the POST is to provide strategic oversight to the development, review, approval and implementation of initiatives to collect and report clinical measures and outcomes of therapeutic procedures and therapeutic procedure-related technologies. Review results, refer findings to appropriate leadership and stakeholder groups, and make strategy recommendations as appropriate.

**Regional Bioethics Committee**  
(Attachment N: Regional Bioethics Committee Charter)

The Bioethics Program includes the individual SCAL Kaiser Permanente medical centers' Directors of Medical Bioethics; medical centers Committee on Bioethics; the Regional Committee on Bioethics; and the Co-Directors of the Bioethics Program. The Bioethics Program:

• Encourages pursuit of health for Kaiser Foundation Health Plan members and Southern California Permanente Medical Group patients in a manner that honors biomedical, personal, social, and spiritual values;
• Provides leadership to promote and sustain the incorporation of Bioethics principles, policies, education, advice, and case consultation into a vertically integrated environment of ethical care provides an advisory, multidisciplinary forum for the open-minded discussion of ethical concerns that arise in the context of legal, regulatory, patient, and professional demands on the practice of medicine and the delivery of health care.

**Regional Credentialing Committee (RCC)**  
(Attachment O: RCC Charter)

The RCC provides oversight of the credentialing processes to assure only fully credentialed and qualified practitioners and credentialed providers treat members. The RCC meets at least ten times a year and provides at least quarterly reports to SCQC. The RCC is responsible for:

• Approving affiliated, per diem, locum tenens, Behavioral Health practitioners and all Contracted Providers for the Southern California program.
• Ensuring credentialing/recredentialing of Contracted Providers.
• Monitoring of credentialed affiliated providers.
• Developing, recommending, and approving privileges.
• Reviewing and recommending delegated credentialing and revisions, as appropriate.
• At least annually, reviewing and recommending revisions of credentialing and privileging policies and procedures and monitors medical center implementation of policies and procedures.
• Communicating and reviewing medical center Credentials and Privileges Committee processes.
• Monitoring sanctioned activities.
• Establishing linkage between contracting/claims/payroll for purposes of ensuring practitioners and providers are credentialed to see the members.
• Developing educational programs, as appropriate within scope.
• Overseeing bylaws revision processes in conjunction with accreditation and licensing.
• Overseeing survey results and corrective action taken within scope.
• Oversees office visits are performed and/or followed up when complaints are received.

Southern California CRC/Diversity Council (SCDC)
(Attachment VII: Regional Diversity and Inclusion Program)

(Attachment P: Southern California CRC/Diversity Council (SCDC) Charter)

Kaiser Permanente recognizes the importance of diversity and cultural responsiveness in the quality and effectiveness of healthcare delivery. In its position as a leader in Southern California in delivery of responsive and culturally competent care, Kaiser Permanente seeks to appeal to the diverse workforce population, current & potential membership pool and the communities that we serve. The Southern California CRC/Diversity & Inclusion Council provides expertise and guidance to leadership on strategies that are culturally responsive to the needs of the population it serves as an employer, provider of quality care and community leader.

The Regional CRC/Diversity & Inclusion Council supports the infrastructure responsible for driving the region's strategic diversity initiatives. This infrastructure includes the Southern California CRC/Diversity & Inclusion Council, Local Diversity & Inclusion leads, and peer groups involved with language services, quality oversight, and member services. The Regional Diversity & Inclusion Department collaborates with Health Plan Regulatory Services, Accreditation, Regulation & Licensing (AR&L), Compliance, Quality, SCPMG Administration and KP HealthConnect to facilitate organizational compliance in the area of cultural and linguistic services. It also collaborates with the HR Department, which champions, recruitment, retention and development of a diverse workforce. The Regional Diversity & Inclusion Department and the CRC Department reports to SCQC annually.

The Regional Diversity and Inclusion Department monitors the overall language assistance program for KPSC and reports the following for the region and by Medical Center:

• 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
• Quality Performance Indicators

The Culturally Responsive Care Department monitors the overall programs related to the physicians' delivery of cultural and equitable care, regional health equity outcomes reporting, trending, and analysis.

For additional information, please see the Regional Diversity and Inclusion Program Description in Attachment VII.

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**Regional Member Advisory Committee (RMAC) / Regional Patient Advisory Committee (RPAC)**  
(Attachment Q: RMAC and RPAC Charters)

Local Member Advisory and Patient Advisory Councils have been implemented at nearly every KPSC medical center since the first one started in Downey in 2005. Since then, KPSC leaders recognized the value of a regional advisory council, which became a reality in the 2012. This committee provides a forum where patient members serve as advisors to improve quality of service and safety, improve systems of care, and educate health care professionals and staff on the patients' perception of their health care experience at KPSC facilities.

**Regional Peer Review Oversight Committee (RPROC)**  
(Attachment R: RPROC Charter)

The function of the RPROC is to enhance oversight of the physician performance review processes and to implement and oversee focused review of licensed independent practitioners on behalf of KFHP and SCPMG. The Committee's purpose is to improve patient care and safety through optimization of the peer and department quality review processes, while meeting all regulatory requirements. The RPROC collaborates with Regional Quality Improvement members and the Regional Credentials Committee (RCC) on an as needed basis, and serves both as a decision making body and in an advisory role to SCQC.

**Regional Pharmacy Nursing Committee**  
(Attachment S: Regional Pharmacy Nursing Committee)

The mission of this multidisciplinary leadership steering committee is to jointly establish strategy, develop policy, and make recommendations for improvements in medication use systems and processes. The desired outcomes of the committee are to:

- Reduce adverse drug events and medication errors
- Develop a collaborative strategy for the development, implementation, monitoring, maintenance and evaluation of medication safety initiatives and processes
- Coordinate efforts between the Interregional Pharmacy/Nursing Committee, KP NCAL Pharmacy/Nursing Committee, and Program wide Medication Safety Work Group to address joint technology and processes concerning Pharmacy and Patient Care Services. (e.g. HealthConnect, Bar coding, eRX, Pyxis, etc.)
- Coordinate KP Southern California efforts of all key stakeholders for the assessment, review, and recommendations for Health Connect medication related processes
- Ensure communication and education of work output related to pharmacy/ medication related processes to all key stakeholders.
**Regional Radiation Safety Committee (RRSC)**  
(Attachment T: Regional Radiation Safety Committee Charter)

Membership includes: Regional SCPMG executive physicians and managers, Regional Director of Medical Imaging Technology and Informatics, Regional Radiation Safety Officer, Chair of Physician Nuclear Medicine Committee and Regional Accreditation, Regulation, & Licensing (AR&L).

The functions of this committee include:

- Providing consistent quality oversight of radiation safety at KFHs and SCPMG medical offices and to escalate quality issues to SCQC as appropriate.
- Ensuring there is regional oversight of radiation safety and compliance with California, US Nuclear Regulatory Commission (NRC) and US Food and Drug Administration rules and regulations across the Southern Californian region.

**Regional Transplant Quality Committee (RTQC)/Renal Program**  
(Attachment U: RTQC Charter)

The KPSC Regional Transplant Quality Committee (RTQC) supports the KPHP Board of Directors Quality and Health Improvement Committee (QHIC) in fulfilling its responsibilities for quality oversight of KPSC transplant care and services. The RTQC facilitates communication and collaboration among the various transplant quality endeavors of the organization at the local, regional and national levels and partners with the Kaiser Permanente National Transplant Network (NTN) Quality Improvement Committee and the Regional Renal Quality Committee in quality improvement activities.

**Renal Program**

The overall goal of the Renal Quality Management Program is to monitor and evaluate the recommendations for quality and appropriateness of patient care, identify and pursue opportunities to improve care, and resolve identified problems in care and service. The Renal Quality Program description, workplan and annual evaluation are reviewed by SCQC. Care and service are provided to chronic kidney disease (CKD) and end-stage renal disease (ESRD) members throughout the region and through contracts with over 200 dialysis facilities. Renal transplants are performed in 5 contracted centers (UCLA, Loma Linda University Medical Center, UCSD, Scripps Green and Cedars Sinai Medical Center). Simultaneous pancreas/kidney transplants are performed at 2 contracted centers, (UCLA and Loma Linda University Medical Center). Peritoneal dialysis (PD) training, care and service are provided in nine Kaiser Permanente medical centers.

**National Transplant Services**

National Transplant Services

National Transplant Services (NTS) is organized to provide case management and quality management/improvement activities for the Kaiser Permanente Medical Care Program’s (Kaiser Permanente) members referred for transplant evaluation and/or services. The National Transplant Services Network Program (NTS), which includes the Southern California Hub, assesses and provides...
oversight of the quality of transplant care (excluding renal transplant) and services provided by centers of excellences (COEs) and is coordinated by NTS staff to the members. Sentinel events occurring with the transplant member are identified and reported locally and aggregated in a Regional report to SCQC. The Southern California Hub Transplant Services Program Description, workplan and Annual Evaluation are reviewed at least annually by SCQC.

The Advisory Council of the NTS establishes transplant Center of Excellence (COE) criteria for inclusion in the Kaiser Permanente national transplant network, monitors performance of the NTN COEs, establishes evidence-based patient selection criteria for transplant services, and identifies opportunities for process improvement for the members' pre-transplant and post-transplant clinical quality and care experience.

The NTSAC provides oversight of the quality management and improvement activities for transplant services and advises on the quality program strategy. The NTSAC is a subcommittee of the KPNQC and a quality committee and as such its membership is comprised of a majority of physicians. The NTSAC is accountable to and acts at the direction of the KPNQC with respect to quality oversight of transplant services. The NTSAC physician members have expertise in clinical areas of transplantation and special interest and knowledge in guiding the transplantation services provided to KP members and patients. The NTSAC physicians are complemented by the expertise of the NTS Quality Improvement Medical Director, Senior Manager for Quality, and NTS Executive Director and representative from Program Office Quality Excellence department. The NTSAC sponsors clinical management subcommittees for the following transplant types: thoracic (heart, heart-lung, lung), abdominal (liver, small bowel, SPK, PTA), kidney, blood and marrow. The clinical management subcommittees are comprised of regional PMG specialists with special knowledge or interest in their respective transplant type.

The NTS and the regions collaborate on quality screening activities. The regions take accountability for leading investigation of individual cases which occur within the regional care delivery system. NTS takes accountability for leading the investigations of individual cases which occur at the COE. The NTS reports on region specific quality program activities at least annually through either scheduled meetings with regional PMG and HP quality leaders or at a regions’ quality committee.

**Utilization Management**
(Attachment III: UM Program Description)

The scope of services subject to the KFHP UM Program includes, but is not limited to: outpatient, acute and post-acute care, specialty referrals, drug, pharmacy and imaging/diagnostic services, emergency services as well as specialized services including acupuncture, organ transplantation and transgender surgery.

The scope of the Behavioral Health UM program is included in KFHP UM Program structure. Behavioral Health Care Services, including Psychiatry and Addiction Medicine, is an integrated component of the KFHP UM Program. UM activities occur at multiple behavioral health service sites and levels of care, including intensive outpatient, partial hospitalization and inpatient settings.
Southern California Executive Resource Stewardship Committee (SCERSC)
(Attachment V: Southern California Executive Resource Stewardship Committee Charter)

The SCERSC is a subcommittee of SCQC. The purpose of this committee is to review operational practices and provide recommendations. Oversee the alignment of all committees reporting to SCERSC and monitor implementation and performance within the strategy and assist in the evaluation of performances. Support continuous efforts, monitor and identify performance and take appropriate actions to improve quality/affordability activities. Establish financial and risk controls, as well as a financial plan and principles necessary for management. Establish oversight by identifying and addressing strategic opportunities to establish and maintain the Southern California Region’s healthcare leadership. Ensure that priorities are aligned and integrated with other key organizational strategic priority areas of work. Prioritize and create accountability deadlines: Define and review strategy for SCERSC on an on-going basis, setting strategic priorities.

SCERSC also oversees the UM Program for Behavioral Health Care (BHC) Services, establishes UMS standards and policy, and develops utilization performance targets and goals annually for the Behavioral Health Care UM Program. The Committee receives updates on program activities from the Regional Director of Behavioral Health Care Services and the Regional Chief of Psychiatry and/or Addiction Medicine at least twice annually.

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

The Utilization Management Steering Committee is a sub-committee of SCQC that ensures the effective implementation of the UM program across the continuum of care in compliance with statutory requirements and accreditation standards. The members represent a cross section of KP Leadership to include Health Plan UM, Quality Management, Membership Services, Health Plan and Regulatory Services, SCPMG and Behavioral Health Care Services.

Utilization Management Steering Committee establishes processes to ensure the achievement of KFHP UM Program goals and Utilization Management Steering Committee discussions focus attention on specific compliance requirements associated with Medical and Behavioral Health Care Utilization Review including timely and clear UM decisions and notifications using UM criteria that is consistent with professional standards of care.

Women and Children’s Health Leadership Team

The Women and Children’s Health Leadership Team is chartered to ensure that the Southern California Permanente Medical Group (SCPMG) and Kaiser Foundation Health Plan/Hospital (KFHP/H) jointly provide sufficient capacity, resources and oversight to Medical Centers in order to provide high quality, cost effective, risk- appropriate perinatal care for the members.

The Committee is a subcommittee of SCQC and provides quality oversight and on-going performance monitoring of the sub-regional perinatal services and reports findings periodically to SCQC. The Committee provides operational recommendations to the operational sponsors (Medical Director – Operations, SVP KFH/P – Operations) on behalf of women and children stakeholders and meets quarterly.
**Other Key Programs and Functions (Reporting to SCQC)**

The SCQC fulfills its responsibility for evaluating the effectiveness of all other aspects of the Quality Program by reviewing the following functional reports:

**Program/Function**

- Behavioral Health Care
- Care Experience
- Care Coordination Center
- Change in Clinical Services
- Clinical Research
- Complex Case Management/Senior Persons with Disabilities (SPD)
- Contract Quality Oversight
- HEDIS/Clinical Strategic Goals
- Infection Prevention
- Medical Education
- Network Quality
- Regional/Local/Program Descriptions/Workplans/Evaluations
- Regulatory Updates
- Risk/Patient Safety Activities
- Special Needs Program (SNP)
- Specialty Care and Ancillary Services Quality

**Local Medical Center Quality Oversight**

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

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

The Leadership Teams are responsible for:

- Establishing quality programs and a quality committee structure that provide oversight and review, and follow up where opportunities for improvement are identified.
- Holding medical center physicians and staff, (KFHP, KFH & SCPMG), physicians, managers and staff responsible for specific functions of quality assessment and performance improvement related to patient safety, risk and utilization management, monitoring and resolution of
member complaints and appeals, assessment of member satisfaction, and regulatory and accreditation compliance, coordination, consultation, facilitation, and review.

- Establishing access, service, and quality goals that are aligned with Regional goals.
- Directing action as indicated to improve access to care and service.

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

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

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

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

Continuous Readiness Assessments at the local medical centers are conducted by a team of internal consultants reporting to the KFHP Vice President for Quality and Regulatory Services and the SCPMG Regional Assistant Medical Director for Quality and Risk Management. This team conducts annual site visits to each medical center, monitoring against identified standards and quality vulnerabilities as identified through previous surveys, trends on sentinel events or other regulatory agency vulnerabilities, and quality performance as reported through regional reports.

4. KFHP SOUTHERN CALIFORNIA OVERSIGHT OF QUALITY FUNCTIONS

Quality Assurance Program Agreement (QAPA)
(Attachment A: QAPA Agreement)

(Attachment C: Regional Resources for the QI Program)

It is the responsibility of KFHP to administer Health Plans Quality Assurance Program Agreement. 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, KFH, and SCPMG in connection with the performance of the quality functions that comprise KFHP's Quality Program. KFHP, KFH, and SCPMG have agreed to perform the quality activities outlined in the QAPA.

**Delegation Statement**

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

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

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

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

The SCQC reviews these aspects of delegation agreement oversight:

- Documentation and data about the performance of the delegated service
- Results of audits of the provider's policies and mechanisms, prior to delegation
- 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

**Affiliated (Contracted) External Provider Services**

In certain circumstances SCPMG contracts with non SCPMG entities (providers/practitioners). Contracts include obligations to cooperate with KFHP's quality program to support member and practitioner communication, to provide access to medical records and to maintain confidentiality of member and personal health information. The KFHP quality program evaluates the care provided by providers and practitioners.
**Credentialing and Recredentialing**
All physicians, allied health practitioners, and Contracted Providers and Practitioners are credentialed according to the requirements set forth in the Kaiser Foundation Health Plan, Inc., Southern California Region Credentialing & Privileging Policies and Procedures prior to treating Health Plan members unless a Letter of Agreement (LOA) has been issued.

**Credentialing/Recredentialing of Licensed Independent Practitioners and Allied Health Professionals Employed by SCPMG**
KFHP in the Southern California Region is required to credential providers and practitioners who provide services to KFHP members. Further, the Professional Staffs of hospitals or other facilities operated by KFH are required under legal and accreditation standards to credential individuals who exercise clinical privileges and/or are members of their respective Professional Staffs.

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

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

Regional Credentialing Committee makes final decisions regarding delegation of credentialing, oversees compliance of delegates, and makes the final recredentialing/credentialing decisions for KFHP regarding contracted practitioners. Additionally, each Medical Center's C&P Committee makes the final credentialing/recredentialing decision for KFHP within its respective Medical Center. Credentialing and recredentialing decisions are separate and independent from employment actions or decisions made by SCPMG, KFHP, or KFH.

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

The Regional Credentialing Department supports credentialing and re-credentialing of Contracted Providers and Practitioners based on regulatory standards and internal Kaiser Southern California Health Plan policies.
As a condition of continued credentialing, a Contracted Provider must continue to meet the criteria set forth in the policy and procedure. Contracted Provider credentials must be re-verified and re-evaluated at least every thirty-six months.

**Monitoring of Credentialed Practitioners**

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

**Notification of Practitioner Conduct**

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

**Practitioner Input into Quality**

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

**Conflict of Interest Statement**

No physician or other individuals involved in performance improvement, utilization management, or risk management shall have the direct responsibility for the review of the quality of patient care or appropriate utilization of resources for a patient with whom the individual is professionally or personally involved. Decisions related to care are made by the member’s physicians and other members of the care team. There is no personal gain or incentives that promote denials or under-utilization.

**Benefits**

All clinical practice guidelines are sent to the Director of Benefits/Policy Development, Health Plan, to ensure that the recommendations are aligned with existing benefits.
Peer Review Process
The Peer Review process is a mechanism by which KFHP continuously assesses the care provided to the members. This process evaluates potential quality of care concerns involving licensed independent practitioners to determine whether standards of care are being met. The Health Plan has initiated and oversees compliance with the "Peer Review & Evaluation of Licensed Independent Practitioners Performance" policy through its RPROC Committee.

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

KFHP offers Behavioral Health, (Addiction Medicine & Psychiatry) services within KPSC. KPSC Behavioral Health Care services are part of our integrated medical care program at each medical center and at the regional level. As such, Psychiatry and/or Addiction Medicine practitioners participate in medical center and regional quality committees. The BHC Program Description, annual work plans and annual evaluations are components of the overall KPSC Quality Program Description. All BH related quality issues are managed through our KPSC Quality structure at both the medical center and regional level; there is no separate BH quality structure.

The goals and objectives of the Behavioral Health Quality Program are consistent with the overall KPSC Quality goals and objectives outlined in the KPSC Regional Quality Program Description, Behavioral Health Care quality goals are focused on Continuity of Care, Collaborative Care, Access, Availability of Practitioners, Patient Satisfaction, Use of Services (HEDIS measures) and Utilization Management. The specific goals and objectives are outlined in the annual BHC Work Plan as authored by the Director, BHC Services.

At the medical centers, each Psychiatry and Addiction Medicine department develops an annual quality plan to address departmental goals through leadership from the Chief and Department Administrator. The departmental plan may incorporate unique goals specific to their department, goals developed at the medical center level and major regional goals as outlined in the Annual BHC Quality Workplan Evaluation.

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

- Southern California Quality Committee (SCQC)
- Southern California Executive Resource Stewardship Committee (SCERSC)
- Access Committee
- Member Concerns Committee
- Autism Related Services Operational/ Quality Oversight Committee (ARSOT)
As this chart illustrates, BHC representatives are members of, or provide expert input to, a variety of Quality and Utilization Management Committees at the regional and mid-level.

Behavioral Health access and availability of services is monitored through the Regional Access Subcommittee where access issues/trends are reviewed and corrective action plans requested based on a defined threshold for action. The Member Concerns Committee provides oversight of this work focusing on identified trends in Behavioral Health access, member complaints and grievances that may indicate potential systemic operational/quality issues.

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

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

The need for additional Behavioral Health facility providers is assessed as part of the overall regional strategic planning process. The components of Behavioral Health Services are outlined in the attached Behavioral Health Care Program Description.
Health Plan Oversight of New and/or Changed Clinical Services
The Agreement for Review and Approval of Changes to or the Addition of Certain Health Care Services and QHIC Guidelines for Change/Internalization of Clinical Services sets forth the Health Plan's process to review and approve new services or a change in the manner in which services are provided under the following circumstances:

Clinical services which are added, discontinued, or modified including regional and sub-regional services and those requiring regulatory approval or notification.

Clinical services that require capital expenditures of $1 million or more

Any service that meets the criteria in the Agreement must be approved by the SCQC and KFHP Board (QHIC) prior to its implementation. In Southern California, requesters of new or changed services which meet any of these criteria are required to develop a comprehensive quality oversight and regulatory compliance plan. Prior to SCQC review, these plans are approved by the Regional VP of Quality and Regulatory Services and Health Plan Physician Advisor in collaboration with regional subject matter experts and leaders associated with the specific service change.

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

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

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

Select HEDIS measures are publicly reported by the California 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 OPA's website. [http://www.opa.ca.gov/report_card](http://www.opa.ca.gov/report_card)

Clinical Practice Guidelines (CPGs) Process
Kaiser Permanente Southern California (KPSC) has a formal evidence-based Clinical Practice Guidelines (CPG) Program designed to assist KPSC physicians, administrators, and other health care professionals in determining the most effective medical practices to improve the health of Kaiser Permanente
members. Many of the clinical practice guidelines (CPGs) address topics that are aligned with Southern California's Regional Clinical Strategic Goals and Imperatives, and other clinical priorities. For selected guidelines affecting large populations of Kaiser Permanente members, KPSC works closely with the KP Care Management Institute (CMI) in the development of these guidelines. Guidelines are updated with the two-year update schedule and distributed via email, the CPG intranet, and SCPMG symposia.

KPSC clinical practice guidelines are designed to assist clinicians by providing an analytical framework for the evaluation and treatment of the more common problems of patients. They are not intended to replace a clinician's judgment or to establish a protocol for all patients with a particular condition. It is understood that some patients will not fit the clinical conditions delineated within these guidelines, and that a clinical practice guideline will rarely establish the only appropriate approach to a problem. Deviations from guidelines are appropriate in specific cases, yet exceptions to the guidelines should be infrequent when there is strong direct medical evidence closely linked to health outcomes. In more controversial clinical subjects with weaker or indirect evidence, occasional exceptions are appropriate and anticipated.

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

**Complete Care Program (Disease Management)**

The Complete Care program uses an evidence-based, population approach to provide care for members across the spectrum of health: healthy, healthy with a specific health issue, chronically ill, and end of life. Disease management is imbedded in the care delivery system, touching the patient before, during, after and between visits. We take every encounter to provide the member the necessary preventive, risk factor and chronic disease care. The approach is person, not disease-centric, focusing on the individual's health profile. CCM criteria include: members with physical or developmental disabilities, multiple chronic conditions, severe injuries, members who will benefit from intensive post-discharge care who are identified using a validated the predictive model which evaluated length of stay, acuity of admission, pre-existing co-morbidities and multiple emergency department visits. Information about the program is published annually in the Member Guidebook. Eligible members are informed about the program, eligibility criteria and how to opt in or out. For a more detailed description of the population assessment, please see the Regional Utilization Management Program Description as well as the Complex Case Management Program Description.

The comprehensive approach toward conditions such as asthma, cancer, cardiovascular disease, chronic pain, diabetes, depression and weight management is not a separate carve out of incremental programs for select populations. The integrated care delivery system, addresses multiple conditions, wellness and prevention from an individual's perspective.

In Southern California, the following functional strategies have been implemented to address the individual's needs at every encounter:
**Proactive Encounter** involves the processes, tools, and workflow that support the health care team prior to, during, and after a patient encounter. This impacts all care settings. Appropriate gaps in care are addressed and documented.

**Proactive Panel Management** to manage PCP physician panels, particularly intervening on those individuals not actively seeking care from their primary care physician. The health care team identifies individuals with gaps in care and brings recommendations to the physician who then directs the team to carry out the approved orders.

**Online Personal Action Plan (oPAP)**

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

**Centralized Outreach** uses batch mechanisms to engage individuals in positive health behaviors for preventive and chronic care. This function helps to improve existing outreach efforts, efficiently launch new evidence-based initiatives and expand outreach capacity through coordination, consolidation and new technologies.

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

**The Heart Failure Transitional** Care Program is an evidence-based opportunity to improve clinical quality (TJC HF bundle), to reduce hospital days’/readmission rate and to improve patient quality of life. This combines inpatient care management, home health evaluation and outpatient care management to provide early intervention and reduce the risk of readmission.

**Medication Management:** Physicians, pharmacists, registered nurses and other advanced practice caregivers provide medication therapy, education, and drug information to patients utilizing evidence-based guidelines, standardized practices, and tools to optimize pharmacologic efficacy and improve clinical outcomes. Clinicians are trained to identify barriers and offer solutions to help patients use medications correctly. In addition, patients overdue for refills for certain medications, or those who have low adherence to taking certain medications receive telephone outreach via recorded message or from a pharmacist.
**SureNet:** The Outpatient SureNet is a small, centralized team with clerical support that works on limited scope projects to catch small numbers individuals with unique care issues. Projects focus on patient safety through medication monitoring, potentially harmful interactions, diagnosis detection, and necessary follow-up care.

**Rare Diseases:** The Southern California Rare Disease Program was developed to improve the care and outcomes for children and adults with rare and uncommon diseases and raise awareness of rare diseases within SCPMG. The program is currently focused on developing a coordinated approach for improving care for members with Down Syndrome, Spinal Cord Injury, and Amyotrophic Lateral Sclerosis (ALS), with the goal of gradually adding additional rare disease cohorts as the program develops.

**Case Management/Complex Case Management**
SCPMG offers case management programs for the coordination of health care and for continuity of care across the continuum. These programs promote high-quality, cost-effective care and services for members through the proactive provision of care coordination, targeted education and resource management. Members who meet pre-established criteria may be automatically enrolled into the case management programs. Referrals may be made by a member of the healthcare team, including physicians, nurses, case/care managers, social workers, and the member's caregiver or by the member. Annually an assessment is conducted to identify the characteristics and needs of the membership. The case/care management programs offered include:

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

The following Complex Case Management programs are offered:

**End Stage Renal Disease Care Management Program** manages the complex needs of the member with Chronic Kidney Disease (CKD) and End Stage Renal Disease (ESRD). The program seeks to maximize health potential while assuring appropriate utilization of resources. Southern California Transplant HUB provides case management and care coordination to member who are pre-, intra- and post-transplantation. The following member types are excluded the Transplant Case Management program:

- New enrollees to KP Health Plan post-transplant
- Non- members
- Members discharged to Skilled Nursing Facility (SNF) from the COE. (These members are admitted to CCM upon discharge to ambulatory care.)
- Post-kidney, simultaneous kidney-pancreas (SPK), and bone marrow transplants

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

**Special Needs Plan (SNP-D)** for its Medicare/Medi-CAL dual eligible members to improve coordination and continuity of care for members with special needs. Each Medical center has a SNP Interdisciplinary Care Team comprised of nursing, social medicine, behavioral health, pharmacy and physicians with specialty training in geriatrics, continuing care, hospice to support the PCP’s patient management. SNP members with complex conditions, to include unmet social or medical needs, are risk-assessed to provide care planning, transition (acute and SNF discharge) management to ensure care coordination and to maximize community benefits with the goal of reducing institutionalization and delaying disease progression.

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

**Chronic Care Improvement Project (CCIP)/Quality Improvement Project (QIP)**
The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) requires Medicare Advantage Organizations (MAOs), as part of their quality improvement efforts, to implement a CCIP and QIP. The Centers for Medicare and Medicaid Services (CMS) requires MAOs to have an ongoing quality improvement program and conduct quality improvement projects that have a favorable effect on health outcomes and member satisfaction. These projects focus on clinical and non-clinical areas and involve performance measurement, interventions, and follow-up on the effect of the intervention.

The MMA requires all MAOs to initiate one QIP per year, lasting a minimum of three years to measure improvement and sustained improvement, and to implement a CCIP. Annual reporting of calendar year (CY) activities are documented on the QIP or CCIP Reporting Templates.

Implementation requires: 1) identification of MA enrollees with multiple or sufficiently severe chronic conditions that would benefit from participation, 2) mechanisms for monitoring participants and 3) a plan to meet reporting requirements. CCIP requirements are met through the Asthma, PHASE and Heart Failure Management Programs. The Quality and Operations Support (QOS) Department is responsible for monitoring these programs and for compliance with CCIP requirements.

**Special Needs Plan (SNP)**
KFHP offers a Medicare Advantage special needs plan (SNP) enrolling beneficiaries who are eligible for Medicare and full benefits under Medi-Cal. As a special needs plan, KFHP offers enhanced benefits that address the complexities of these high risk, vulnerable members. The goal for these members is to improve access to care and better health outcomes by reducing hospitalizations and nursing home placements.

SNP members are assigned to local Interdisciplinary Care Teams (ICT) at each Medical center who are responsible for care needs oversight, to include pre-and post-discharge contact, annual health risk assessment, care plan/patient goal development and unmet care needs (POE), etc. The dual-benefit also
necessitates investigating community benefit needs and facilitating inquiries regarding membership or benefits through Kaiser Permanente coverage, State MediCAL or the MediCAL designated Health Plan.

The ICT is comprised of a Physician Lead, SNP Manager and a case management team of RNs, RNP s, SWs with reporting and administrative support from project managers or administrative personnel. To support the specific needs of this population, additional care management is also provided by a dedicated LTSS liaison, pharmacist and a behavioral health liaison.

SNPs must collect data on quality indices as required and in concert with the KP program plan. SNP Members are measured separately from the Medicare population to include Medicare 5 Star for Care of the Older Adult (Pain, Functional Status, and Medication Review), CMS metrics for Care Management Assessments, HEDIS measures (CSGs) and End of Life Planning. SNPs must also provide a chronic care improvement project (CCIP) and a quality improvement project (QIP) to improve health outcomes for the healthy heart initiative for the CCIP and new efforts for the QIP in addressing health disparities in hypertension control for the SNP population.

SNP Structure - The SCAL Regional SNP is part of Regional Utilization Management, with the core team comprised, at a minimum, of the Regional Executive Director of UM & Resource Management, Regional Physician Champion, and Regional Director. SNP reports through the SCPMG Assistant Medical Director and KPH/P VP Outside Medical, Continuing Care Support Services up to Executive Leadership to SCPMG and KPH/P and to the SCAL Executive Resource Stewardship Committee (SCERS C) and SCAL Quality Council (SCQC). Local Interdisciplinary Care Teams report to either Medical Group or Hospital Executive Leadership, and their respective Quality oversight, with responsibilities to the Regional SNP Program.

**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.

**Member Care Experience - Member Satisfaction**

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

- Members will have a primary care provider (PCP)
- Members will have the ability to see their own PCP when they come in for primary care
- Members will be satisfied with the appointment wait times for primary care or specialty 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
Availability of Practitioners

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

Annually, the availability of practitioners for primary care, high volume specialty care, and high impact specialty care, including Behavioral Health, are analyzed and reported to the Regional Access Committee. Geographic availability of practitioners is analyzed at the regional and Medical center levels. The geographic analysis provides details such as the percentage of members who are within 15 miles/30 minutes of their PCP’s office. Bi-annually, provider/enrollee ratios for primary care and high volume specialty care are analyzed and reported to the Regional Access Committee. Provider/enrollee ratios are analyzed at the regional level.

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

Accessibility

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

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

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

Member Input into Quality

Members are encouraged to take an active role in managing their health. KFHP Southern California promotes member input into its Quality Program regarding the members care experience. Depending on the specific program, project or topic, this input may be accomplished through member focus groups and member surveys, for example. A document summarizing the quality program is available to members upon request. Members are notified via the Member Guidebook of the availability of this
summary. Members may request and receive the "Quality Program at Kaiser Permanente" document by calling the Member Service Call Center to request a hardcopy. This document may also be read online at kp.org/measuring quality.

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

- CAHPS
- Complaint and appeal data
- Member Experience Tracking Evaluation and Opinion Research (METEOR)
- Patient Assessment Survey (PAS) of California Physician Organizations
- Home health survey
- Skilled nursing facility survey
- Hospice patient and family satisfaction survey
- Behavioral Health Survey

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

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

**Oversight of Member Complaint, Grievance, Appeals**
Kaiser routinely collects valid data on member complaints and appeals for all services in all care settings (including behavioral health) for all product lines (including Marketplace)

- Quality of care
- Access
- Attitude and service
- Billing and financial issues
- Quality of practitioner office sites

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

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

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

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

**Health Education Programs**
KFHP requires providers to have 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 that are available in multiple languages. The Regional Center for Healthy Living department (formerly Health Education) works in partnership with other regional departments and medical facility staff to build innovative tools and services for members and clinicians to support member care efforts and to integrate the developed tools and services into care delivery. (Attachment VIII-2017 Southern California Kaiser Permanente Regional Center for Healthy Living Program Description)

The Center for Healthy Living (CHL) develops, produces, and Maintains:

- Content for Member classes, print and on-line resources that is accessible, evidence-based, understandable, actionable, and culturally appropriate
- Resources and practice tools for clinicians and trainings for care managers, class instructors, clinical health educators, and other clinicians who assist Members in developing behavior change skills.
- Health coaching strategies for behavior change, chronic conditions management, prevention, behavioral health education, and health education in employment settings

**Areas of Expertise:**
The Center for Healthy Living, with 13 local area CHL departments, leads and collaborates in the consultation, communication, and coordination of high-quality, consistent, cost-effective healthy living programs, products, and services that advocate and integrate the total health brand position
at Kaiser Permanente to motivate health behavior change and self-care. Our expertise lies in the following areas:

- **Healthy Living Programs and Resources** - Develop action-oriented communications about key health topics and resources for members, leaders, physicians, employees, and purchasers.
- **Member Education Materials** - Develop, produce, translate, promote, and distribute quality, branded, accurate, and understandable educational materials in print and for the Web that meet with regulatory and health literacy standards. Materials are delivered in classes, emailed for telephonic wellness coaching sessions, online, and in medical encounters.
- **Health Information and Education Programs** - Manage and promote Kaiser Permanente Wellness Coaching by Phone, and promote the Health Encyclopedia and education resources on kp.org.
- **Consulting** - Provide needs assessment, planning, and identification of interactive learning tools and programs to support lifestyle behavior change, self-management, and achievement of our clinical strategic goals and strategic organizational initiatives, including our community partners.

### Southern California Regional Products:

- Program-wide resources and programs: online Health Encyclopedia and Health Education pages
- Standardized regional manuals for core class curricula
- Standardized health education and promotional material
- Wellness Coaching by Phone
- Worksite wellness consultation and health education program delivery

### Member Education Materials

All the publications available for members are listed by category and can be found on Clinical Library. Publications are available in Spanish as well as English, and many are available in other languages, including Arabic, Armenian, Chinese, Russian, Vietnamese, Korean, Cambodian/Khmer, Farsi, and Tagalog.

**How to Use Clinical Library**: [clinical library how-to.pdf]

Handouts produced by Kaiser Permanente are available for order or can be printed directly from Clinical Library. Third-party items are described and listed with ordering information. If members have questions, they can contact their local Center for Healthy Living or Publications Review Committee (PRC) Member ([PRC Committee Members.pdf](#)).

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

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

**Continuity of Care/Notification for Members/Practitioners Terminate**

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

- An acute condition, for the duration of the condition.
- A serious chronic condition, for a period of time necessary to complete a course of treatment and provide for a safe transfer of the enrollee, not to exceed 12 months from the contract termination date or the effective date of the new enrollee's coverage.
- A pregnancy, for the duration of the pregnancy and through the immediate postpartum period.
- A terminal illness, for the duration of the illness.
- Care of a child, between birth and 36 months, not to exceed 12 months from the contract termination date, or the effective date of the new enrollee's coverage, or the child's 3rd birthday (whichever is earlier).
- Performance of a surgery or other procedure, authorized by the plan as part of a documented course of treatment, and recommended and documented to occur by a Qualified Current Enrollee's terminated Plan Provider or a Qualified New Enrollee's Non-Plan Provider within 180 days of the contract termination date or the effective date of the Qualified New Enrollee's coverage, respectively.
KFHP also works with members to assist them with transitioning to other care if necessary when KFHP benefits terminate.

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

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

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

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

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

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

The comprehensive approach toward conditions such as asthma, cancer, cardiovascular disease, chronic pain, diabetes, depression and weight managements is not a separate carve out of incremental programs for select populations. And because we are an integrated care delivery system, it is convenient for members to manage multiple conditions because all necessary services are likely to be in the same location.

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

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

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

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

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

Performance Improvement Methodology
KFHP utilizes the Institute for Health Care Improvement (IHI) Model for Improvement as well as other performance improvement models and tools. 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 the "Rapid Cycle Small Tests of Change Methodology."

The "Plan–Do–Check/Study–Act Cycle" (PDC/SA) is used to implement and test the effectiveness of changes. This model focuses on identifying improvement opportunities and changes, and measuring improvements. Successful changes are shared throughout the Region.
PDC/SA is the implementation and testing step in the larger scope of improvement.

<table>
<thead>
<tr>
<th>Assess</th>
<th>Develop</th>
<th>Test</th>
<th>Share/Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Mapping</td>
<td>Standardized and simplify</td>
<td><strong>PDC/SA</strong></td>
<td>Share throughout Region</td>
</tr>
<tr>
<td>Collect Baseline Data</td>
<td>Reduce Waste</td>
<td><strong>DO</strong></td>
<td>Implement</td>
</tr>
<tr>
<td></td>
<td>Apply evidence based practice</td>
<td><strong>ACT</strong></td>
<td>Training</td>
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<td></td>
<td></td>
<td><strong>CHECK/STUDY</strong></td>
<td>Develop or revise Policy and Procedures</td>
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</table>

**Performance Improvement Leadership**

Each Medical Center is led by a KFHP Senior Vice President/Area Manager. SVPs report to the Senior Vice President of Operations and to the KFHP Regional President, and are responsible for KFHP operations, including the quality of care provided to all members and patients within the applicable medical center. These KFHP leaders are accountable for ensuring that the Quality Program addresses the quality of care, utilization management, and services provided/available to all members within their respective medical center.

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

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

**Prioritization of Quality Improvement (QI) Activities**

It is the responsibility of leadership to establish priorities for performance improvement and member health outcomes, with an emphasis on using outcomes-oriented measurement as a key method to improve the quality of care. Prioritization of QI activities 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 by rank-ordering projects using selected criteria and professional judgment. When determining the prioritized metrics, the following are considered:

- Linkage with strategic goals
- Clinical quality
- Service and access
- Patient safety
- Risk management
- Legal/regulatory and accreditation requirements
- Performance gaps,
- Member complaints
- High volume diagnoses and procedures
- Problem prone diagnoses and procedures
- Leapfrog safe practices criteria

2017 Key Quality/Strategic Goals

<table>
<thead>
<tr>
<th>Quality</th>
<th>Affordability</th>
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</thead>
<tbody>
<tr>
<td>HCTI</td>
<td>HCAHPS (9-10), Incl. Maternity RN Communication CAHPS/ METEOR/service</td>
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<tr>
<td>Sepsis</td>
<td>Service</td>
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<tr>
<td>Chest Pain</td>
<td>AIP</td>
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<tr>
<td>C-Diff</td>
<td>HAI: (CDiff; BSI; TII)</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Hand Hygiene (Avatar)</td>
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<tr>
<td>Ambulation</td>
<td>SRAE</td>
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<tr>
<td>Telemetry</td>
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<tr>
<td>Tobacco Cessation</td>
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<tr>
<td>Colorectal and</td>
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<tr>
<td>Breast Cancer</td>
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<tr>
<td>Glycemic</td>
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<tr>
<td>Control in</td>
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<tr>
<td>Diabetics</td>
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<tr>
<td>Asthma</td>
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<tr>
<td>Medication</td>
<td></td>
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<tr>
<td>Ratio</td>
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<tr>
<td>Combined</td>
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<tr>
<td>Measure of</td>
<td></td>
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<tr>
<td>Commercial</td>
<td></td>
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<tr>
<td>NCQA Rating and</td>
<td></td>
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<tr>
<td>CMS 5 Star</td>
<td></td>
</tr>
<tr>
<td>Rating</td>
<td></td>
</tr>
<tr>
<td>HSMR Readmission</td>
<td>Members with BMI ≥30 who attend a Weight Management Program</td>
</tr>
</tbody>
</table>

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

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

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

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

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

The Southern California Health Plan has established the Spread Group to accomplish the following in clinical and operational practices that occur within the medical centers:

- Facilitate a standard approach to identifying and spreading effective practices across the SCAL region that fosters engagement and collaboration between medical centers and regional leaders
- Embed spread of "effective" practices into our culture
- Learn how can we use spread and scale to more quickly improve performance

The Spread Group is supported by an evaluation sub-group that includes a physician, a Kaiser Permanente member, performance improvement leaders, operational leaders, labor leaders, and a finance representative.
Performance Improvement: Ambulatory (Outpatient) Quality Initiatives
Clinical Quality Goals

To address the growing challenge of publicly reported data, the Southern California Health Plan and Medical Group leaders identify clinical quality goals as areas of focused improvement. These are "Clinical Quality of Care Key Measures", which include several of the HEDIS-like measures as well as other non-publicly reported performance measures.

The list of 2016 Clinical Quality of Care Key measures is available in the SCAL Clinical Strategic Goals (CSG) website http://insidekp.kp.org:81/california/scpmg/csg/communications/index.html

2017 Metrics and Targets

The complete list of the 2017 Clinical Quality Key Measures is in the table below:

<table>
<thead>
<tr>
<th>2017 Clinical Quality Key Measures</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSG Quality Composite Score</td>
<td>100</td>
</tr>
</tbody>
</table>

Being Healthy

Tobacco Cessation Management                               | 40%    |
Weight Management Program Encounters                        | 27     |
Flu Immunization – All members older than 6 months          | 51%    |

Hospital Care

    All-Cause 30-day Readmission Observed/Expected Ratio     | <0.78  |
    *(Lower is better)*                                      |        |

Visit the [CSG website](http://insidekp.kp.org:81/california/scpmg/csg/communications/index.html) to monitor ongoing progress on the CSG measures, Z-Scores, and 2016 Clinical Quality of Care Key Measures.

For additional information refer to the 2016 [CSG Measure Definitions](http://insidekp.kp.org:81/california/scpmg/csg/communications/index.html).

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

Hospital Strategic Priorities

KFHP in partnership with KFH has embarked in a comprehensive performance improvement strategy for KFH Hospitals. Success is reflected in public and internal information such as access to care, service, quality and safety "report cards."
The Hospital Quality Measures are guided by:

- KP strategic priorities
- The Joint Commission’s Core Measures initiatives
- California Assembly Bill 524 of 1991, which mandated that hospitals report certain specific health outcomes to California's Office of Statewide Health Planning and Development (OSPHD).
- SCQC and QHIC review data on inpatient quality measures via regional, local, and program office report cards.

Performance Improvement: Member/Patient/Workplace Safety

(Attachment II: Patient Safety Program Description)

The focus of the KFHP Safe Care Program is to promote reliable, consistent and safe care for KFHP members throughout the continuum of care. The program is founded on a philosophy that patient safety is every patient's right and everyone's responsibility. The Safe Care Program utilizes patient safety, workplace safety, and risk management principles.

Six strategic themes have been identified to assure individual responsibility and mutual accountability for patient safety throughout our organization. Kaiser Permanente implements activities broadly aimed at achieving improved safety, across the care continuum, in each of the following themes:

<table>
<thead>
<tr>
<th>Core Themes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe Culture</td>
<td>Create and maintain a strong, unified patient safety culture at Kaiser Permanente, with patient safety and error reduction embraced as shared organizational values and acknowledged pre-requisites of “quality you can trust”</td>
</tr>
<tr>
<td>Safe Care</td>
<td>Ensure the actual and potential hazards associated with high risk procedures, processes, and patient care populations are identified, assessed, and controlled in a way that demonstrates continuous improvement and moves the organization toward the ultimate objective of ensuring our patients freedom from accidental injury or illness.</td>
</tr>
<tr>
<td>Safe Staff</td>
<td>Ensure staff possess the knowledge, competence and equipment to safely perform required duties and improve system safety performance</td>
</tr>
<tr>
<td>Safe Support Systems</td>
<td>Identify, implement, and maintain support systems that provide the right information, to the right people, at the right time. This includes knowledge sharing networks and responsible reporting.</td>
</tr>
<tr>
<td>Safe Place</td>
<td>Design, construct, operate, and maintain the environment of care as well as evaluate, purchase, and utilize equipment and products in a way that enhances the efficiency and effectiveness with which safe healthcare is provided.</td>
</tr>
<tr>
<td>Safe Patients</td>
<td>Engage the patient, and their family, as appropriate, in reducing medical errors, improving overall system safety performance, and maintain trust/respect.</td>
</tr>
</tbody>
</table>
6. KP HEALTHCONNECT, ELECTRONIC MEDIA, AND MEDICAL RECORDS

Kaiser Permanente HealthConnect Program Overview

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

- Access to KP HealthConnect is available 24/7.
- Any Member's EMR can be viewed by more than one clinician at any point in time.
- Having the complete EMR available allows practitioners to have complete knowledge regarding co-morbidity, past visits and complaints, and recommendations the Member has received from other clinicians.
- Test results are immediately available allowing clinicians to view the most complete information available and provide the best service possible.
- Clinicians have access to recommended best practices in real time. The latest clinical information and evidence-based research is available to provide point-of-care recommendations for a wide variety of clinical conditions.
- HealthConnect has helped to reduce medication errors stemming from difficulties reading hand-written prescriptions.
- Visual patient alerts assist clinicians when a Member’s record is brought up in HealthConnect (e.g. alerting clinicians to medication allergies).
- A visit review is available to print and give to each Member at the end of each appointment. This visit review reinforces any verbal instructions given by the clinician.
- Members can be shown relevant parts of their record while visiting with a clinician and Members can access their medical record by visiting www.kp.org.
- Use of HealthConnect enhances personalized care. Since all information about the Member is available, even a clinician who has not yet seen the Member can immediately know a Member's history and preferences.

Electronic Media

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

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

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

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

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

REGIONAL BEHAVIORAL HEALTH QUALITY PROGRAM DESCRIPTION

2017
<table>
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<tr>
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<th>Title</th>
<th>Page</th>
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<td>BHC Other Committees/Work Groups/Teams</td>
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<td>3</td>
<td>Overview – Kaiser Permanente Southern California BHC Program</td>
<td>9</td>
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<td>5</td>
<td>Behavioral Health Accessibility of Services</td>
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<td>6</td>
<td>Availability of Behavioral Health Practitioners</td>
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<td>Assessment of Behavioral Health Network Adequacy</td>
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<td>8</td>
<td>Collaboration between the Organization and Behavioral Health Specialists</td>
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<td>Continuity and Coordination Between Medical Care and Behavioral Healthcare</td>
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<td>MedCal Services</td>
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<td>11</td>
<td>Patient Safety &amp; Significant Events</td>
<td>30</td>
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<td>12</td>
<td>Oversight of Contracted BHC Providers (Facilities) &amp; High Volume Practitioner Offices</td>
<td>31</td>
</tr>
<tr>
<td>13</td>
<td>Behavioral Health Help Line and Triage and Referral Process</td>
<td>31</td>
</tr>
</tbody>
</table>
Behavioral Health Care Vision: Kaiser Permanente is known as the national leader in providing a safe and effective behavioral health care experience that meets the needs of the patient and the community.

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

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

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

Physicians and other appropriate licensed professionals who provide care to the plan’s enrollees are an integral part of the quality improvement program. They adequately participate in the implementation and monitoring of clinical services rendered, resolve problems, and ensure that corrective actions are taken when opportunities are identified. An appropriate range of specialist providers are involved as necessary.
Implementation of the QA program is supervised by a designated physician(s), or other licensed professional provider, as appropriate.

Attached is an organizational chart of the KPSC Quality Structure demonstrating involvement of Behavioral Health (*Health Plan Quality Oversight Structure for Behavioral Health: see appendix 1)*

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

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

- **Kaiser Permanente Southern California Behavioral Health Quality Oversight Committee (BHQOC)**

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

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

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

- The BHQOC is a subcommittee of the Southern California Quality Committee (SCQC) and reports to SCQC on at least a semi-annual basis.
- The SCPMG Regional Chief Administrator Officer and KP Vice President of Quality & Regulatory Services are committee sponsors.

- **Access Subcommittee of the Member Concerns Committee** – Behavioral Health Care Regional Leaders participate in reviewing access and member satisfaction performance metrics, trends, and opportunities. Corrective Action Plans are monitored through resolution to ensure the regulatory targets are met.

- **Regional Behavioral Healthcare Services Department** – The Regional Behavioral Health Care Services team (BHC Team) encompasses seven (7) fulltime FTE’s including a Regional Administrator. All staff members are involved in some aspect of the clinical quality and/or utilization management oversight process.

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

  - Physician Chief of Service meetings
  - Clinical Department Administrator meetings
  - Access Subcommittee of Member Concerns Committee
  - BH Council and/or QuEST
  - SCQC
  - Care Management Institute (CMI) Integrated Behavioral Health Care

The BHC Team is involved in review of medical center access action plans as part of the regional access oversight process.
An annual BHC Program Description, annual BHC Work Plan and annual BHC Work Plan Evaluation are completed each year and presented to appropriate regional quality committees. The quality reports include an analysis of selected HEDIS measures including the Anti-Depressant Medication Management (AMM) measures, Follow-up after Mental Illness Hospitalization measures and the Initiation & Engagement in Treatment (IET) measures.

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

- **Autism Related Services Operational/ Quality Oversight Committee (ARSOT)** – The Developmental Disabilities Practice Specialist acts as a key operational leader of the ARSOT and functions as the primary clinical operations liaison for applied behavioral health (ABA) services.

- **Psychiatry and Addiction Medicine Chiefs and Department Administrator Meetings.**
  
  o Joint meetings of the Psychiatry and Addiction Medicine Chiefs occur at least two times per year. Representatives of the Department Managers from these departments attend these meetings.

  o Joint meetings of the Psychiatry Chiefs and their Department Managers and joint meetings of the Addiction Medicine Chiefs and their Department Managers occur at least three times per year.

  o Chief of Service and Department Manager meetings include discussions on operational issues that examine current care processes and identification of opportunities for standardization within KPSC. Topics include: access, quality, member experience, feedback informed care, clinical outcomes and utilization.
Goals & Objectives of the BHC Quality Program

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

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

Effectiveness of BHC Quality Program/Annual Evaluation

The KPSC quality program assesses its overall performance against the previous year’s work plan through an annual BHC written evaluation completed by the Regional BH team in collaboration with the regional quality staff and other relevant medical group operational departments. The annual BHC Work Plan Evaluation is reviewed by the BH Council and/or QuEST and SCQC. The annual evaluations are approved by Senior Management, and submitted to the KFH/HP Boards' QHIC for review and approval. The evaluation contains elements required by the KFHP/KFH Board and QHIC.

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

KPSC Behavioral Health Utilization Management

KPSC Behavioral Health departments are included as part of our KPSC UM Program description. For more details, see the 2017 KPSC UM Program description for Authority, Accountability and Responsibility.
2. BHC Other Committees/Work Groups/Teams

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

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

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

- **Regional Credentialing and Privileging Committee (RCPC)** – The Regional Director, BHC Services (or designee) serves as an ad hoc expert consultant to the RCPC. In that role, the Director, or designee participates in RCPC meetings on an as needed basis and provides expert input on credentialing and privileging issues that may have a behavioral health component.

- **Confidentiality Access Privacy & Security (CAPS)** – A BHC representative is a member of the CAPS Committee. In that role, the representative participates in CAPS meetings by providing expert input on confidentiality issues that may have a behavioral health component.
Clinical Strategic Goals Steering Group (CSGSG) -- BHC is involved with the regional clinical strategic goal setting process in KPSC as evidenced by the existence of several behavioral health clinical strategic goals related to selected HEDIS measures.

3. Overview – Kaiser Permanente Southern California BHC Program

BHC Services & Continuum of Care

KPSC offers a comprehensive health care delivery system, including behavioral health (mental health and substance use treatment) services.

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

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

- Acute Psychiatric Inpatient
- Inpatient Detoxification
- Residential
- Partial Hospital
- Day Treatment
- Intensive Outpatient
- Outpatient Service
Within these levels, individualized treatment plans based on medical necessity may include:

- Individual Therapy
- Group Therapy
- Medication evaluation/monitoring
- Case management
- Access to treatment and follow-up for members with co-existing medical and mental health disorders
- External Referrals

Kaiser Permanente physicians and health care professionals make medical decisions based on the clinical appropriateness of care for members’ medical needs and may use a variety of tools to assist them in their decision-making process.

KPSC’s Psychiatry and Addiction Medicine Chiefs of Service have adopted InterQual Level of Care guidelines for admission and discharge guidelines as a resource to the physicians and other health care professionals.

BHC Services are in full compliance with all the DMHC Language Assistance Regulations.

**KPSC is committed to patient centered care and “feedback informed care”**

- In Addiction Medicine, adult patients complete an evidenced based clinical questionnaire called SATSS (Substance Abuse Treatment Support System) at intake and during the course of treatment. Initial patient severity scores are produced based on the Addiction Severity Index (ASI) and other clinical areas of focus. Changes in patient severity scores are monitored during the course of treatment. SATSS includes PHQ and GAD clinical questionnaires as part of their mental health assessment.

- In Psychiatry, adult patients complete an evidenced-based clinical questionnaire called TPI (Treatment Progress Indicator) at intake and during the course of treatment. Initial patient severity scores related to overall behavioral health impairment, symptom severity (including the PHQ9 and GAD7), overall functional impairment, social impairment, alcohol misuse (AUDIT-C) and therapeutic alliance.
4. Behavioral Health Member Experience

KPSC implements mechanisms to assure member satisfaction and monitors experience within its services and identifies potential areas for improvement; and shares results with practitioners, providers and members.

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

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

- Member Experience Survey

- Monitoring complaints and grievances/appeals

- Monitoring telephone access

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

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

- Patient Advisors (KPSC members) are asked to provide input on Behavioral Health issues that affect patients throughout the Kaiser Permanente Southern California Region.

- Regional KPSC Behavioral Health leaders, project leads and members of committee’s present ideas to obtain patient and family perspectives in the design and delivery of Behavioral Health care.

- Council meetings will occur regularly with dates and times to be determined by the Council.

- BH-RPAC goals include member’s providing input on new or existing clinical and educational programs, forum to surface issues/concerns from the member perspective and advocacy for the inclusion of patients or family members on appropriate regional and local workgroups.
Behavioral Health Member Survey

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

Using a sampling methodology, the survey is administered using an online survey software (Qualtrics) to KPSC members across all geographic areas who have had at least one visit in our Psychiatry department for mental health services. The goal is to have a minimum of 500 responses.

- Questions about member experiences with the therapist and/or psychiatrist and the front office staff are included.
- Patients who self-identified having more than one visit in the last 12 months are asked to reflect on all their experiences in the 12-month period; patients who had only one visit were asked to reflect on that one experience.
- Patient’s complete questions that apply to the provider(s) they saw in the last 12 months: psychiatrist, therapist, or both.

Behavioral Health Complaints and Grievances/Appeals

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

- quality of care
- access
- attitude and service
- billing and financial issues
- quality of practitioner office sites
The organization works to improve member’s experience with behavioral healthcare and services, annually (new in 2015) by:

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

**Telephone Access**

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

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

**After Hour Operations**

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

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

- The Helpline is a crisis line that is answered live by a staff composed of Licensed Clinical Social Workers, Marriage Family Therapists. Each quarter the State of California receives a current listing of the Helpline staff and verification of their licensure.
The staff responds to crisis calls and informational calls from members, as well as employee assistance professionals. The interventions of the clinician are guided by protocols.

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

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

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

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

### 5. Behavioral Health Accessibility of Services

The organization establishes mechanisms to assure the accessibility and maintains appropriate access to behavioral health services including standards for telephone access to behavioral health care.

The following definitions are encompassed in our KPSC Appointment Standards and Definitions that are reviewed, at least annually, by our Regional Service & Access Department in collaboration with our the BHC Team and reported to the Regional Access Subcommittee and SCQC.

Based on valid methodology, KPSC monitors its access performance against established access target on at least a quarterly basis. A report is generated by the Regional Access department and is reviewed by the Access Subcommittee of the Member Concerns Committee. The report is distributed to the local and regional Medical Group and Health Plan leaders. Actions are taken by the Local Medical
Group and Health Plan leaders. The actions are monitored by the Local and Regional Access Committees.

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

**NCQA Standards**

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

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

**Emergent** - Sudden, unforeseen illness or injury that requires immediate medical attention or which, if left untreated, could result in serious disability or death. The following clarifying statements were added for our behavioral health departments:

- **Psychiatry**: A behavioral health life threatening or non-life threatening crisis that may result in a danger to self or others or concern of further decompensation (e.g. intra-psychic or environmental)

- **Addiction Medicine**: May include components of a medical or psychiatric emergency

**Urgent care within 48 hours**

- **Urgent Behavioral Medicine** - A behavioral health crisis that is not deemed to be emergent, but symptoms demonstrate impaired ability to function in normal roles at home, work and/or school.
- Our standard for urgent behavioral health appointments is 48 hours (0 – 2 calendar days).
Routine Initial Office visit for either MD’s or non-MD practitioners within 10 business days

- **Routine Initial** – Physician, Therapist or member initiated appointment for initial assessment by specialist which is not deemed to be of an emergent nor urgent need.

- Our standard for routine behavioral health appointments is 10 business days (14 calendar days).

Routine Follow-up Appointment

- **Routine Follow up** - Member we want to see again in 8 weeks or less because there is an active issue we are managing; individual and group visits included.

- Our standard for routine behavioral health appointments is 7 calendar days from the date specified by the practitioner.

DMHC Standards

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

Urgent Care within 48 hours

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

- Our KPSC standard for urgent behavioral health appointments is 48 hours (0 – 2 calendar days).

- KPSC has established a standard of 90% of patients that are booked to an urgent access visit type will be seen in 2 days or less.
MD Consult (routine) Access within 15 business days

- **Routine Initial** - Physician or member initiated appointment for initial assessment by specialist which is not deemed to be of an emergent nor urgent need.
- Our standard for routine behavioral health appointments is 15 business days (21 calendar days).
- KPSC has established a standard of 80% of patients that are booked to MD Consult visit type will be seen in 15 business days or less.

Non-MD Routine Initial Access within 10 business days

- **Routine Initial** - Therapist or member initiated appointment for initial assessment by specialist which is not deemed to be of an emergent nor urgent need.
- Our standard for routine behavioral health appointments is 10 business days (14 calendar days).
- KPSC has established a standard of 80% of patients that are booked to a non-MD routine initial visit type (RBM) will be seen in 10 business days or less.

6. Availability of Behavioral Health Practitioners

Behavioral Health Practitioners Definitions

Behavioral Health Practitioner definitions are reviewed annually and updated as necessary. This review includes definitions of high volume behavioral health practitioners, high volume behavioral health medical office and common behavioral health practitioner types which are used for Geo Access and BH Practitioner Availability Analysis.
• Behavioral Health Practitioners are defined in KPSC as: Psychiatrists (MD), Addiction Medicine physicians (MD), Psychologists (Ph.D./Psy.D.), Licensed Clinical Social Workers (LCSW), Licensed Marriage & Family Therapists (LMFT), Medical Social Workers (MSW), Psychiatric Clinical Nurse Specialists (CNS), Psychiatric Nurse Practitioners (NP), Physician Assistants (PA), substance abuse counselors and Psychiatric nurses (RN).

• A high volume Behavioral Health practitioner is a licensed external or Southern California Permanente Medical Group clinician who sees 50 or more unique members per year based on claims or internal encounter data.

• We exclude Psychologists from this definition as they are used primarily for Psychological testing which is done to support the determination or the severity of a diagnosis in conjunction with other BH Practitioners.

We group the above high volume Behavioral Health Practitioners into 5 major common types as follows:

• Adult Psychiatrists: includes MD’s whose primary practice is adult patients, RNP’s, PA’s in Psychiatry

• Child Psychiatrists: includes MD’s whose primary practice is greater than 50% children ages 0-17

• Psychiatric Therapists: includes LCSW’s, LMFT’s, MSW’s, Clinical Nurse Specialists, and Psychiatric RN’s who provide therapy services.

• Addiction Medicine Physicians: includes MD’s, RNP’s, PA’s in Addiction Medicine

• Substance Use Practitioners: includes LCSW’s, LMFT’s, MSW’s, Clinical Nurse Specialists, and substance abuse counselors working in the Addiction Medicine Department

• A high volume behavioral health medical office is defined as a provider location that has more than 10 licensed high volume Behavioral Health practitioners who see Kaiser Permanente members.
Behavioral Health Practitioner Availability Analysis

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

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

Analysis of practitioner ratios is an NCQA requirement for Behavioral Health

- There are no nationally accepted standards of mental health staffing
- Minimum practitioner ratios are NOT used to determine staffing but serve as a guidance metric
- Analysis for the NCQA requirement occurs at the regional level with Medical Center input
- Reporting delineates the five (5) common practitioner types as defined above and in relation to relevant membership populations served by the practitioner.

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

KPSC Staffing methodology is based on:

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

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

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

Definition of Substance Use Practitioners

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

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

BHC Geographic Locations Overview and GeoAccess Analysis

BHC Geographic Locations Overview

- BHC services are provided in thirteen geographic areas within KPSC and are managed by KPSC senior managers and physicians collectively known as the Medical Center Administrative Team (MCAT) (of which the KFHP Executive Director is a member) in each geographic area. Reporting to the Area Medical Center leadership team, each Psychiatry and Addiction Medicine Department is managed by a physician Chief of Service and Department Manager.
• BHC services in the Ventura geographic area have been integrated into the Woodland Hills Psychiatry Department.

• Management responsibility for the Antelope Valley/Lancaster geographic area was separated from the Panorama City Medical Center and is now managed locally by the Antelope Valley Area Leadership team. The department is managed by a Chief of Psychiatry & Addiction Medicine and a Department Manager.

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

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

**GeoAccess Standards & Analysis**

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

- For the purpose of Availability Analysis for Adult Psychiatrists, Child Psychiatrists and Psychiatric Therapist practitioner types, KPSC uses a standard of 15 miles (*which is generally accepted to be equivalent to 30 minutes or less*) in our GeoAccess reporting.
- For the purpose of Availability Analysis for Addiction Medicine MD’s and Substance Use Practitioner types, KPSC uses a standard of 30 miles (*which is generally accepted to be equivalent to 60 minutes or less*) in our GeoAccess reporting.
• KPSC evaluates geographic access at the Chemical Dependency program level.

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

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

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

Behavioral Health Facility Planning

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

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

Potential projects are prioritized and phased by the Region, as part of the overall planning process. Once approved, the projects are executed throughout the year, per the overall capital plan.

7. Assessment of Behavioral Health Network Adequacy

KPSC conducts an assessment of member experience accessing the network which includes:

- Quarterly analysis of member complaints and grievances/appeals
- Annual behavioral health member survey

Analysis of the member experience results includes consideration of whether the complaints and grievances/appeals are specific to particular geographic areas.

KPSC prioritizes identified improvement opportunities from analysis of availability, accessibility and member experience results.

- KPSC identifies at least one opportunity for improvement and implements interventions
- KPSC measures the effectiveness of the interventions.
8. Collaboration between the Organization and Behavioral Health Specialists

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

**Behavioral Health Clinical Practice Guidelines**

- The organization is accountable for adopting and disseminating clinical practice guidelines relevant to its enrolled membership for the provision of acute, chronic and behavioral health services.

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

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

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

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

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

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

- Collaborative Disease Management Programs which involve medical care and behavioral health care providers working together to provide care for our members.

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

Depression Care management is an evidence-based collaborative care program for patients with mild-to-moderate depression in a primary care setting. The program is administered by trained mid-level providers, nurses and social workers that specialize in the treatment of depression. A full Depression Care Management team is comprised of the following:

- Population Care Management Support Coordinator (PMSC)
- Level 1 Care Manager (RN, LCSW)
- Level 2 Care Manager (PA/RNP/LCSW)
- Administrative Champion
- Consulting Physician Champion
  - Primary Care
  - Psychiatry

The medical center depression care management (DCM) teams interface with the primary care teams throughout a medical center service region to assist with the implementation of evidence-based guidelines for identifying, diagnosing, and treating depression.

- Primary care teams are encouraged to refer patients to the DCM program when a patient scores 10 or higher on the Patient Health Questionnaire (PHQ9), or when they feel the patient needs further assessment and in depth discussions about treatment options for their depression.

- Referrals to the DCM program are processed within 3 business days. The level 1 care manager has first contact with the patient and does a full assessment of their depression symptoms, readiness for treatment, and then referral to either health education, internet-based programs,
Level 2 care manager, or psychiatry depending upon the severity of the patient’s symptoms, their readiness for treatment, and their treatment preferences provide a combination of behavioral activation and problem solving treatment using motivational interviewing for a minimum of 3 months and a maximum of 12 months.

Most patients average 6 months in the program.

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

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

Program outcomes are excellent with 48% remission and 76% improvement in depression symptoms after an average 6 months of treatment. These outcomes are better than those reported for national programs based on the same model of care (25% remission and 68% improvement).

9. Continuity and Coordination between Medical Care and Behavioral Healthcare

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

At least annually, the organization collects data about the following opportunities for collaboration between medical and behavioral health care:
Exchange of information

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

Appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care

BHC clinicians are involved in a collaborative guideline development and review process of clinical practice guidelines related to Mental Health and/or Addiction Medicine with Medical Care colleagues.

Appropriate uses of psychotropic medications

KPSC monitors performance related to the HEDIS Antidepressant Medication Management measure collaboratively with Behavioral Health and Medical Care Practitioners.
Management of treatment access and follow-up for members with coexisting medical and behavioral disorders

KPSC collects data and monitors performance of behavioral and medical practitioner adherence to prescribing guidelines.

Collaborative efforts between the medical care and behavioral health care on improving the HEDIS measures *Antidepressant Medication Management or Follow-Up Care for Children Prescribed ADHD Medication* meets the requirements of this factor.

Primary or secondary preventive behavioral health program implementation.

KPSC collects data and monitors performance on issues that could be preventable if appropriate primary or secondary program were developed and implemented. KPSC also identifies the programs that the collaboration deems most appropriate and implements them.

Special Needs of Members with Severe and Persistent Mental Illness

The organization collects data on specific issues around the continuity and coordination of services for members with severe and persistent mental illness. Areas of focus may include suicide prevention and members with substance use problems.

10. **Medi-Cal Services**

**CHEMICAL DEPENDENCY OR SUBSTANCE USE DISORDER BENEFIT & COVERAGE POLICY**

*The information in this policy is strictly confidential and proprietary to the Health Plan. No part of this policy is to be distributed outside of Kaiser Permanente without the express written consent of the Health Plan Regulatory Services, Benefit Interpretation and Consulting Unit.*

Chemical dependency also known as Substance Use Disorder (SUD) services are covered Medi-Cal benefits and are available through county alcohol and drug programs as part of the Drug Medi-Cal program.
Chemical Dependency or Substance Use Disorder Coverage

- Chemical dependency services are not covered benefits by Health Plan except for:

- **Emergent Acute Inpatient Detoxification** - the medical management of active withdrawal symptoms. Coverage for emergent inpatient detoxification would be the same as any other medical condition that requires inpatient hospitalization.

- **Alcohol Misuse Screening Services** - screening, brief Intervention, and referral to treatment (SBIRT) for members ages 18 and older as follows:
  
  - **Covered Alcohol Misuse Screening services:**
    - One expanded screening for risky alcohol use per year
    - Three 15-minute brief intervention sessions to address risky alcohol use per year

Mental Health Services

Benefit includes non-specialty, outpatient behavioral health services, labs, meds, consults. Specialty mental health services stay as County responsibility.

- KPSC conducts a thorough evaluation to determine if the MediCal member meets local “specialty care services” as defined by Counties. If the member is believed to meet the “specialty care service” definition, KPSC directs the member to the appropriate County resources who conduct an evaluation and to make final determination of whether the member meets their criteria for “specialty care” service.

11. **Patient Safety & Significant Events**

These events are handled at the medical centers through local Significant Event reporting processes. Refer to the Regional Risk Management/Patient Safety Program Description for further information. An integrated quality plan reflects patient safety activities for behavioral health members.
12. Oversight of Contracted BHC Providers (Facilities) & High Volume Practitioner Offices

In collaboration with the appropriate local and regional Quality and Credentialing staff, a BHC Department Administrator, BHC Chief of Service or designee provides expert consultation in regards to contracting for new providers or practitioners. As part of the on-going oversight process, a BHC Department Administrator, BHC Chief of Service or designee is involved in review of relevant quality measures/issues.

Newly contracted BHC Providers (offices) receive an initial site visit if the facility is un-accredited. Accredited facilities may provide their accreditation certificate and/or receive an initial site visit if deemed necessary.

Ongoing monitoring of contracted BHC Providers (facilities) includes review of quality & complaint data on at least an annual basis. More frequent reviews are conducted should specific quality issues be identified for a provider. A site visit is required at least every three years for non-accredited providers. Accreditation status is monitored annually for accredited providers.

Oversight activities of contracted providers and practitioners are reported to the Regional Credentialing Committee and to the SCQC at least on annual basis.

13. Behavioral Health Help Line and Triage and Referral Process

The Behavioral Healthcare Helpline is an adjunct service to support the operations of the Southern California Regional BHC services. The Helpline is a 24 hour/day, 7 day/week crisis line that is answered
live by a staff composed of Licensed Clinical Social Workers and Marriage Family Therapists. All staff that answer the Helpline are California Licensed Mental Health professionals.

The staff responds to crisis calls and informational calls from members, as well as employee assistance professionals. The interventions of the clinician are guided by protocols. Along with providing crisis intervention and information, they facilitate access to Kaiser medical offices and/or emergency departments.

The Behavioral Healthcare Helpline Coordinators are supervised by a Licensed Clinical Social Worker with post-Master’s clinical experience. A board certified Psychiatrist with experience in clinical risk management oversees all clinical operations.

Triage and referral are guided through the approved protocols which are reviewed and approved every two years by the BHC Helpline Management Group and are approved by the Southern California Quality Committee. The protocols address appropriate mental health and substance abuse situations for the Kaiser Permanente membership. Each protocol describes the level of urgency appropriate for the situation and the setting of care needed.
Risk Management Patient Safety Program Description 2017

Southern California Health Plan Hospital Kaiser Permanente
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Kaiser Permanente Safety Strategy

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

2017 Driver Diagram
Primary Drivers: Accountability, Resilience, and Reliability

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

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

a. Patient Safety Huddle Calls: Biweekly regional inter-professional call to discuss serious patient safety events. Teams involved in the event discuss the issues, learnings and action plans resulting from the analysis. All care providers are encouraged to participate. The regional safety team will ensure that any specific information important to share broadly will be included in communication forums.

b. Health Care Ombudsman (HCOM): The HCOM assists patients and providers with concerns about unanticipated adverse outcomes, medical errors, provider-patient communication breakdown, and dissatisfaction with treatment outcome or quality of care. The HCOM navigates the dynamics of patient-provider communication and the relational aspects of dispute resolution with sympathy and empathy. The four cornerstones of this unique role, is independence, neutrality/impartiality, confidentiality, and informality. The HCOM does not participate in any formal processes of event investigation, such as a Comprehensive Systematic Analysis.

c. Early Resolution: When an unanticipated adverse outcome affects a patient, there are circumstances when the executive leadership team will offer financial assistance to assist the patient and/or family with unintended expenses that may have resulted due to the event itself. The intent of early resolution is to lessen the burden of the immediate problem, not to deter litigation.

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

a. Communicating Unanticipated Adverse Outcomes (CUAO) / Situation Management Team (SMT) Calls: The reactive side of risk management requires a team of experts to understand how to deal with presenting crisis in real time. As close to the event as possible, a core group with defined leadership expertise will convene to discuss unanticipated adverse patient care outcomes. The SMT will work out the details of how the disclosure to the patient and or family member(s) will take place and what immediate steps are needed to repair patient/family members, provider/staff, and organization.

b. Executive Summaries: Certain risk issues unfold from event analysis that require each medical center executive leadership team to be accountable to implementing the action plans identified to prevent re-occurrence. The communication
channel for these is through an Executive Summary. At the Southern California Quality Committee (SCQC), each medical center will report out on their progress in completing the action plans laid out within the Executive Summary.

c. **Unusual Occurrence Reporting Online (UOR-O):**

Healthcare team members are encouraged to identify patient safety issues through the online event reporting system. This is a system where team members can report anonymously if they chose. This is a confidential system that is protected under the quality privilege. Reports from this system can identify trends to consider pro-active patient safety improvements.

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

a. **Learning Climate and Speaking Up Indices from the People Pulse Annual Survey:** There is substantial evidence in safety science, that a healthcare team’s attitudes related to comradarie and teamwork within their department, correlate with better clinical outcomes for the care they deliver. The People Pulse survey is administered annually and integrates questions that enable a better understanding of the culture of safety for a given department. Currently SCAL is working on transferring the physician wellness survey into People Pulse, and assuring that the questions specific to Learning Climate and Speaking Up are embedded. This will enable every member of the healthcare team to have a voice in the safety culture annual assessment.

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

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

2. **Resilience**: The ability of physicians, other clinicians and employees, and the organization, to function optimally, recover from setbacks, adapt well to change, and make improvements in the face of adverse events while continuing to function. Resilience has two functional domains that promote this driver:

   I. **Individual**: Fostering emotional, physical and mental harmony within our healthcare teams to support engagement from our workforce when providing care to our patients. Initiatives that support individual resilience include:

   a. **Empathy Programs / “KP Cares” / Employee Assistance Program (EAP)**: It is important to recognize and address the wellness of the Second Victim (healthcare team member(s) involved in the patient harm event) when a medical error occurs. Addressing the devastation that a team member may feel, in the aftermath of a patient harm event, is critical to the wellness of physicians, clinicians, and employees. A variety of programs are available to promote recovery and resilience to healthcare team members. Staff and physicians are encouraged to participate.

   b. **Good Catch Awards**: Awards that celebrate physicians and employees who trapped a patient safety harm event before it touched the patient are routinely given out at medical centers. Quarterly, the medical centers have the opportunity to nominate their local medical center Good Catch Awards for a Regional Good Catch Award. Rewarding proactive surveillance of patient safety will foster resilience and encourage team members to speak up for safety.

   II. **Organizational**: Hardwiring the organizational culture that values patient safety training, learning from harm events, and adopting transparent venues in which to share and learn and spread best practices. Initiatives that support organization resilience include:

   a. **Just Culture Promotion**: Individuals involved in a patient safety event are evaluated in an objective process to understand individual accountability. System issues are separated from individual culpability. A standard algorithm is used to categorize reckless actions, at risk actions, and system induced human errors. An important component of this algorithm involves a substitution test to discern if other healthcare team members would do the same thing, given the same circumstance. This allows understanding if department education is needed, rather than assuming the team member should have known the right procedure. Aside from this standard tool to guide event management, all members of the healthcare team, including the patients, are always encouraged to speak up about any concerns they have.
Leaders promote a speaking up culture during rounds, town halls, huddles, and department meetings.

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

3. **Reliability**: The ability of the healthcare system to consistently perform its intended function or mission, in spite of complexity and risk, without diminished performance or failure. This primary driver has three functional domains that promote reliability:
   
   I. **People**: Promoting teamwork and active communication amongst the healthcare team and amongst our patients and family will enable consistent performance across the organization. Initiatives that support people include:

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

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

   c. **High Reliability Teams (HRT)**: Many high risk departments are working on standardizing safety practices, making it easy to do the right thing, and incorporating briefings / huddles into their daily workflows. Interprofessional teamwork and communication are the practices that are emphasized within these teams. The Perinatal Patient Safety Program is the first example of a department that adopted the HRT program. They were the first area to rehearse emergencies then debrief the process.

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

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

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

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

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

d. Clinical Information System Quality and Patient Safety Committee: The importance that the electronic medical record and all the technology programs that interact with it (lab, pharmacy, imaging, membership legacy systems, etc.) can not ever be overlooked. Constant vigilence and identification of clinical system technology glitches are continually under surveillance and escalated as needed.
III. Safety Science: To become a High Reliability Organization, a continual effort to proactively identify hazards, redesign clunky systems, and scale and spread successful evidence-based leading practices. Initiatives that support safety science include:

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

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

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

Utilization Management Program Description
2017

KAISER FOUNDATION HEALTH PLAN
SOUTHERN CALIFORNIA REGION
I OVERVIEW
Kaiser Permanente Southern California (KPSC) is an integrated healthcare delivery system composed of three closely aligned organizations, Kaiser Foundation Health Plan (KFHP), Kaiser Foundation Hospitals (KFH) and the Southern California Permanente Medical Group (SCPMG).

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

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

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

II UTILIZATION MANAGEMENT PRINCIPLES

UM Principles
The KFHP UM Program and associated documentation is organized for staff, members, practitioners and others to understand the program structure, scope, processes and oversight. The UM Program is comprised of both utilization and resource management (RM) activities and functions. UM activities 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. The KFHP UM Program is subject to direct regulation under the Knox-Keene Act.

Resource Management is the collective set of actions KFHP undertakes to ensure the affordability and quality of health care services delivered to its members. Activities focus on prudent and clinically appropriate allocation of resources in the provision of health care services.

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

KFHP promotes open practitioner-patient communication regarding appropriate treatment alternatives and options without penalizing practitioners for discussing all medically necessary

1 Section 1367.01 (a) of the Knox Keene Act
or appropriate care with the member. KFHP does not reward, hire, promote, or terminate practitioners or other individuals for issuing denials of coverage or care.

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

III UTILIZATION MANAGEMENT PROGRAM GOALS AND OBJECTIVES
The goal of the KFHP UM program is to ensure the appropriate, high quality, cost effective utilization of Medical and Behavioral Health Care services and resources for all members, through:

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

IV KAISER FOUNDATION HEALTH PLAN UTILIZATION MANAGEMENT LEADERSHIP STRUCTURE
The KFHP UM Program is led by Kaiser Permanente Executives: Health Plan Physician Advisors (HPPA), the SCPMG Regional Physician Director of Psychiatric Utilization Management, the KFHP Regional Executive Director of Utilization Management and Resource Stewardship and the SCPMG Regional Chief Administrative Officer. These individuals work in partnership to oversee and ensure the effective implementation of the KFHP UM program in compliance with statutory requirements and accreditation standards.

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

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

- Guidance and oversight of UM Program daily operations;
- Oversight of delegated UM functions performed on behalf of the Plan;
- Development and update of UM policies and for communication of UM decisions to providers and members;
- Review and update of UM criteria developed in compliance with statutory requirements and accreditation standards at least annually;
- Development of UM clinical criteria and guidelines by SCPMG providers to ensure that they are consistent with sound clinical principles and professionally recognized standards of care;
- Evaluation of member and practitioner experience with the UM Program and processes;
- Surveillance of the healthcare delivery system to identify potential UM activities through the review of UM appeals, Independent Medical Review (IMR) cases related to medical necessity denials and other cases as warranted (e.g. reconstructive surgery);
- Communication with the SCAL Regional Health Plan President and the Southern California Quality Committee regarding the activities and findings of the UM Program at least annually.
- Active participation in the implementation, supervision, oversight, and evaluation of the Utilization/Drug Utilization Review (DUR) program for Medicare Advantage (MA) and Prescription Drug Plans (PDP) in the SCAL region to include adhoc communication to the Medical Director regarding:
  - Situations that have potential for KFHP, Inc. operation-wide concern, i.e., may impact all Medicare Advantage plans, Cost plans and PDPs;
  - Situations where the region feels the organization is at risk, i.e. coverage decisions involving medical necessity;
  - Consultative advice regarding Medicare Advantage (MA) and Prescription Drug Plans;
  - Notification of decisions on appeals from an Administrative Law Judge(ALJ) or Medicare Appeals Council (MAC)

Regional Physician Director of Psychiatric Utilization Management, SCPMG
The SCPMG Regional Physician Director of Psychiatric Utilization Management is the designated behavioral health care practitioner for the KFHP UM Program. This board-certified psychiatrist partners with the HPPA to ensure that UM of behavioral health care services is aligned and in parity with the UM of medical care. Hence, the Regional Director oversees the development and implementation of UM policies and criteria, utilization review and decisions and triage and referral processes for behavioral health care services.
Regional Executive Director, Utilization Management and Resource Stewardship, KFHP
The Executive Director, Utilization Management and Resource Stewardship, is responsible for the implementation and evaluation of the KFHP UM Program and ensures that KFHP complies with notice requirements which result from a utilization management decision, i.e., all services that require prior authorization. The Executive Director provides operational and consultative support for UM functions performed by KFHP, KFH and SCPMG across the continuum of care. The Executive Director maintains liaison relationships with the KFHP Quality Management Program and with State and Federal programs that oversee the KFHP UM Program.

Regional Chief Administrative Officer, SCPMG
The Regional Chief Administrative Officer co-chairs the Utilization Management Steering Committee (UMSC) in partnership with the HPPA to ensure the effective and efficient utilization of resources/services to KP members across the continuum of care. The Regional Chief Administrative Officer ensures an effective UM program structure with appropriate scope and processes in compliance with requirements of state/federal and accrediting entities.

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

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

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

Utilization Management Steering Committee (UMSC)
[REFER TO ADDENDUM 1: UMSC CHARTER] The Utilization Management Steering Committee (UMSC) is a sub-committee of SCQC that ensures the effective implementation of the UM program across the continuum of care in compliance with statutory requirements and accreditation standards. The committee is chaired by KFHP Health Plan Physician Advisors and SCPMG Chief Administrative Officer. The committee members represent a cross-section of KP Leadership to include the SCPMG Regional Physician Director of Psychiatric Utilization Management, Health Plan UM, Health Plan Quality Management, Health Plan Membership Services, Health Plan and Regulatory Services, SCPMG Physicians and Behavioral Health Care Services.
UMSC oversees utilization management across ambulatory, acute and post-acute care settings and reviews and resolves operational issues affecting successful UM functions in compliance with statutory requirements and accreditation standards. The Committee establishes UM standards and policy, and develops utilization performance targets and goals annually. The Committee makes inquiries and takes action on UM issues as appropriate and recommends UM resource allocation.

**Kaiser Foundation Health Plan, Southern California Region**

Utilization Management Program Reporting Structure

- Kaiser Permanente Health Plan/ Hospital Board of Directors
- Quality and Health Improvement Committee QHIC
- Southern California Quality Committee SCQC
- Utilization Management Steering Committee UMSC

**Scope of Services**

- Acute Care Services
- Ambulatory Services
- Ancillary Services
- Behavioral Health Care Services
- Care/Case Management Services
- Continuing Care Services
- Durable Medical Equipment
- Emergency HealthCare Services
- Medical Transportation Services
- Outpatient Services
- Pharmacy Services

**VI KAISER FOUNDATION HEALTH PLAN UTILIZATION MANAGEMENT SCOPE OF SERVICES**

[FOR A DETAILED LIST OF SERVICES, REFER TO ADDENDUM 2: SCOPE OF THE UTILIZATION MANAGEMENT PROGRAM]

The scope of medical and behavioral health services subject to the KFHP UM Program includes, but is not limited to: outpatient, acute and post-acute care, specialty referrals, drug, pharmacy and imaging/diagnostic services, emergency services as well as specialized services including acupuncture, organ transplantation and transgender surgery.
The scope of the BH UM program is included in KFHP UM Program structure. Behavioral Health Care Services, including Psychiatry and Addiction Medicine, is an integrated component of the KFHP UM Program. UM activities occur at multiple behavioral health service sites and levels of care, including intensive outpatient, partial hospitalization and inpatient settings.

VII DECISION MAKING PROCESS FOR PRACTITIONER REQUESTED SERVICES SUBJECT TO AUTHORIZATION REVIEW OVERVIEW

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

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

UM notices involving a decision to deny, delay or modify a provider-requested service are processed through the Regional Utilization Compliance and Consultation Center (RUC). RUC is staffed with Registered Nurses, Consultants, Project Managers, Analysts, and Administrative Support who ensure that UM decisions are made and communicated timely and that notice letters include a clear and concise reason for the denial, UM criteria to support the decision and a clinical explanation to the member. RUC staff provide telephonic consultation and training to Medical Center-based decision-makers and support staff regarding benefit interpretation, coverage decisions, and denial notification requirements.

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

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

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

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

Practitioner requested services that require prior and/or concurrent authorization include:

[REFER TO ADDENDUM 3: REQUESTED SERVICES THAT REQUIRE PRIOR AUTHORIZATION]
- Acupuncture Services
- Acute Inpatient Medical Care in Non KFH Facilities (continued stay requests)
- Acute Inpatient Psychiatric Care in Non KFH Facilities (continued stay requests)
- Behavioral Health Treatment for Autism Spectrum Disorder (for re-authorization request only)
- Community Based Adult Services (CBAS) Services
- Dental Anesthesia
- Durable Medical Equipment (DME)/Prosthetics and Orthotics (P&O)/Soft Goods
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Supplemental Shift Nursing Services
- External (Out-of-Plan) referrals (including post stabilization care requests)
- Home Health Continuous Shift Care
- Home Venipuncture
- Occupational and Physical Therapy Services (not available in plan)
- Organ Transplantation Services
- Plastic Surgery Consultation for Breast Reduction Mammoplasty
- Plastic Surgery Consultation for Panniculectomy
- Post Stabilization Acute Inpatient Medical Care in Non KFH Facilities
- Post Stabilization Acute Inpatient Psychiatric Care in Non KFH Facilities
- Residential Treatment for Behavioral Health Disorders (continued stay)
- Speech and Language Therapy Services (not available in plan)
- Spinal Cord Stimulators for the Management of Chronic Pain
- Transgender Surgical Procedures

**UM Decisions**

**Prior Authorization – Review and Decision**

When prior authorization (PA) is required, any practitioner request for a PA listed service must be reviewed and approved by the Plan prior to care being rendered. The prior authorization review and decision is made by SCPMG Assistant Area Medical Directors (AAMD) and/or Chiefs of Service (COS). Prior authorization is performed utilizing UM criteria which is developed in accordance with statutory requirements and accreditation standards, and consistent with professional standards of care. Prior authorization reviews are processed according to the urgency of the request.
Continued Care Authorizations in Out of Plan Facilities (Inpatient/Outpatient) – Review and Decision

Any practitioner request to extend a previously approved ongoing course of treatment, requesting additional time or adding to the number of treatments, is subject to prior authorization.

Post-Service Authorization (Retrospective) – Review and Decision

Care or services that have already been received will be reviewed and a decision will be made regarding whether such care will be authorized by the Plan. For example, a request for coverage of care that was provided by an out of network or contracted practitioner and for which the required prior authorization was not obtained, is subject to retrospective review and a post-service authorization decision.

VIII SERVICE SPECIFIC UTILIZATION MANAGEMENT REVIEW PROGRAMS

Refferrals Management

[REFER TO REGIONAL UTILIZATION MANAGEMENT POLICY AND PROCEDURE 1: CONSULTATION, REFERRAL AND SECOND OPINION PROCESS]

Out of Plan Referrals

Prior authorization is required for all out of plan referrals requesting consultation and/or treatment. Physician requested Outside Care Referrals are processed through the Outside Referrals Department (ORD).

Out of Plan – Second Opinions

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

Out of Plan – Organ Transplantation

SCPMG physicians may refer members for Organ Transplantation Evaluation for kidney, heart, lung, heart/lung, liver, small bowel, simultaneous kidney pancreas, pancreas alone and blood/marrow (stem cell) transplantation. Members are referred to contracted Centers of Excellence (COE) within Kaiser Permanente’s National Transplant Network (NTN). Referrals outside of the NTN are facilitated through an exemption process. Organ-specific transplant committees review cases referred for transplant evaluation using organ-specific patient selection criteria developed through current medical literature, research and knowledge. The National Transplant Services (NTS) organ-specific Clinical Management Committees (CMC) review the organ-specific patient selection criteria at least twice annually. Cases approved by the organ-specific transplant committee are referred to the appropriate transplant COE for final determination of transplant candidacy. If a COE determines that a member is not a suitable candidate for organ or stem cell transplantation, the member may request a second opinion and/or file the grievance with the Health Plan.
Standing Referrals
Members are provided standing referrals to a SCPMG or contracted specialist or specialty care center when the member’s primary care provider (PCP) determines, in consultation with the specialist, that the member needs continuing care from a specialist and that the member requires specialized care over a prolonged period of time for the purpose of having the specialist coordinate the health care, including HIV/AIDS.
A treatment plan is developed, in consultation with the PCP, specialist and member, that describes the course of care, number of visits to the specialist and the period of time that the visits are authorized. A provider request for a Standing Referral to facilitate continuing specialist care from an out of plan provider is subject to UM review. If care is rendered outside the KFHP contracted care delivery network, the specialist reports to the PCP on the care provided to the member.

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

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

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

Durable Medical Equipment (DME)
Provider requests for DME, including Prosthetics and Orthotics (P&O), requires prior authorization and benefit coverage review using DME Formulary UM criteria. In the event a request does not meet DME UM criteria, a DME Physician Champion reviews the request for medical appropriateness. All DME benefit decisions are made by trained staff; medical necessity denial decisions are rendered by SCPMG physicians and appropriate denial notices are issued to the provider and member by KFHP.

Emergency Services and Hospital Admissions Out of Plan Screening and Stabilization
KFHP does not require prior authorization for emergency services. Post-service claims review considers whether the member’s decision to present to the Emergency Department was reasonable under the circumstance.

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2 California Health and Safety Code Section 1373.96
Post-stabilization
KFHP requires review and authorization for all out of plan post-stabilization care, and follows all statutory requirements and accreditation standards in making post-stabilization care authorization decisions.

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

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

Outside Utilization Resource Service (OURS)
[REFER TO REGIONAL UTILIZATION MANAGEMENT POLICY AND PROCEDURE 17, OUTSIDE UTILIZATION MANAGEMENT PROCESSES]
OURS is a centralized program that oversees the utilization of services, and coordinates the care for KFHP members receiving inpatient or other relevant health care services out of network. OURS is staffed 24/7/365 by qualified nurses with real-time access to dedicated physician advisors. OURS responsibilities include, but are not limited to:

- Conducting concurrent reviews for on-going acute hospitalization of members in out of Plan facilities;
- Conducting a UM review of member care, provided by an outside facility prior to request for authorization from the Plan, for medical necessity;
- Responding to provider requests for inpatient post-stabilization authorizations within the required regulatory timeframes;
- Ensuring that the form and content of all such authorization responses are consistent with statutory requirements and accreditation standards;
- Offering and arranging stable member transfer to a KFHP-designated facility when continued acute care is still required and transfer is not medically contraindicated.

Behavioral Health Care (BHC) Utilization Management
BHC services are subject to the same UM review processes and Plan oversight as provided for medical care. Review processes include benefit coverage determination for and medical necessity determination for all Plan and non-plan mental health admissions. BHC UM utilizes and adopts commercially recognized criteria sets to assist in the provision of BHC services in the appropriate setting and at the appropriate level of care. All criteria sets are reviewed annually and/or revised as appropriate by licensed and board certified physician specialists within SCPMG.

The BHC UM program supports the overall KFHP UM program in tracking and managing the coordination of services between medical and mental health services at the appropriate level of care. The BHC UM program operates 7 days per week and is staffed by Registered Nurses (RN) and Licensed Clinical Social Workers (LCSW) who have experience in inpatient psychiatric work. The staff performs daily concurrent UM reviews, consults with SCP ME mental health
IX UTILIZATION MANAGEMENT DECISION TIMEFRAMES

Decisions to approve, modify, or deny a requested health care service are based on medical necessity and urgency of the request, and are appropriate for the nature of the member’s condition. Decision timeframe should not exceed five business days from the Plan’s receipt of relevant information reasonably necessary to make a determination.

In the case of a retrospective review, the decision is communicated to the individual who received services, or to the individual’s designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and is communicated to the provider in a manner that is consistent with statutory requirements and accreditation standards.

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

X UTILIZATION REVIEW CRITERIA

UM Criteria

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

KFHP UM criteria are:

- developed with involvement from actively practicing health care providers;
- consistent with sound clinical principles and processes;
- evaluated, and updated if necessary, at least annually;
- When used as the basis of a decision to modify, delay, or deny services in a specified case under review, are disclosed to the provider and the enrollee in that specified case;
- available to the public upon request.

UM Criteria sets include, but are not limited to:

- Acupuncture Services
- Behavioral Health Treatment for Autism Spectrum Disorder (for re-authorization request only)
- Durable Medical Equipment (DME)/Prosthetics and Orthotics (P&O)/Soft Goods
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Supplemental Shift Nursing Services
- Home Venipuncture
- Occupational and Physical Therapy Services (not available in plan)
- Organ Transplantation Services
- Plastic Surgery Consultation for Breast Reduction Mammaplasty

footnote

3 Section 1367.01(h) of the Knox-Keene Act
• Plastic Surgery Consultation for Panniculectomy
• Speech and Language Therapy Services (not available in plan)
• Spinal Cord Stimulators for the Management of Chronic Pain
• Transgender Surgical Procedures

KFHP also utilizes commercial criteria sets published by McKesson, Inc. and benefit coverage criteria published by government programs such as Medicare and Medi-Cal to include:
• InterQual® Criteria: Procedures (adult, pediatric) Imaging, Specialty referral, Level of care (adult, pediatric)
• InterQual® Criteria: Behavioral Health Care InterQual Criteria: Adult and Geriatric psychiatry, Child and Adolescent psychiatry, Substance use disorder, Procedures
• InterQual® Criteria Level of Care Adult Pediatric
• Medicare Coverage Guidelines
• Medi-Cal Coverage Guidelines

Inter-Rater Reliability
[REFER TO REGIONAL UTILIZATION MANAGEMENT POLICY AND PROCEDURE 8: CONSISTENCY IN UTILIZATION REVIEW CRITERIA / GUIDELINE APPLICATION (INTER-RATER RELIABILITY)]

An Inter-Rater Reliability (IRR) process is deployed to evaluate and ensure that UM criteria are applied consistently for UM decision-making. Annually, both physicians and staff involved participate in the IRR process.

XI WRITTEN NOTICES OF UM DECISIONS

When a physician requests a health care service that is subject to prior authorization and the request has been reviewed, approved, modified or delayed as a result of UM review, the member and provider are provided a written communication that includes the following required elements:
• A clear and concise explanation of the reasons for the Plan’s decision;
• A description of the utilization review criteria used, and the clinical reasons for the decision regarding medical necessity;
• Information as to how the member may file a grievance with the Plan and, in case of Medi-Cal members, information and explanation on how to request an administrative hearing in compliance with Title 22 of the California Code of Regulations;
• Notice of availability of language assistance services;
• Written notice to physicians or other health care providers of a denial, delay, or modification of a request, including the name and telephone number of the health care professional responsible for the decision. The telephone number is a direct number or an extension that allows the physician or health care provider easy access to the professional responsible for the UM decision. UM staff and physicians are available during normal business hours to assist members and physicians with UM concerns;
• Written Notice to the physician and member includes information on Independent Medical Review4.

4 Section 1374.30(j) of the Knox Keene Act: No later than January 1, 2001, every health care service plan shall prominently display in every plan member handbook or relevant informational brochure, in every plan contract, on enrollee evidence of coverage forms, on copies of plan procedures for resolving grievances, on letter of denials issued by either the plan or its contracting organization, on grievance forms (Section 1368), and on all written responses to grievances, information
Denial notices are issued in accordance with applicable regulations and accreditation standards. The HPPA, Regional UM and Health Plan Regulatory Services Department (HPRS) provide direction to and oversight of the process of issuing written notification of non-coverage to KFHP members.

XII DISCLOSURES OF UTILIZATION MANAGEMENT PROGRAM AND CRITERIA
KFHP is responsible to ensure compliance with statutory UM Program disclosure requirements in accordance with Section 1363.5(a) of the Knox Keene Act, and any other statutory requirements and accreditation standards. The disclosure to regulators and to network providers references the process used to authorize, modify, or deny health care services under the benefits provided by the Plan. KFHP includes on its internet website, a summary describing the process by which the Plan reviews and authorizes or approves, modifies, or denies requests for health care service. Enrollees and members of the public may receive a copy of UM Policies and Procedures upon verbal or written request to the Member Services Call Center.

The criteria or guidelines used by the Plan, or any entities with which KFHP contracts, that include utilization review to determine whether to authorize, modify, or deny health care services, are disclosed to the provider and the member as appropriate. The criteria/guidelines are available to the public upon request. The disclosure is accompanied by the following notice:

“The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract.”

XIII GRIEVANCE AND RECONSIDERATION (APPEALS) PROCESSES

Notice of Right to Appeal a UM Decision
When a member receives notice that a provider requested service has been denied or modified through the plan’s utilization review process, the member has a right to appeal and is given information on the process to appeal the UM decision through Member Services. [SECTION 1368][50-2F] FEDERAL EMPLOYEE HEALTH BENEFIT PROGRAM (FEHBP)], 50-2CSI |CALIFORNIA SELECT INSURANCE (CSI)], 50-2M [MEDI-CAL], 50-2C [MEDICARE PART C] AND 50-2D [MEDICARE PART D].

Appeal Decision Process
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 determination on behalf of the member. Advisors to the JRAC include legal counsel, the HPPA and other physicians competent to evaluate the specific clinical issues presented in the request for review. Other representatives include staff from HPRS and Member Services. The JRAC is chaired by the Director of the Regional Member Case Resolution Center and is staffed by Regional Member Relations Senior Health Plan representatives. Appeals are reviewed, resolved and communicated within applicable statutory and regulatory timeframes and notice requirements.

concerning the right of an enrollee to request an independent medical review in cases where the enrollee believes that healthcare services have been improperly denied, modified, or delayed by the plan or by one of its contracting providers.

5 Section 1363.5(c) of the Knox Keene Act
Expeditied Review and Expedited Appeals

All KFHP members have the right to ask for an expedited decision on pre-service or concurrent requests for health care services and supplies, and/or expedited review of decisions to terminate health care services. When a member’s life, health, or ability to regain maximum function could be jeopardized using standard utilization review time frames, or when a provider familiar with the member’s clinical situation states that the need for review is urgent, the appeal is expedited.

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

Independent Medical Review

Commercial and Medi-Cal members can request independent medical review (IMR) on denied appeals involving medical necessity, including requests related to experimental/investigational services and receipt of out of Plan Emergency Department services. The DMHC administers the IMR program in the State of California at no cost to the member in compliance with applicable statutory requirements and accreditation standards. The IMR decision is binding on KFHP.

Medicare Appeals

Managed Medicare member grievances and appeals are processed according to the requirements established by the Centers for Medicare and Medicaid Services (CMS), to include mandatory review of qualifying adverse KFHP reconsideration decisions by the CMS-designated independent review entity (IRE), MAXIMUS Federal Services, Inc., before any KFHP decision is finalized and communicated to the member. The IRE decision is binding on KFHP. A case may be considered for review by the IRE when a disputed health care service/supply/drug has been denied by KFHP at the initial level and upheld during reconsideration, or, when KFHP does not provide a resolution to the member request within the required regulatory timeframe.

All KFHP members have the right to ask for an expedited decision on pre-service or concurrent requests for health care services and supplies, and/or expedited review of decisions to terminate health care services. When a member’s life, health, or ability to regain maximum function could be jeopardized using standard utilization review time frames, or when a provider familiar with the member’s clinical situation states that the need for review is urgent, the appeal is expedited.

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

XIV DELEGATION OF UTILIZATION MANAGEMENT FUNCTIONS

KFHP has the discretion to delegate, and the responsibility to oversee, UM functions performed by either SCPMG or KFH in support of the KFHP UM goals and objectives. KFHP, through the Quality Assurance Program Agreement (QAPA) delineates the respective roles, responsibilities and oversight among KFHP, SCPMG, and KFH that support the UM Program. KFHP also has discretion to delegate responsibility, in whole or in part, for UM to contracted affiliated providers. KFHP retains accountability for all delegated Utilization Management activities conducted for members and ensures that delegated UM processes are designed to meet member service and access needs. [REFER TO ADDENDUM 4: SCAL QAPA]

UM Delegation to Affiliated Providers

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

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

KFHP performs a pre-delegation assessment to ensure the ability and capacity of the delegated entity to perform the UM functions. Based on the pre-delegation assessment and demonstrated ability and capacity to perform certain UM functions, SCQC approves and recommends delegation of UM activities. The final letter of agreement that includes the delegation matrix and the delegation agreement will stipulate specific UM functions as delegated or retained by KFHP. On an annual basis, KFHP performs a comprehensive assessment of the delegated UM activities to include a UM file review. The entity's annual evaluation of delegated UM functions and assessment summaries of activities are presented to UMSC for review and approval.

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

XV RESOURCE MANAGEMENT ACTIVITIES

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

- Drug Utilization
- Laboratory Utilization
- Product Utilization
- Radiology Utilization
- Surgical Utilization

Prior and/or concurrent authorization is not required for services provided in KFH acute medical care hospitals, KFH 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
Management of At-Risk Populations

Care/Case Management Programs

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

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

**Case Management services provided through the Behavioral Health Department:** Case Management services are available to all members with serious and persistent mental health conditions that interfere with their ability to participate in life roles. Typically, patients that benefit from case management are those with a history of frequent psychiatric hospitalizations, diagnosed with addiction diagnoses, and non-adherence to medication/psychiatric follow up.

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

- **Southern California Transplant HUB** provides case management and care coordination for transplant referrals. Transplant coordinators, in collaboration with specialty physicians and multidisciplinary team members, coordinate the care of the member pre-intra- and post-transplant.

- **End Stage Renal Disease (ESRD) Care Management Program** is a coordinated team approach to manage the complex needs of Chronic Kidney Disease (CKD) and End Stage Renal Disease (ESRD) patients. The Program provides a systematic approach of proactive and preventive care focused on improved health outcomes.

- **Medicare Special Needs Program (SNP)** coordinates and helps guide the clinical care management of Medicare members in the SNP program who are frail or high risk for hospitalization.

- **Managed Care Medi-Cal** provides services to a variety of Medi-Cal members administered by the Medi-Cal Managed Care contracts in the counties of Los Angeles, Orange, San Bernardino, Riverside and San Diego. In order to comply with the various contractual requirements associated with managing the special needs of this population, additional services/coordination may be provided within Plan and out of Plan to ensure that these members receive the services required per the contract and benefit agreements.

- **The Patient Centered Medical Home (PCMH) model** focuses on providing personalized, comprehensive, and evidence-based medical care using a physician-led team of professionals. PCMH promotes cohesive coordinated care by integrating the diverse, collaborative services a member may need. Patient decisions are based on the fullest
understanding of information in the context of a patient’s values and preferences.

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

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

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

**XVI CONFIDENTIALITY STATEMENT**  
*Health Insurance Portability and Accountability Act (HIPAA)*  
KFHP complies with all applicable HIPAA requirements supported by HIPAA compliance policies. All HIPAA related policies are accessible to UM Physicians and staff on the Kaiser Permanente Intranet compliance site. Ongoing mandatory education is required for all staff.

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

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

**XVII UTILIZATION MANAGEMENT PROGRAM INTEGRATION WITH KAISER FOUNDATION HEALTH PLAN QUALITY MANAGEMENT PROGRAM**  
The UM Program is an integral part of the KFHP Quality Management Program and incorporates quality, risk and safety processes and initiatives into prospective, concurrent, and retrospective review. Identification of quality, safety and risk incidents, patterns and trends through UM
Clinical review are escalated to the appropriate quality department in a timely manner. Results of monitoring and analysis of utilization of care and services, including over- and under-utilization trends, are integrated into the KFHP Quality Program through reports to the Program’s Quality Committees. Activities related to the KFHP UM Program are reported to SCQC.

Utilization reports that display metrics across regional, service area, and medical center level performance are collected and analyzed to identify improvement opportunities, ensure consistency, and decrease variation in practice and care delivery. UM reports include:
- Coordination of Care
- UM Decision Notification Timeliness and Content
- Evaluation of Member Experience with the UM Program
- Evaluation of Provider Experience with the UM Program
- Pharmaceutical Utilization
- Selected Health Plan Effectiveness Data and Information Sets (HEDIS)
- Use of Service measures, including Behavioral Health Utilization
- UM Grievances and Appeals/Independent Medical Review (IMR)

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

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

## Utilization Management Steering Committee (UMSC)

A Sub Committee of Southern California Quality Committee

### 2017 Charter

| Authority | The President of Kaiser Foundation Health Plan (KFHP), Southern California Region, and the Executive Medical Director, Southern California Permanente Medical Group (SCPMG), are responsible for the implementation of the Kaiser Foundation Health Plan Utilization Management (UM) and Resource Management (RM) Program. The UM/RM Program scope extends across the continuum of care to ensure the provision of efficient and appropriate patient care services based on medical necessity and using healthcare resources efficiently and appropriately.

Oversight responsibility for the KFHP UM/RM Program is assigned to the Southern California Quality Committee (SCQC). As a Sub-Committee of SCQC, the Utilization Management Steering Committee (UMSC), monitors and supports the KFHP UM Program.

The Senior Vice President and Chief Operating Officer, Clinical Operations, KFHP and the Medical Director, Quality and Clinical Analysis, SCPMG, are members of SCQC and executive sponsors for the Utilization Management Steering Committee (UMSC).

| Purpose | The UMSC oversees and supports the implementation, monitoring and evaluation, and continuous quality improvement of the KFHP UM Program to maintain an effective, organized UM program in compliance with applicable Federal and State laws/regulations and standards set forth by accrediting bodies.

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

UM decision-making related to medically necessary treatment decisions is consistent with accepted standards of practice, to include severe mental illness, terminal illness, and benefit mandates such as Reconstructive and Transgender Surgery;

Ensuring Mental Health parity in the development and application of UM policies and procedures;

Oversight, monitoring, evaluation and implementation of processes by which the Plan conducts utilization review;¹

Oversight and monitoring of the timely and accurate communication of UM decisions in accordance with state and federal requirements;

Oversight and monitoring of the entities with delegated UM functions;

Development and annual review of UM criteria with participation by actively practicing physicians in compliance with applicable state and federal requirements;

Telephonic access for requests for authorization of health care services;

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¹ Section 1367.01(a), defines utilization review or utilization management functions as those processes “that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers.”
Appropriately licensed and credentialed physicians/healthcare professionals make UM decisions, based on medical necessity, to deny or modify services requested by providers of healthcare services for plan enrollees;

Oversight and monitoring of UM education and training to all relevant stakeholders;

No financial incentives exist that encourage UM decisions that result in denials or create barriers to care and services.

**UMSC conducts ongoing monitoring to identify potential UM practices within the KP delivery system to oversee the structure of the UM Program and to identify potential quality issues, including:**

Integration of UM into the KFHP Quality Improvement Program to ensure the effectiveness of the Utilization Management Program and to monitor compliance with established UM processes to include:
- evaluation of complaints and assessment for trends
- review of provider referral and specialist care patterns of practice
- review for potential over-under utilization of services
- implementation of performance improvement plans as needed
- mechanisms to communicate actions and results to key stakeholders
- monitor of measures of success related to performance improvement plans
- review and evaluation of other Health Plan committee proceedings

Develop, implement, and periodically review and revise UM policies and procedures in compliance with applicable federal and state requirements and accreditation standards.

Develop, implement, and annually review and update clinical criteria for UM decisions based on sound clinical evidence.

Periodic monitoring and oversight of the Utilization Management/Drug Utilization Review (DUR) program for Medicare Advantage (MA) and Prescription Drug Plans (PDP) in the SCAL region

**UMSC supports the effective implementation of the UM Program to include:**

- Removal of impediments to ensure an effective Utilization Management Program
- Foster optimal communication between all stakeholders regarding utilization management
- Charter performance improvement teams for specific high-priority utilization management issues/initiatives
- Make recommendations regarding resource allocation to ensure success of the Utilization Management program
- Develop and propose recommendations to the President of Kaiser Foundation Health Plan, Southern California Region, and the Southern California Quality Committee (SCQC) in support of and in compliance with all matters related to utilization management
- Coordinate, review and approve information communicated to or from the Southern California Quality Committee (SCQC) related to utilization management
The membership of the Planning Group shall be approved annually by the Southern California Quality Committee. The Voting Membership will include:

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<th>Committee Chairperson(s)</th>
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<td>&gt; Physician Advisors, KFHP</td>
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<td>&gt; Regional Chief Administrative Officer, SPMG</td>
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<th>Vice President, Value &amp; Clinical Operations Support, SCAL Region, KFH/HP</th>
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<td>Executive Director, Utilization Management and Resource Stewardship, SCAL Region, KFH/HP</td>
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<td>Executive Director, Grievance Operations, California and Hawaii Member Services, KFHP</td>
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<tr>
<td>Practice Leader, Regulatory Response, Health Plan Regulatory Services (HPRS), KFHP</td>
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<tr>
<td>Director, Utilization Management, SCAL Region, KFH/HP</td>
</tr>
<tr>
<td>Director, Case Coordination Center, SCAL Region, SPMG</td>
</tr>
<tr>
<td>Director, Survey Readiness Unit, Health Plan Regulatory Services, KFHP</td>
</tr>
<tr>
<td>Physician Leader, Behavioral Health Care, SCAL Region, SPMG</td>
</tr>
<tr>
<td>Physician Leader, Utilization Management, SCAL Region, SPMG</td>
</tr>
<tr>
<td>Group Leader, Quality &amp; Regulatory Services, SCAL Region, KFHP</td>
</tr>
<tr>
<td>Coordinator, Autism &amp; Developmental Disabilities, SCAL Region, SPMG</td>
</tr>
</tbody>
</table>

Confidentiality

All UMSC minutes, reports, recommendations, memoranda, and documented actions are confidential. They are maintained in accordance with KFHP Southern California policies and procedures, and are privileged and protected. All records are maintained in a manner that preserves their integrity in order to assure that patient and practitioner confidentiality is protected.

<table>
<thead>
<tr>
<th>Frequency</th>
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</thead>
<tbody>
<tr>
<td>The Committee shall meet as often as necessary but at least six times per year.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agenda</th>
</tr>
</thead>
<tbody>
<tr>
<td>A standing agenda shall be prepared annually to ensure that the committee oversees the utilization management activities required by regulating agencies.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Minutes</th>
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<tbody>
<tr>
<td>The committee shall keep a permanent record of its proceedings and attendees. All committee minutes shall be provided to the Southern California Quality Committee.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessment of Committee Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>The performance of the committee relative to its charter shall be evaluated annually and shall be reported to the Southern California Quality Committee.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reporting Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>The committee shall provide periodic reports on its activities to the Southern California Quality Committee.</td>
</tr>
</tbody>
</table>
SCOPE OF THE UTILIZATION PROGRAM

The KFHP Utilization Management program is established to ensure an effective and efficient Medical and Behavioral Health Care delivery system. The scope of the Utilization Program spans the care continuum to include, but not limited to the following Medical and Behavioral Health Care services:

A. Acute Inpatient Hospital Services
   1. Medical/Surgical/Maternal Child Health Care
   2. Behavioral Health Care

B. Ambulatory Services;

C. Ancillary Services
   1. Imaging and Diagnostic Services
   2. Therapeutic Services

D. Behavioral Health Care Services
   1. Addiction Medicine
   2. Intensive Outpatient Treatment
   3. Residential Treatment
   4. Behavioral Therapy Services for Autism Spectrum Disorder and Pervasive Developmental Disorder including Speech, Occupational and Physical Therapy
   5. Partial Hospitalization

E. Care/Case Management Services;

F. Continuing Care Services
   1. Home Care Services
   2. Hospice
   3. Palliative Care
   4. Post Acute Care
   5. Long Term Care

G. Durable Medical Equipment/Prosthetics and Orthotics and Soft Goods;

H. Emergency Healthcare Services;

I. Medical Transportation Services;

J. Outpatient Services;

K. Pharmacy Services
<table>
<thead>
<tr>
<th>Requested Service</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture Services</td>
<td>Criteria developed and reviewed by Physical Medicine Chiefs</td>
</tr>
<tr>
<td>Acute Inpatient Medical Care in Non KFH Facilities (continued stay requests)</td>
<td></td>
</tr>
<tr>
<td>Acute Inpatient Psychiatric Care in Non KFH Facilities (continued stay requests)</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Treatment for Autism Spectrum Disorders (for re-authorization request only)</td>
<td><strong>Initial requests</strong> related to treatment of Autism Spectrum Disorders do not require prior authorization</td>
</tr>
<tr>
<td>Community Based Adult Services</td>
<td>Criteria used for Medi-Cal members only based on requests for care received by practitioner, member or member-authorized representative</td>
</tr>
<tr>
<td>Dental Anesthesia</td>
<td>UM Decisions based on Federal and State regulations</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)/ Prosthetics and Orthotics (P&amp;O)/Soft Goods</td>
<td>Criteria developed by DME Formulary Work Group which includes actively practicing physicians in California DME formulary based on Medicare Rules and Regulations and State of California Medi-Cal Provider Manual</td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Supplemental Shift Nursing Services</td>
<td>Services provided to Medi-Cal beneficiaries only less than or equal to 21 years of age</td>
</tr>
<tr>
<td>External (Out-of-Plan) Referrals</td>
<td></td>
</tr>
<tr>
<td>Home Health Continuous Shift Care</td>
<td>Not used for EPSDT Shift Care determinations</td>
</tr>
<tr>
<td>Home Venipuncture</td>
<td>Criteria reviewed by Coumadin Clinic Pharmacist and Continuing Care Physician Leader</td>
</tr>
<tr>
<td>Occupational and Physical Therapy Services (not available in plan)</td>
<td><strong>Initial therapy</strong> requests related to the treatment of ASD conditions do not require prior authorization</td>
</tr>
<tr>
<td>Organ Transplantation Services</td>
<td>Patient Selection Criteria Development and Review: The National Transplant Service clinical management subcommittees develop and recommend to the NTSAC adoption, and publication of evidence-based patient selection criteria and pre and post transplant patient care protocols. Criteria are reviewed annually. <strong>NTS Advisory Council (NTSAC)</strong> provides oversight of the quality management and improvement activities for transplant services The NTSAC is a quality committee and as such its membership is comprised of a majority of physicians. The NTSAC sponsors <strong>clinical management subcommittees</strong> for the following transplant types: thoracic (heart, heart-lung, lung), abdominal (liver, small bowel, SPK, PTA), kidney, blood and marrow. The clinical management subcommittees are comprised of regional PMG specialists with special knowledge in their respective transplant type</td>
</tr>
<tr>
<td>Plastic Surgery Consultation for Breast Reduction Mammoplasty</td>
<td></td>
</tr>
<tr>
<td>Plastic Surgery Consultation for Panniculectomy</td>
<td></td>
</tr>
<tr>
<td>Requested Service</td>
<td>Notes</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Post Stabilization Acute Inpatient Medical Care in Non KFH Facilities</td>
<td>Emergency care does not require prior authorization</td>
</tr>
<tr>
<td>Post Stabilization Acute Inpatient Psychiatric Care in Non KFH Facilities</td>
<td>Emergency care does not require prior authorization</td>
</tr>
<tr>
<td>Residential Treatment for Behavioral Health Disorders (continued stay requests)</td>
<td></td>
</tr>
<tr>
<td>Speech and Language Therapy Services (not available in plan)</td>
<td>Initial therapy requests related to the treatment of ASD conditions do not require prior authorization.</td>
</tr>
<tr>
<td>Spinal Cord Stimulators for the Management of Chronic Pain</td>
<td>Criteria developed, Reviewed Approved by SCAL Physical Medicine Chiefs</td>
</tr>
<tr>
<td></td>
<td>Criteria used to adjudicate out-of-plan requests in Coachella Valley, West Ventura County, and Kern County only</td>
</tr>
<tr>
<td>Transgender Surgical Procedures</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Services Exempt from Prior Authorization for Managed Medi-Cal Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency services</td>
</tr>
<tr>
<td>Family planning services</td>
</tr>
<tr>
<td>Preventive services</td>
</tr>
<tr>
<td>Basic prenatal care in-network</td>
</tr>
<tr>
<td>Sexually transmitted disease services and HIV testing/counseling</td>
</tr>
<tr>
<td>Sensitive and confidential services and treatment</td>
</tr>
<tr>
<td>Outpatient mental health counseling and treatment</td>
</tr>
<tr>
<td>Drug and Alcohol abuse</td>
</tr>
<tr>
<td>Services related to sexual assault</td>
</tr>
<tr>
<td>Obstetrician and Gynecological services in-network</td>
</tr>
<tr>
<td>Out-of-area renal dialysis services</td>
</tr>
<tr>
<td>Urgent Care sought outside of the service area</td>
</tr>
<tr>
<td>Urgent Care under unusual or extraordinary circumstances provided in the service area when contracted medical provider is unavailable or inaccessible.</td>
</tr>
<tr>
<td>Tobacco Cessation</td>
</tr>
</tbody>
</table>
Addendum 4

KAISER FOUNDATION HEALTH PLAN, INC.
QUALITY ASSURANCE PROGRAM AGREEMENT

This Quality Assurance Program Agreement (the “Agreement”), dated as of September 9, 2013, is by and among Kaiser Foundation Health Plan, Inc. (“Health Plan”), Kaiser Foundation Hospitals (“KFH”), The Permanente Medical Group, Inc. (“TPMG”), and Southern California Permanente Medical Group (“SCPMG”). All parties are collectively referred to herein as the “Contracting Parties.”

RECITALS

WHEREAS, the mission of the Health Plan, KFH, TPMG and SCPMG is to provide and/or arrange for the provision of high quality, affordable health care services, and to improve the health of the communities they serve; and

WHEREAS, the Health Plan, KFH, TPMG and SCPMG are each committed to assuring, assessing, and continuously improving the care and service delivered to or arranged for Kaiser Permanente members and patients; and

WHEREAS, Health Plan acknowledges that both TPMG and SCPMG engage in comprehensive quality activities designed to evaluate and ensure the quality of care provided to Kaiser Permanente members and patients and that Health Plan’s quality program uses and builds upon the significant and integral contributions of TPMG’s and SCPMG’s quality activities and functions related to the assessment and improvement of the quality of care provided to members and patients; and

WHEREAS, KFH maintains quality assurance activities pursuant to separate legal and regulatory obligations under California Health & Safety Code, Section 1250 et seq. and Title 42 of the Code of Federal Regulations, Section 482.21. The provisions of this Agreement are not intended to interfere with KFH’s separate quality assurance obligations, but to encourage Health Plan to use and build upon the significant contributions of the KFH quality activities; and

WHEREAS, Health Plan maintains accreditation by meeting standards set forth by the National Committee for Quality Assurance (“NCQA”) and meets federal requirements set forth by the Centers for Medicare and Medicaid Services (CMS) and Medicare Advantage. KFH, TPMG and SCPMG agree to cooperate and support the Health Plan in order to meet all NCQA accreditation and federal program requirements; and

WHEREAS, pursuant to Section 1349 of the Knox-Keene Act, Health Plan has secured a license from the Department of Managed Health Care and must comply with California laws governing licensed health care service plans; and

WHEREAS, KFH, TPMG and SCPMG acknowledge and agree to support the Health Plan in meeting its legal obligation to demonstrate to the California Department of Managed Health Care its compliance with statutes and regulations governing quality of care review, that includes monitoring the quality of care, performance of medical personnel, utilization of services and facilities, and costs in accordance with California Health & Safety Code, Section 1370 and Title 28 of the California Code of Regulations, Section 1300.70; and
Addendum 4

WHEREAS, Health Plan, KFH, TPMG and SCPMG agree that Health Plan is responsible for demonstrating to the California Department of Managed Health Care the adequacy of quality review and the efficacy of the ensuring quality improvement activities, including improvement of the quality review process itself in accordance with California Health & safety Code Section 1370 and Title 28 of the California Code of Regulations, Section 1300.70; and

WHEREAS, Health Plan, TPMG, SCPMG, and KFH desire to memorialize the authority, accountabilities, roles and responsibilities of each party related to quality assurance functions performed in connection with Health Plan’s quality assurance program (“QAP”).

NOW THEREFORE, the Contracting Parties support the Health Plan’s QAP as follows:

A. General Roles and Responsibilities

The Contracting Parties agree to perform the quality activities (“Quality Activities”) as described in this Agreement and Program Documents (see definition of Program Documents in Part D., below). The Agreement is hereby incorporated by reference into the Program Documents.

B. Guiding Principles Related to Identification, Review and Disposition of Quality Issues and Delineation of Utilization Management Activities

Health Plan is required by California Health & Safety Code, Section 1370 and Title 28 of the California Code of Regulations, Section 1300.70 to establish a quality assurance program. The scope of the Health Plan’s QAP includes the continuous review of the quality of care and utilization of services and shall be maintained by Health Plan, with assistance and input from KFH and TPMG in Northern California and KFH and SCPMG in Southern California.

The QAP shall be designed to identify, thoroughly review, and resolve quality issues (“Quality Issues”) in a timely manner. In support of the QAP, the Contracting Parties agree to the following goals and principles:

1. Effectively identify, evaluate and respond to each potential quality issue in a timely manner, regardless of the information source, (e.g., member grievances, clinical department referral, Regulator).

2. Consistently apply a standard set of review criteria to each case evaluation and document findings conclusions and actions, as appropriate, in common QAP systems.

3. The QAP will generate an effective system of reports that will enable Health Plan 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).

4. Feedback from the QAP to clinical operations, KFH 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.

5. The Utilization Management Program (“UM”) is an integral part of the Health Plan’s QAP. Quality, risk and safety processes and program initiatives are incorporated into the Plan’s UM Program.
6. Quality and risk issues, patterns and trends identified through UM clinical review processes are escalated to the appropriate 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.

C. Responsibilities of the Contracting Parties

Cooperation with QAP Oversight Activities and Audits
The Contracting Parties agree to cooperate with each other to help ensure that each Contracting Party complies with all applicable laws and regulations governing QAPs (e.g., California Health & Safety Code, Section 1370; Title 28 of the California Code of Regulations, Section 1300.70; standards and guidelines promulgated by NCQA).

Each Contracting Party agrees to cooperate fully with all audit and Health Plan oversight activities conducted in accordance with the Program Documents, as well as those oversight activities conducted by their respective regulatory and/or accreditation agencies, including, without limitation, providing access to all requested files and documents during regular business hours.

The Contracting Parties agree to cause their respective employees and/or partners to participate in meetings, projects or other tasks or activities related to the QAPs, or services reasonably related and necessary or ancillary thereto.

Associated Contractual Obligations
TPMG, SCPMG and Health Plan all acknowledge that they must perform all of their associated obligations as set forth in the Medical Service Agreement (“MSA”), and KFH acknowledges that it must perform its associated obligations as set forth in the Hospital Services Agreement (“HSA”) with Health Plan, in order to enable each of the Contracting Parties to provide high quality medical services at an affordable price (this includes, for example, Health Plan’s provision of facilities and administrative services incident thereto, as well as general administrative services in connection with membership enrollment, membership records, collection of Program Revenue, Reimbursement and Service Claims and other membership relations functions). Nothing in this Agreement is meant to modify any of the obligations set forth in the respective MSAs and HSA.

Delineation and Performance of Quality Activities
KFH, TPMG and SCPMG agree to perform the applicable Quality Activities set forth in the Program Documents. Quality Activities include, without limitation, quality and peer review, adverse action determinations and fair hearing procedures, identification of systems issues, review of arbitration decisions, credentialing and privileging activities, notification of physician conduct, submission of reports, and participation in quality initiatives.

Delineation and Performance of Utilization and Resource Management Activities
The Contracting Parties participate in a variety of utilization management and resource management activities and processes to continuously evaluate the efficiency, efficacy, medical necessity and quality of care provided to Kaiser Permanente Members. In most instances, KFH, TPMG and SCPMG providers are not required to obtain prior authorization from the Health Plan or authorization from KFH, TPMG or SCPMG, to provide or obtain services for members.
Addendum 4

Utilization Management Activities/Functions

For purposes of this Agreement, utilization management activities and functions means those activities described in Health and Safety Code §1367.01(a), which states, “A health care service plan and 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 prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section [§1367.01].”

While the various requirements of §1367.01 are in the first instance the responsibility of Health Plan, §1367.01 recognizes that a health plan may delegate utilization management decisions to others, including contracted medical groups. If such delegation does occur, a health plan retains the responsibility to oversee the delegated activity to ensure that it is in compliance with all requirements of §1367.01. Accordingly, whenever any utilization management decision-making function is performed within Kaiser Permanente the Contracting parties agree to work collaboratively to ensure compliance with §1367.01 and related provisions in the Knox-Keene Act and regulations, including §1363.5.

Resource Management

Resource Management 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 Contracting Parties work collaboratively in performing effective resource management. The activities that comprise resource management do not involve prior authorization of services and resource management activity is not subject to direct regulation under the Knox-Keene Act as is the utilization management activity described above. Resource management is the activity concerned with the prudent and clinically appropriate allocation of resources in the provision of health care services.

<table>
<thead>
<tr>
<th>UTILIZATION MANAGEMENT FUNCTIONS DESCRIPTION</th>
<th>AUTHORITY</th>
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<tbody>
<tr>
<td>Decisions to create, modify, or discontinue the requirement for prior authorization for certain health care services and the selection and/or development and adoption of utilization management criteria used in determining medical necessity.</td>
<td>TPMG, SCPMG, KFHP, KFH</td>
</tr>
<tr>
<td>Approvals and denials of services requiring prior-authorization, concurrent care authorization and post service care authorization.</td>
<td>TPMG, SCPMG, KFHP</td>
</tr>
<tr>
<td>Develop, review and approve the policies and procedures used to perform the selected UM activities</td>
<td>KFHP, TPMG, SCPMG, KFHP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UTILIZATION REVIEW AT LOCAL LEVEL</th>
<th>AUTHORITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admission and concurrent review for non-contracted, non-KFH facilities and Contracted Facilities.</td>
<td>TPMG, SCPMG, KFHP</td>
</tr>
<tr>
<td>Referrals management (i.e., Out of Plan Specialty Care)</td>
<td>TPMG, SCPMG, KFHP</td>
</tr>
<tr>
<td>Out of plan and subcontracted - Skilled nursing facility and acute rehab admission and concurrent review.</td>
<td>TPMG, SCPMG, KFHP</td>
</tr>
<tr>
<td>Issuance of Notices of Non-Coverage (NONCs) for both KFH and non-KFH Inpatient Utilization.</td>
<td>TPMG, SCPMG, KFHP</td>
</tr>
</tbody>
</table>
Addendum 4

Delegation and Oversight of Sub-Contractors

Health Plan may delegate Utilization Management functions to sub-contracted entities delivering health care services to Kaiser Permanente members such as Chiropractic and Acupuncture Care. These entities such as American Specialty Health Plan (ASHP) are typically Knox-Keene licensed health plans with qualified, licensed health care professionals such as chiropractors who make medical necessity determinations for Chiropractic and Acupuncture Care. Health Plan maintains accountability for all UM functions delegated to and performed by the sub-contractor and have mechanisms in place to oversee all Utilization Management Program activities at least annually to ensure compliance with all Federal, State and accrediting body standards and regulations.

Health Plan Oversight

Health Plan retains authority to administer Health Plan’s QAP and will oversee and monitor Quality Activities performed by each Contracting Party to ensure the provision of quality care and timely and appropriate utilization of services in accordance with professionally recognized standards of practice and legal requirements.

Health Plan may delineate certain of its administrative functions to KFH, TPMG and SCPMG. These functions may include, but are not limited to, quality improvement and utilization management. The Health Plan remains ultimately accountable for all services provided to its membership through KFH, TPMG and SCPMG and affiliated provider contracts. Health Plan continuously oversees and evaluates the performance of delineated functions and administrative contractors by:

- Formal evaluation of capacity to perform the assigned activities in accordance with state and federal regulatory and accreditation standards
- Oversight performed locally by Health Plan Area Managers/ Executive Directors assigned to specific services areas
- Oversight performed through appropriate Health Plan Quality and Utilization Management Committees
- Oversight activities performed by the Health Plan’s Physician Advisor in conjunction with the appropriate Health Plan Utilization Management and Quality Committees as appropriate.
- Reviewing routine periodic Quality and Utilization Management reports submitted by TPMG, SCPMG and KFH.
- Tracking and analyzing provider and member complaints, grievances and other performance indices.
- Conducting periodic reviews of systems, staff, and policies and procedures.

Evaluation of Performance/Audits

Health Plan continually evaluates the Contracting Parties’ performance of the Quality Activities. Evaluation of a Contracting Party’s performance includes: (a) evaluation of the performance of the Contracting Parties to ensure that the quality program is operating in accordance with standards and processes set forth in the Program Documents, (b) evaluation of the efficacy of the Quality Activities, including without limitation, physician and system improvement plans, hospital operations improvement plans and other corrective actions imposed as part of the review process and identification and referral of systems issues, and (c) audits of compliance with the Program Documents in accordance with the audit procedures contained in the Program Documents.

Corrective Action

Health Plan will notify a Contracting Party of any instance where, as a result of Health Plan’s oversight activities, Health Plan determines that the Contracting Party’s performance is not in compliance with the Program Documents, performance expectations, NCQA standards, or applicable laws and regulations. If
Addendum 4
Health Plan has reason to believe that a Contracted Party has not carried out the Quality Activities in accordance with the terms of this Agreement, Program Documents, or in accordance with Health Plan’s reasonable performance expectations, Health Plan may take all steps it deems necessary to ensure effective operation of the quality assurance program, including but not limited to, the following:

- Meet and confer with the Contracting Party to attempt to come to an agreement about the steps the Contracting Party needs to take to comply with policies and procedures set forth in the Program Documents.
- Conduct additional audits of the Contracting Party’s performance of the Quality Activities upon reasonable advance notice.
- Require the Contracting Party to submit to Health Plan, within a reasonable time frame, a corrective action plan to address any non-compliance, or other problems identified by Health Plan.
- Require the Contracting Party to implement, by a specific time, a corrective action plan approved by Health Plan.

D. Program Documents
Program Documents include Quality and Utilization Management Program Descriptions, associated policies and procedures designed to comply with regulatory, legal and accreditation requirements, books and records maintained by Committees and Forums responsible for the QAP and the Quality and Utilization Management Delineation Agreement (the “Documents”).

Each Contracting Party will cooperate and provide support as needed to maintain the Program Documents. All Documents are subject to annual review and revisions as appropriate and ad hoc based on regulatory, legal and accreditation changes to quality improvement and utilization review/resource management programs and processes.

Adoption of Program Documents
Each Contracting Party will adopt and comply with the Program Documents, including, without limitation, the provision of required reports, minutes and exhibits in the form and format and with the frequency specified.

Maintenance of Records
The Contracting Parties will each prepare and maintain all information and records created in connection with performing the Quality Activities in accordance with the Program Documents, and will permit Health Plan, the California Department of Managed Health Care, the California Department of Health Services, and the United States Department of Health and Human Services to review the information and records in accordance with the requirements of law.

Review of Reports/Committee Minutes
The Contracting Parties have full access to regional reports and committee minutes to ensure compliance with Program Documents.

E. Reporting Adverse Events
Sentinel Events and Practitioner Conduct
The Contracting Parties shall provide prompt notification to each other of incidents that are likely to affect any license, certification, privileges or accreditation of the Contracting Party (or a provider or health practitioner employed by or contracted with the Contracting Party) or which materially affect the ability of the Contracting Party (or a provider or health practitioner employed by or contracted with the Contracting Party) to meet its obligations to Kaiser Permanente members and patients.

In the event another Contracted Party has reason to believe that a Quality Issue needs to be addressed
by Health Plan, the Contracting Party and Health Plan agree to meet and confer to discuss the steps that
might be taken by Health Plan to address the Quality Issue.

F. Notices

Termination of Agreement

The Health Plan directs the scope of its authority delineated to KFH, TPMG and SCPMG and may revoke all
or part of its authority at any time. In addition, KFH, TPMG and SCPMG may terminate this Agreement as to
any other Contracting Party, without cause, upon the provision of ninety (90) days written notice to the
Health Plan, with a copy of the notice to the other Contracting Parties.

Any notice required under this Agreement shall be provided to the following, as applicable:

| Health Plan/KFH NCAL: Regional President | TPMG: Executive Medical Director |
| Health Plan/KFH SCAL: Regional President | SCPMG: Executive Medical Director |

This Agreement was reviewed and approved by: KFH: Regional President

Kaiser Foundation Health Plan, Inc./Hospitals
Northern California

By [Signature]
Date 9/3/13

The Permanente Medical Group, Inc.

By [Signature]
Date 9/4/13

Kaiser Foundation Health Plan, Inc./Hospitals
Southern California

By [Signature]
Date 9/3/13

Southern California Permanente
Medical Group

By [Signature]
Date 9/4/13
Position Title: Kaiser Foundation Health Plan Physician Advisor  
Region/National Function: Southern California Region  
Work Location: Pasadena, California  
Date: February, 2017  
Incumbent: N/A  
Supervisor: Julie Miller-Phipps, Southern California Regional President, KFHP/KFH

COMPANY PROFILE

America's leading nonprofit integrated health plan, Kaiser Permanente (KP) serves over 10.6 million members, 38 hospitals, 626 medical centers and other facilities in eight states and the District of Columbia. Through the dedication of more than 250,000 employees, nurses and physicians, in a single year Kaiser Permanente may schedule more than 40 million outpatient visits, deliver more than 100,000 babies, perform nearly 224,000 inpatient surgeries, and conduct nearly 80 million prescription refills. The people of Kaiser Permanente are focused on the health and well-being of KP members and communities, continually elevating the state of health care with progressive products, services, and advancements.

Our eight Regions are comprised of separate but closely cooperating organizations:

- Kaiser Foundation Health Plans (KFHP): A non-profit, public-benefit corporation that contracts with individuals and groups to provide HMO and other health benefit plans. KFHP contracts with Kaiser Foundation Hospitals and the Permanente Medical Groups to provide services.

- Kaiser Foundation Hospitals (KFH): A non-profit, public-benefit corporation that owns and operates hospitals in California, Oregon, and Hawaii; owns or operates hospital-affiliated outpatient facilities in all states where they do business; provides or arranges hospital services; and sponsors charitable, educational and research activities.

- Permanente Medical Groups (PMG): Partnerships or professional corporations of physicians, with one in each Kaiser Permanente Region. The PMG is responsible for providing and arranging all medical care and services in each Region.

Under the Labor Management Partnership (LMP), front-line physicians, managers, and union members work together in unit-based teams to solve problems collaboratively—continually improving the quality of care, service, and affordability while creating a better workplace for all employees. Unit-based teams are guided by a system of values that puts member needs at the center of every decision. This focus and the work of the LMP help make Kaiser Permanente an outstanding health plan and workplace.

Leveraging its integrated care delivery system, new tools and technology, Kaiser Permanente is taking preventive, proactive, and chronic care to a new level, resulting in better care, better health and more convenient access at an affordable cost.

POSITION SUMMARY

Utilization Management (UM) serves to provide and coordinate high quality and effective medical management for Health Plan members while striving continuously to achieve appropriate and efficient utilization of resources. The Health Plan must fulfill certain regulatory requirements and accountabilities related to UM. The physician in this role has accountability to the Regional President for assisting Health Plan in fulfilling these requirements.

This position reports to the Regional President, Kaiser Foundation Health Plan for the Southern California Region, who in turn reports to the National President and Chief Operating Officer. The individual in this position will spend time working directly with Health Plan and Southern California Permanente Medical Group
(SCPMG) departments/designees to perform the functions discussed in detail below. The individual will also spend time practicing at a Southern California Medical Center.

The Health Plan Physician Advisor (HPPA) has accountability to the Regional President for assisting Health Plan in fulfilling its regulatory requirements and accountabilities related to UM. This includes providing oversight, guidance, and direction on UM related activities and functions on behalf of the Health Plan. The HPPA shall make decisions in the best interests of Health Plan and its members, and will not be subject to or influenced by any financial incentives.

The Health Plan Physician Advisor will demonstrate knowledge and experience in both internal Kaiser Permanente operations as well as the external regulatory environment.

The Health Plan Physician Advisor must be a practicing SCPMG physician with a current, unrestricted license to practice medicine in the State of California and a respected leader by both the Health Plan and SCPMG. The Health Plan Physician Advisor must have knowledge of how Health Plan oversight is rendered and how medicine is practiced by members of Southern California Permanente Medical Group in order to understand when a utilization management event or activity occurs that requires Health Plan oversight.

The Health Plan Physician Advisor will be selected by the Health Plan Regional President. He/she will be engaged by the Health Plan and compensated by the Health Plan for that time. The Health Plan Regional President will complete this person’s annual performance review and ongoing performance reviews, and has the right to dismiss the individual from the role.

PRINCIPAL RESPONSIBILITIES

- Perform duties in the best interests of the Health Plan and its members. Escalate concerns to the Regional President as appropriate.
- Oversee and actively participate in the ongoing education and training of all personnel involved in the UM decision making process.
- Ensure ongoing monitoring for the consistent application of UM criteria by personnel involved in the UM decision making process.
- Ensure ongoing monitoring of UM documentation for completeness, comprehension and regulatory compliance.
- Establish and maintain working relationships with external regulatory organizations as appropriate.
- Actively participates in the Regional UM Committees and in the Southern California Quality Committee (SCQC) for the purpose of exercising, or directing the exercise of, Health Plan oversight of the utilization management function as defined in Health and Safety Code §1367.01.
- Actively participate in the annual review and approval of UM policies and procedures, UM provider surveys, and member and provider communications related to UM.
- Review and approve annually on behalf of Health Plan the criteria and/or guidelines used for services that Health Plan acknowledges fall within the scope of UM. Such review must clearly demonstrate and document that the Health Plan’s UM clinical criteria and guidelines are consistent with sound clinical principles and professionally recognized standards of care. The HPPA will also, as required, conduct review and oversight of any delegated UM activities or materials.
- Work with appropriate Health Plan departments to ensure that assessments are performed on relevant areas/functions and to ensure that SCPMG follows statutory timelines and content requirements for its communications regarding determinations to modify, delay or deny health care services requested by providers.
• Work with appropriate Health Plan and SCPMG 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 physician must request authorization from another party before the requested service is rendered. If such instances are identified, the Health Plan Physician Advisor must bring it to the attention of Health Plan and SCPMG for discussion and action, when indicated.

• Review appeals from UM denials, Independent Medical Review (IMR) cases related to UM 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 will be shared with the Health Plan and SCPMG.

• Provide an annual report of activities/findings to SCQC, which will then be included in that Committee’s reports to the KFHP Board of Directors. Feedback and data will be provided to the Regional President and other parties. The content and frequency of additional reports will be agreed-upon by the parties.

COMPLIANCE AND INTEGRITY

• Models and reinforces ethical behavior in self and others in accordance to the Principles of Responsibility, adheres to organizational policies and guidelines, supports compliance initiatives, maintains confidences, admits mistakes, conducts business with honesty, shows consistency in words and actions, and follows through on commitments.

• Regional leaders are accountable for communication, implementation, enforcement, monitoring, and oversight of compliance policies and practices in their departments.

EDUCATION/EXPERIENCE

• Have a current, unrestricted MD or DO license to practice medicine in the State of California
• Have current Board Certification in a medical specialty
• Knowledgeable of the care delivery processes across the continuum of care
• Previous Health Plan UM experience preferred

KP CORE BEHAVIORS

• Focuses on the Customer
• Collaborates
• Takes Accountability
• Drives for Results
• Communicates Effectively
• Champions Innovation and Change
• Develops Self/Others

KP MENU BEHAVIORS

• Thinks and Acts Strategically
• Exerts Influence
• Demonstrates Business Acumen
• Makes Effective Decisions
• Solves Problems through Planning and Analysis
• Leverages Technology
• Demonstrates Resource Stewardship
• Demonstrates Creativity
• Pays Attention to Detail
• Deals with Ambiguity
Complex Case Management

Program Description

5/15/2017
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II. OVERVIEW

The Complex Case Management (CCM) Program for Kaiser Permanente – Southern California Region (KP SCAL) is available to all product lines offered by Kaiser Foundation Health Plan (KFHP) to include KP HMO plan, KP Medi-Cal, KP Medicare Senior Advantage, and KP Special Need Plan (SNP). The CCM program targets high risk members with complex health care needs due to multiple chronic conditions, limited functional status, or with underlying psychosocial factors effecting frequent encounters with the health care delivery system. The CCM program provides intensive, personalized case management and services coordination to members who have complex medical and psychosocial needs.

KP SCAL has secured NCQA Patient Centered Medical Home (PCMH) Recognition representing more than 90% of outpatient primary care practices and has received auto-credit for NCQA QI 5 Complex Case Management Standard for Medicare and Commercial population. Therefore intensive and personalized complex case management and services coordination are only available upon self-referral or provider referral for the Medicare and Commercial membership.

The Medi-Cal members including the dual eligible and Seniors and Persons with Disabilities (SPDs) will be eligible to enroll in for CCM program through risk stratification, health risk assessment and through self-referral or provider referral.

III. COMPLEX CASE MANAGEMENT PROGRAM

The model of care adopted by the Complex Case Management Program is based on standards of care established by the Case Management Society of America\(^1\). Through the implementation of this model of care, the program effects a patient-centered, collaborative case management approach that focuses on assessment, planning, facilitation, care coordination, advocacy for options, implementation, and evaluation of the care plan across the health care continuum, with the support of the Primary Care Physician and other members of the healthcare team to include social services, case management (inpatient, outpatient and disease-specific), home health, physical therapy, pharmacy, and community resources to effect progress in the achievement of goals that are centered on member health, wellness, safety, adaptation, and self-efficacy. The complex case management program addresses factors such as the member’s financial needs, support systems, ethical and legal needs, and other social barriers that influence adherence behaviors.

Components of the program include the completion of a comprehensive assessment to evaluate the member’s health status, social needs, and personal preferences including values and areas of interest, from which an individualized case management plan is created. The member is assisted in establishing and prioritizing goals to target behaviors that adversely affect their health condition, in addition to coaching with decision-making on how to best self-manage their health.

\(^1\)Case Management Society of America (CMSA), 2016. Standard of practice for case management. Arkansas: CMSA

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condition. The member’s response to the case management plan is evaluated by the healthcare team on an ongoing basis with proactive adjustments to the plan of care as needed. The member and/or caregiver are actively engaged in the development, implementation and evaluation of progress toward the achievement of mutually-established goal(s). Members are graduated from the program when goals are achieved, thereafter, care is transitioned to the Primary Care Physician (PCP) and disease-specific care manager, or to basic case management as appropriate to ensure that self-care knowledge and skills are maintained. Care of members, who were not able to achieve their wellness goals due to their inability to change their behavior or participate in health maintenance activities, are transitioned to the PCP. Members who have reached regressive conditions are referred for Palliative Care or Hospice evaluation. Graduated members are re-enrolled in the programs via referrals. At any time, members have the right to decline participation in Complex Case Management program.

The Complex Case Management program uses evidence-based guidelines from various sources for which shall include the following:

- Case Management Society of America’s Standards of Practice Case Management, 2016;
- Best Practice Advisories;
- Proactive Office Encounter;
- Department of Health Care Services (DHCS) guidelines;
- Centers for Medicare and Medicaid Services (CMS) guidelines;
- Local and Intermediary Medicare Carrier coverage guidelines;
- Preventive Health Guidelines (e.g. U.S. Preventive Services Task Force, HEDIS);
- Centers of Excellence guidelines.

IV. MISSION STATEMENT

The mission of the Complex Case Management program is to optimize member’s wellness, improve clinical outcomes and promote self-efficacy and appropriate resource management across the care continuum, through efficient care coordination, education, referrals to health care resources, and advocacy.

V. PROGRAM GOALS

The goals of the Complex Case Management program are:

- To proactively identify eligible members for CCM program
- To make CCM program is available to all KP eligible members
- To optimize health status and quality of life by promoting health awareness, self-care management, and efficiency of care
- To provide proactive interventions to reduce the risk of readmissions
- To promote efficiency of care delivery through advocacy and collaboration with the health care team
- To provide coordinated services to members and/or member’s caregiver
- To assist members to access available benefits and resources
- To identify appropriate community based services and refer as appropriate
VI. POPULATION ASSESSMENT

Annually, Kaiser Permanente (KP) shall perform population assessment by using data from various sources (i.e. claims, encounters, lab, pharmacy, utilization management, socioeconomic data, and demographics) to identify the needs of its population. The population assessment shall include but are not limited to the following elements:

- Assess the characteristics and needs of its member population and relevant subpopulations: children, adolescents and persons with disabilities. The assessment includes, but is not limited to, the following characteristics:
  - Race;
  - Ethnicity;
  - Language preference;
  - Member age;
  - Member gender;
  - Low-income members;
  - Members covered by federal or state programs (e.g. Medicare, Medi-Cal, SSI, or dual-eligible);
  - Members with multiple chronic conditions or severe injuries;
  - Behavioral health diagnoses;
  - Risk scoring
- Assesses the needs of children and adolescents;
- Assesses the needs of individuals with disabilities;
- Assesses the needs of individuals with serious and persistent mental illness (SPMI)

Based on the 2016 population assessment study, KP will review its assessment results and take appropriate actions to meet the needs of its membership. These actions shall include:

- Review and update the complex case management structure and resources;
- Modify and refine complex case management enrollment criteria;
- Develop and/or enhance processes to effectively and efficiently facilitate and linking members to community resources as appropriate

VII. IDENTIFYING MEMBERS FOR COMPLEX CASE MANAGEMENT

KP utilizes multiple avenues for identifying Members for CCM program.
Kaiser Permanente SCAL Complex Case Management program uses data received from DHCS and health plan partners such as Health Information Form/Medical Evaluation Tool (HIF/MET) and Long Term Services and Supports data to identify members for Complex Case Management program.

KP proactively identifies members who are eligible for complex case management by utilizing the following data sources:

- Claims or Encounter data;
- Hospital, or discharge data;
- Pharmacy data;
- Data collected through the utilization management (UM) process;
- Data supplied by purchaser/State or Federal, i.e. HIF/MET;
- Data supplied by members through self-reported data such as health assessments or information given by caregivers;
- Data supplied by practitioners such as via integrated electronic health record;
- Predictive modeling risk score

KPSC CCM program is available to all KP members (e.g. Medi-Cal, Medi-Cal SPD, SSI, dual-eligible, Medicare, Commercial, etc). Members must meet at least one or more of the CCM eligibility criteria as outlined below. Other conditions may be considered for CCM program when it is an interdisciplinary care team’s recommendation. Members for CCM are identified based on the member’s past twelve month’s experience with the following risk predictor variables. The most frequently managed conditions, diseases or high-risk groups include but is not limited to the following:

Criteria for enrollment in Adult Complex Case Management

- > 6 hospitalizations and/or > 6 ER visits in past 6 months; and/or
- KPOC calls > 5 in the last 3 months; and/or
- Non-adherence to High-Risk Medications; and/or
- Non-Adherence to practitioner treatment plan of care (e.g. visits / referrals / diagnostics) within twelve-month period; and/or
- Multiple chronic illnesses that result in high utilization. Total predicted cost equal or greater $50,000 (excluding dialysis cost); and/or
- Catastrophic/Serious trauma (e.g spinal cord injury) and requiring assistance in coordination of services; and/or
- Cancer (with additional complex condition) requiring assistance in coordination of services; and/or
- Serious and Persistent Mental Health Illness requiring coordination Complex healthcare needs; and/or
- Members with a medical condition and a complex social situation that affects the medical management of the member's care and requires extensive use of resources; and/or
- Referrals from health plan partners and regulatory agencies (i.e. DHCS, DMHC, etc)

Criteria for enrollment in Pediatric Complex Case Management

- Hospitalization, ER visit or ≥2 urgent care visits related to chronic condition in the past six (6) months; and/or
- KPOC calls ≥ 5 in the last 3 months; and/or
- Non-Adherence to practitioner treatment plan of care (e.g. visits / medications / diagnostics) within six-month (6) period; and/or
- Institutional discharges requiring assistance in coordination of new services; and/or
- Catastrophic/Serious trauma (e.g spinal cord injury) and requiring assistance in coordination of services; and/or
- Major life changes in care situations (e.g. loss/change of caregiver, relocation of residence, caregiver strain requiring assistance in transitioning services); and/or
- Placed in foster care or change of foster care and requiring assistance in coordination of services / court appointed medical care; and/or
- Congenital anomaly/ newly diagnosed complex conditions requiring caregiver education/assistance with resources; and/or
- Multiple chronic illnesses that result in high utilization. Total predicted cost equal or greater $50,000 (excluding CCS and dialysis costs); and/or
- Members with a medical condition and a complex social situation that affects the medical management of the member's care and requires extensive use of resources; and/or
- Referrals from health plan partners or regulatory agencies (i.e. DHCS, DMHC, etc)

- Employer-supplied data is used for the identification of members for complex case management as follows:
  - Three full-scale employer onsite health centers have been established in Southern California—California Steel Industries (Fontana) and Paramount Citrus, Delano and Paramount Farms, Lost Hills (Kern County). At these sites KPSC specifically uses the data of the employee and dependent populations to target outreach and develop/roll-out health programs. These locations are fully KP Health Connect equipped so all health/visit information is documented in Health Connect.
  - Since April 2010, the Kaiser Permanente Mobile Health Vehicle has brought the medical team to the employer in order to offer employees easy access to care at worksites throughout Southern
California. Members receive a range of services when visiting the vehicle, which is equipped with two exam rooms and with Kaiser Permanente Health Connect. Caregivers can view the member’s full personal health record, identify necessary preventive screenings, identify and refer members to complex case management and log the services rendered. The care giver can coordinate laboratory work, EKGs, and prescriptions with the Kaiser Permanente Facility linked to the member. Services offered by the mobile clinic include but not limited to:

- Routine preventive care
- Routine OB/GYN services
- Same day care
- Blood pressure checks
- Body mass index measurement
- Glucose and Cholesterol screening
- Immunizations
- Blood and urine collection/processing to regional lab with doctor visit
- Referrals to specialists and complex case management when necessary

VIII. ACCESS TO COMPLEX CASE MANAGEMENT

A member may be referred to CCM from various sources which may include but are not limited to the following:

- **Referral Sources:** Referrals from physicians, utilization (UM) case managers, disease care managers, Home Health, Special Needs Plan (SNP) interdisciplinary team, community based agencies, Social Services, and Inpatient (IP) Continuing Care/Discharge Planners, community based agencies, etc. Information about CCM including how to refer members are published in the Provider’s Annual Letter and distributed to all contracted Physicians, KPSC SCPMG Physicians, and KP employees. Referrals to complex case management are made either by calling CCM department or by using Tapestry, which is a referral module included in the KP Health Connect electronic medical record.

- Referrals from the KP Medi-Cal plan Seniors and Persons with Disabilities program for members who require intense (daily to weekly) case management follow-up.

- **Member or caregiver referral:** Member’s self-referral or caregiver’s referral through direct call to the department. Information about Complex Case Management is published annually in the *Member Guidebook to KP Services*, produced in 13 geographic editions and 11 languages.

- **Health information line referral:** Referrals for frequency of calls to the nurse advice line (KP on Call), i.e. 7 or more calls related to chronic conditions within the last rolling 3 months.

IX. CASE MANAGEMENT SYSTEM

KP Health Connect (KPHC), an electronic medical record system, supports referral process, documentation of case management activities, and timely coordination of care. Members of the health care team may access the electronic
medical record to review case management documentations from any KPHC enabled computer throughout the Southern California region.

The KPHC system supports the following functionalities:

- Automatic name/ID/date/time - stamp documentation of every member-encounter, or when interaction with the member occurred including staff message entry
- Display of embedded care reminders to identify gaps of care that need attention by the members of the health care team within their designated scope of practice
- Direct member communication with Physicians and case manager via the interactive e-mail system. Electronic communications with a member are downloaded into the medical record
- Daily ED visit and hospital admission data capture via Clarity Report interface
- Display of ordered and refilled medications
- Display of diagnostic results
- Identification of members managed in the CCM program
- Snap shot display of member diagnoses
- In-basket messaging among the health care team including notice of a referral
- The inclusion of various assessment tools to meet specific program objectives, e.g. Depression screening and Transitions assessment questionnaires, CCM initial assessment template, and member letters templates
- The case management activities of the Complex Case Management program are also supported by the Permanente Online Interactive Network Tool for Complex Case Management (POINT CCM) system, which is integrated with KPHC, through the following functionalities:
  - Care planning and tracking of progress of goals
  - Automated prompts for follow-up activities. Overdue alerts are delivered in red prompts
  - Systematic alerts for ED visits, admissions and missed clinic appointments
  - Case Manager work queue that displays member demographics, chronic conditions, count of ED visits or hospital admissions within the last 12 months, calls made to nurse advice line, and case management episodes of care (active or surveillance)

The KP intranet portals provide a variety of clinical websites accessed routinely by the case managers as reference tools to support clinical decisions within the scope of practice such as:

- Clinical Library which houses evidenced-based clinical guidelines and the KPSCAL approved member-education materials routinely sent to members when applicable
- National Transplant Services website which houses the post-transplant care guidelines
X. CASE MANAGEMENT PROCESS

A. PRE-ENROLLMENT/ENROLLMENT OUTREACH

Members identified for CCM by referral, or through KPHC/Tapestry referral or direct call to CCM department
are screened by the case manager for inclusion in CCM. The CCM program is an opt-out program and that
all eligible members have the right to decline to participate. Thereafter, the program is introduced to the
member or caregiver by phone and an appointment for initial assessment is offered. A welcome letter is sent
following the phone outreach with the contact information of the attending case manager, and the
appointment for initial assessment or follow up call appointment if initial assessment was initiated during the
initial outreach. If the member or caregiver declines participation, the case manager documents such in
KPHC and links the member, as indicated, with the appropriate resources, such as, basic case management,
disease care management, or community resources. Thereafter, all case management-related care is
provided through the PCP as part of KP’s usual care delivery system. The referral source and the PCP are
notified with recommendations as indicated.

B. INITIAL ASSESSMENT

A comprehensive initial assessment is conducted for participating members and completed within 30 days.
The initial assessment has the following evaluation components:

- Current health status and condition-specific issues which includes physical and developmental
disabilities, serious mental illness, multiple chronic conditions or severe injuries.
- Clinical history which includes onset of conditions or co-morbidities, key events such as frequency of
ED visits or hospital admissions, past and current medications, treatment history, and significant
procedures for chronic conditions triggering the frequency of ED visits or hospital admission, follow up
appointments with a mental health provider within KP, and/or outside KP for members with carve out
benefits for their severe and persistent mental illness.
- Functional Status which includes Activities of Daily Living (ADL) and Instrumental Activities of Daily
Living (IADL) including capability to travel
- Mental health status including screening for Depression, cognitive functions such as ability to follow
and comprehend instructions, and process information
- Psychosocial factors which include assessment of health habits such as alcohol, street drugs, or
tobacco use, level of education, living arrangement and support systems
- Life care planning which includes end of life decisions, Advance Directives, power of attorney and
potential return to work. An Advance Directives brochure is mailed to members who have determined
that end of life decisions are appropriate or to members who express interest for further information
• Cultural and linguistic needs, preferences, or limitations including ability to speak or understand English and the need for an interpreter, food and dietary preferences, religious affiliation and practices that discourage treatments or procedures, and traditions related to death and dying

• Visual and hearing impairment, limitations, and adaptation preferences such use of a visual-adaptive device or hearing aid

• Evaluation of caregiver resources including adequacy of caregiving skills and availability to provide care

• Evaluation of benefits including long term services and supports and secondary payer or dual coverage (Medicare/Medi-Cal)

• Evaluation of benefits provided through community resources and waiver programs. Coordination of carved out services and refer to appropriate community resources such as mental health, Education Action Plan (EAP), Palliative Care programs, disease management, and other health education classes.

• Individualized case management plan and goals are based on member’s needs that includes member’s and caregiver’s prioritized goals, preferences, and the desired level of the care giver’s involvement in the case management plan. Member’s personalized goals includes the following
  ▪ Timeframe for re-evaluation
  ▪ Resources to be utilized, including appropriate level of care
  ▪ Planning for continuity of care, including transition of care and transfers
  ▪ Collaborative approaches to be used, including level of family and/or caregiver participation

• Quality of life assessments relative to self-perception of health compared to others within the same age group

• Identify barriers or issues that may inhibit the member’s ability to meet goals and plan of care such as support system, readiness to change, language, literacy, physical, lack of understanding of condition or health insurance, financial, cultural beliefs, vision or hearing limitation, psychological impairment, or transportation limitations affecting participation in care

• Facilitation of member referrals to resources and follow up with the member and/or caregiver to determine whether members act on referrals, including referrals to internal as well as external resources.

• Development of a schedule for follow-up and communication with a member which may include, but not limited to, counseling, follow-up after referral to a disease management, follow-up referral to a health resource, and education on self-management
Assess members’ progress towards meeting case management plans and goals and overcoming barriers to care. The process includes reassessing and adjusting the care plans and its goals as needed.

C. CASE MANAGEMENT PLAN AND GOALS

Using objective data obtained from the initial assessment, the case manager works with the member and caregiver to identify medical and mental health concerns, psychosocial factors, behavior issues, functional status and barriers affecting adherence to the treatment plan or to self-care management. The case manager together with the member or caregiver develops a patient/caregiver-centered plan of care and prioritizes health concerns to improve or maintain optimal health status with consideration for the preferences and desired level of involvement of the member/caregiver. A self-care management plan and health care goals are established with the member/caregiver to be achieved on a mutually agreed upon targeted period. The completed care plan is electronically sent to the PCP for endorsement to ensure the physician’s participation in the care planning process. The progress of goals and resolution of health concerns and barriers are assessed with the member/caregiver periodically throughout the case management process. The frequency of contacts with the member is determined by the acuity of health concerns. Typical contacts with a newly enrolled member are daily to weekly until the condition stabilizes. Goals are modified and/or interventions are adjusted accordingly if the goals are not met within the targeted time frame.

The case management plan includes the following:

- Member/caregiver’s prioritized health concerns
- Member/caregiver’s prioritized goals, either outcome or process goals, aimed at resolving health concerns or eliminating barriers, with targeted time frames for achievement
- The resources to be used to achieve goals, such as home health care, DME, rehabilitation therapies, long term services and supports, community resources, transportation services, practitioner(s), or public assistance programs
- Ongoing collaboration and communication between member/caregiver, physician(s), and other disciplines as need.
- Follow-up plans for continuity of care such as referred services, consults with physician(s) or pharmacist
- Interventions directed toward moving the member toward self-care such as monitoring and reporting of symptoms; recording and reporting weight, glucose levels, or blood pressure or motivational techniques to effect behavior change
- Ongoing assessment of progress against case management plans and goals, and modify plans and goals as needed with member/caregiver’s involvement and input.
- Collaborative practices with other disciplines
- Participation in team conference and advocacy approaches
• Follow-up schedule for contacts to re-evaluate goals, discuss effectiveness of interventions and outcomes of referred services

• Care planning for transitions to the PCP or other care management programs upon graduation from CCM

The care plan taxonomies are adapted from various evidenced-based nursing guidelines to appropriately capture case management diagnoses, member health concerns, and intervention clusters in various levels of care across the health care continuum. The problems, goals, and interventions are organized according to cluster categories adapted from the *Iowa Nursing Outcomes Classifications* (NOC)² and *Iowa Nursing Interventions Classifications* (NIC)³ by the Iowa nurse investigators in various clinical settings. The investigators validated outcomes that are sensitive to nursing interventions. The case management plan is represented by five area **Domains**:

- **Psychosocial Health**: taxonomy of psychological and social functioning problems/outcomes/interventions that facilitates lifestyle changes
- **Functional Health**: taxonomy of problems/outcomes/interventions that describe the capacity for and performances of basic task of life
- **Health Knowledge and Behavior**: taxonomy of problems/outcomes/interventions that describes the attitudes, comprehension, and action with respect to health and illness
- **Family Health**: taxonomy of problems/outcomes/interventions that describe health status, behavior, or functioning of the family as a whole or of an individual as a family member
- **Physiologic Health**: taxonomy of problems/outcomes/interventions that describe homeostatic regulations or organic functioning

The **North American Nursing Diagnosis Association** (NANDA)⁴ diagnoses are used to state health concerns in general terms and are further customized by the case manager to meet the needs of each individual member.

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⁴ North American Nursing Diagnosis Associations (NANDA), 1211 Locust St., Philadelphia, PA 19107. (215) 545-8105

http://www.nanda.or
A NANDA diagnosis is defined as “any health-related issue with which the nurse may interface and develop interventions and achieve outcomes for which the nurse is accountable”.

D. EPISODES OF CARE

Members are managed under active care status during the initial phase until their condition stabilizes. Active care status is further stratified by acuity level based on the frequency of contacts between the case manager and the member due to risk factors and intensity of required interventions. The member’s response to interventions is evaluated to determine progress toward established goals. Toward the end of every member contact, the next steps for follow-up are reviewed which may include but not limited to planned communications with the physicians or members of the health care team, follow-up on diagnostic result, medication refills, coordination of DME delivery, education materials to be mailed, referral to services such as social worker or community resources.

1. CRITERIA FOR ACUITY LEVELS

**Acuity level 1:** Review and/or follow-up daily to weekly of one or more of the following:

- Active cognitive decline or cognitive impairment without a reliable caregiver
- Inadequate or lack of knowledge of disease entity, signs/symptoms, and health care need
- Inability to manage medications; problems maintaining, and administration schedule
- No regular appointments with PCP
- Need for multiple ancillary services such as PT, OT, HH, MSW
- Lack of caregiver or inadequate support system
- Requires extensive coordination of services such as DME, transportation, community resources, financial assistance program
- Poor nutritional status as evidenced by low albumin level
- Persistent and unresolved psychosocial factors affecting plan of care
- Non-adherence to treatment plan as evidenced by 2 or more missed appointments related to chronic condition follow-up
- Discharge from hospital or skilled nursing facility with immediate transition of care issues
- Compromised home safety that would potentially cause injury, such as non-functioning DME or home safety devices, hazardous materials, etc.
- Conditions consulted with MD and Pharmacy

**Acuity Level 2:** Review and/or follow-up biweekly of one or more of the following:

- Inconsistent knowledge of disease process
- Needs assistance with IADLS and/or ADLs, safety not compromised
- Limited knowledge of dietary needs and/or poor compliance with prescribed diet
- Inconsistent adherence with self-care management
- Follow-up on post-hospital discharge referrals
- Need for assistance in navigating the KP system
- Caregiver role strain

**Acuity Level 3:** Review and/or follow-up every 3 weeks one or more of the following:
- Less frequent coordination of ancillary services and or community resources
- Monitoring for potential issues; such as safety, nutrition, functional decline, medication compliance, DME, community resources etc.
- Follow-up with Advanced Directives
- Monitoring of adherence with self-care management activities
- No missed appointments related to chronic condition follow-up
- Transition planning to Surveillance
- Monitoring for appropriate utilization of ED or Urgent Care

**Acuity Level 4:** Surveillance – review and follow-up monthly up to 3 months for the following:
- Unable to reach members
- Members who are admitted to skilled nursing facility (SNF)
- Members who Medi-Cal benefits have been terminated while active with CCM

### 2. SURVEILLANCE CARE STATUS

Upon achievement of goals, members are placed under **surveillance care status** for a time period where members are monitored for ability to maintain self-care management skills, consistent adherence to treatment regimen. Case management activities during surveillance include but not limited to the following:

- Monitoring for long term stability
- Occasional reinforcement of education for affirmation of sustained behavior
- Transition of care planning

During surveillance members are evaluated for re-assignment to **active** care status when the following conditions occur:

- Hospital admission related to poor control of chronic condition
Decline in functional status with rehabilitation potential
- Frequent ED visits
- New issues identified
- Inability to sustain consistent behavioral changes required for self-care management

E. ONGOING CASE MANAGEMENT

The progress of goals is tracked from the date of goal identification through date of achievement, using POINT-CCM. The target date of achievement may be changed, goals may be modified, or interventions may be adjusted based on the member’s response to case management interventions and to physician treatment options. At each encounter, the case manager queries the member for any new concerns, and determines the member’s action related to a referral, including a follow-up appointment with PCP or subspecialist. Goals are reviewed and discussed to optimize established interventions, implement new interventions and to identify and resolve barriers to goal achievement. The case manager updates the member on new treatment plans whenever a physician is consulted and discusses new interventions to resolve barriers if the previous interventions are not working for the member. In addition, the case manager assesses the member’s self-care skills, identifies progress or lack of, discusses previously agreed upon actions and reviews the status of self-care management plan. If the goals are not progressing, the care plan is revised as mutually agreed. The case manager updates the physician or nurse practitioner and other team members involved in care on the progress of the member.

XI. SCHEMA OF COMPLEX CASE MANAGEMENT PROCESS: COLLABORATIVE PRACTICES WITH OTHER DISCIPLINES

**Overall Approach**

Medical care for Kaiser Foundation Health Plan of the Southern California (KFHP-SCAL) members is collaboratively co-managed by KFHP-SCAL, Kaiser Foundation Hospitals (KFH) and Southern California Permanente Medical Group (SCPMG). The three entities together are referred to as Kaiser Permanente Southern California (KP SCAL). Members receive care from KP SCAL through an integrated delivery system where medical group and health plan clinicians and staff work together as one team to provide patient centered, coordinated care.

The Patient Centered Medical Home (PCMH) model develops relationships between primary care providers, their patients and families and other members of the health care team. In the PCMH model, primary care promotes cohesive coordinated care by integrating the diverse, collaborative services a member may need. This integrative approach allows primary care providers to work with their patients in making healthcare decisions. These decisions are based on the fullest understanding of information in the context of a patient’s values and preferences.

The PCMH model at KP SCAL requires health care team members to work together to assess patient needs, develop an appropriate plan of care and coordinate services for the patient. Appropriate care coordination depends in large measure on the complexity of needs of each individual patient or population of patients. Factors that increase
complexity of care include multiple chronic conditions, acute physical health problems, the social vulnerability of the patient, and a large number of providers involved in the patient’s care.

The medical home team or health care team (HCT); which may consist of nurses, pharmacists, nurse practitioners, physicians, physician assistants, medical assistants, educators, behavioral health therapists, social workers, case managers, and others are supported in delivering care through the medical home by use of an integrated electronic medical record, KP Health Connect (KPHC), where all HCT members can document information about a patient. HCT members may also use KPHC to send secure messages to each other to coordinate care and proactively identify outreach and in reach opportunities to provide case management, disease management and prevention activities.

Complete Care Program (Disease Management)

The Complete Care program uses an evidence-based, population approach to provide care for members across the spectrum of health: healthy, healthy with a specific health issue, chronically ill, and end of life. Disease management is imbedded in the care delivery system, touching the patient before, during, after and between visits. Every encounter is an opportunity to provide the member the necessary preventive, risk factor and chronic disease care. The approach is person, not disease-centric, focusing on the individual’s health profile. CCM criteria include: members with physical or developmental disabilities, multiple chronic conditions, severe injuries, members who will benefit from intensive post-discharge care who are identified using a validated the predictive model which evaluated length of stay, acuity of admission, pre-existing co-morbidities and multiple emergency department visits

Complex Case Management & Disease Management

Complex Case Management and Disease Management within KP SCAL’s PCMH model, includes the following activities:

Identification of complex members and those in need of disease management services: KP SCAL PCMH’s model of care is designed to improve the coordination, quality, appropriateness, timeliness, and efficiency of care including those with complex chronic conditions and newly diagnosed chronic conditions. It is the expectation that each PCMH assesses the needs of its population to identify those in need of case management or disease management services and to address gaps in care for all patients. This may be accomplished by any member of the health care team through reports and information contained in KPHC or through queries or through Panel Management, a proactive panel management tool that links to KP identifies gaps in care for chronic conditions, preventive services and utilization. The Panel Management Tool utilizes pharmacy, encounter and lab data to identify and flag gaps in care and supports identification of potentially complex members or those who may need disease management services. The Complex Case Management and Disease Management programs identify proactively members through the EMR for inclusion in our programs.

Evaluate the member’s needs and create a plan of care: The PCMH will evaluate the physical and psychosocial needs of its patients’ and establish an interdisciplinary, patient driven plan of care. The evaluation may include an assessment of past medical history, current health care needs, health behaviors, functional status, self-management abilities and goals and preferences. This information is documented in KPHC and used to inform development of a care and treatment plan. The patient-centered care plan outlines prioritized health goals developed by the patient
and/or their family. Self-management plans may also be developed to aide patients in achieving success with their plan of care. The care plan is reviewed periodically and updated as appropriate to address patient progress towards goals.

**Determine needs for care coordination:** It is expected that the PCMH facilitates the process for care coordination across the continuum of care. This may include communication and collaboration with health plan, hospital and other community providers. PCMH clinicians and staff will partner with health plan and other providers to identify opportunities to improve transitions in care and follow-up with patients when appropriate to ensure each patient receives timely, safe and effective care between providers and settings.

**Connect with resources:** It is the responsibility of the PCMH to educate patients about health and wellness resources within KP SCAL and the community and to coordinate services with community resources as needed. Community resources may include financial assistance programs, social services, educational resources, support groups, or support programs (i.e. Meals on Wheels, medical transportation services.)
Communication: Communication allows for the exchange of information, preferences, goals, and experiences among participants in a patient’s care. Communication may take place in person, by phone, in writing, and electronically.

All members of the health care team use the integrated EMR, KPHC which allows case managers and providers to view the most current patient information and communicate in real time to support and manage the needs of the patient. Case managers within the PCMH identify health plan members eligible for complex case management and/or other chronic disease case management programs. They notify members’ PCP of eligibility at the time of identification through a routed electronic message in KPHC with the expectation of a response.

PCPs or other health care team members may also refer patients to case management services through an electronic referral. The referring provider includes information to the case manager regarding reason for referral and specific concerns to be addressed through case management. Referrals are processed and the physician is notified of patient eligibility and enrollment via electronic messaging in KPHC.

XII. TRANSITION OF CARE/DISCHARGE PLANNING

Transition of care planning starts from the time of member’s enrollment to CCM. The case manager on an ongoing basis confers with the member regarding the transition care plan. The case manager assesses for any continuity of care issue and assesses the member’s readiness for the transition care plan and the integrity of the member’s support systems. If no additional issues are identified during the surveillance episode of care, the transition care plan is communicated to the PCP for consensus and to query for any discharge planning issues or concerns. If no discharge planning issues are identified by the PCP, the member is informed of the transition care destination, is provided with the continuing care manager’s contact information and is assured that there is no change in care except for the discontinuation of complex case management. Discharge documentation in KPHC includes a brief summary of health concerns or barriers resolved, achieved goals and date, outcomes of referred services, reduction in the frequency of ED visits and/or hospital admissions, and the transition of care destination. The transition of care is concluded with a warm hand-off to the receiving care manager via verbal report and electronic message.

Members are discharged from CCM and care is transitioned to the PCP or another care setting when the member continues to demonstrate maintenance of the gains achieved and when one or more of the following criteria is met:

- Target plan of care is achieved
- Goals are met
- Member requests to terminate participation
- PCP requests to terminate member’s participation
- Member is lost to follow-up despite due diligence
• Goals are not met due to member’s inability to change behavior
• Enrollment to Hospice
• Enrollment to Palliative Care
• Assignment of benefit to another health plan

Criteria for Discharge:
• Expiration
• Plan termination
• Residence out of service area or out of the country for more than 6 months

The receiving care setting or care manager may include but is not limited to the following:
• PCP
• Complete Care Management (DM, HF, Asthma care management)
• Basic case management for members with Medi-Cal benefits
• Behavioral Health Services
• Special Need Plan (SNP) interdisciplinary team (IDT)
• Senior and Persons with Disabilities (SPD) care management
• Specific Organ Transplant Services
• Palliative Care
• Hospice
• Complete Care Program

XIII. MEMBER SATISFACTION WITH CASE MANAGEMENT

Annually, Kaiser Permanente (KP) shall perform member satisfaction survey and analyze member complaints. The satisfaction survey will focus on complex case management program and specifically on these areas:

• Information about the overall program
• The program staff
• Usefulness of the information disseminated
• Member’s ability to adhere to recommendations

Member satisfaction is surveyed by mail after 30 days of CCM program enrollment. Survey results are analyzed annually for improvement opportunities and reported to the Southern California Quality Committee (SCQC). Member complaints are processed based on the provisions of the Regional Health Plan Member Rights Policy and Procedure for non-Medicare and Medicare members and analyzed annually for improvement opportunities.

XIV. MEASURING EFFECTIVENESS
The effectiveness of the Complex Case Management Program is measured on an ongoing basis. The selection of the outcome measures is based on their significant and demonstrable bearing on the entire complex case management. The focus of measurement selection is to demonstrate significant improvement in the population. The outcome measures for the Complex Case Management Program are based on selected clinical and HEDIS measures and member complaints. The clinical outcome measures may include but are not limited to the following:

- Reduce readmissions
- Decrease avoidable ED visits
- A1C Hgb < 8.0
- Blood Pressure < 140/90
- Flu Vaccination
- Member satisfaction with Complex Case Management services

Monthly Clarity report are generated for ED visits and hospital admissions and are analyzed to assess the effectiveness of case management interventions in reducing inappropriate ED utilization and to identify members for potential re-enrollment. In addition, the ED visit report provides information on prevalent diagnoses that trigger an ED visit and allows for focused interventions for preventing avoidable ED utilization or hospital readmission. Quarterly utilization data are generated by the department of Management Information Analysis (MIA) and aggregated annually to evaluate the overall reach of the program on ED utilization; readmission rates, and hospital days.

The clinical outcomes data measures the effectiveness of case management interventions for promoting optimal health and wellness for the member. The CCM program strives for member progression the “At Goal” level despite the complexity of co-morbid conditions.

XV. ACTION AND RE-MEASUREMENT

Performance metrics data are collected quarterly and aggregated annually to analyze opportunities for improvement. The Rapid Improvement Model: Plan, Do, Study, Act (PDSA) is used to rapidly evaluate the impact of change in care delivery processes. Feedback obtained from the case managers and from members via the satisfaction survey are analyzed, trended over time, and correlated to the quality measures and care workflows.

XVI. REFERENCES


Case Management Society of America (CMSA), 2002: http://www.cmsa.org

National Committee on Quality Assurance (NCQA): http://web.ncqa.org


North American Nursing Diagnosis Association (NANDA), 1211 Locust St., Philadelphia, PA 19107:
http://www.nanda.org
Kaiser Permanente operates in Southern California as a closed HMO with an integrated system of hospitals, ambulatory clinics, diagnostic and pharmacy services in eight counties that serve over 3.6 million members. Healthcare services and supportive programs are in place for the Special Needs Plan Members as part of entire Kaiser Permanente membership.

Kaiser Permanente Southern California operates a Special Needs Plan (SNP-D) for its dual eligibles who have both Kaiser Permanente’s Medicare coverage with full benefits under Medicaid, consistent with program goal to improve coordination and continuity of care for Medicare members with special needs.

In Southern California, the approximate population is 36,000 members. Our Case Management model has regional oversight for Medical Center-based operations in each of 13 Service Areas in eight counties throughout Southern California. SNP Members are assigned to one of the 13 Service Areas by zip code; that specific SNP Interdisciplinary Care Team (ICT) serves as the point of contact for the member regardless of where the member accesses care throughout the Southern California Region.

Administrative Leadership for Southern California Regional program operations is provided through the Regional SNP Team that consists of a Medical Director and Director of Complex Case Management with Project Management support. This includes facilitating regulatory requirements, training needs, program requirements, and providing SCAL’s overall program performance information to Kaiser Permanente’s Program Office for CMS, NCQA and other required reporting. The Regional SNP Team provides a monthly dashboard for Service Area specific data on metrics to include HEDIS, Medicare 5 star or other quality and utilization performance.

Each Service Area SNP Program has oversight by a Program Manager and Physician Lead that report to Service Area Leadership for Kaiser Foundation Health Plan/Hospitals and Southern California Permanente Medical Group. The Interdisciplinary Care Team has nursing, social medicine, behavioral health, pharmacy and physicians who work together to develop a care plan after patient contact, primarily telephonic, to complete Health Risk Assessment, Clinical Assessment, Care Planning, Transition Management and care coordination for KP and community benefits. The ICT also has Pharmacy, Behavioral Health and Long Term Supports and Services representatives, in addition to the Member or Caregiver as needed. The ICT supports the Primary Care Physician (PCP) manage the health needs of the SNP Member.

Kaiser Permanente SCAL SNP has the benefit of other affiliated KP organizations to facilitate SNP Program Operations. The Health Risk Assessment process is mailed Health Status Questionnaire (HSQ) by one such organization, the Center for Health Research (CHR) independent processing and scoring. KP SCAL SNP ICT staff facilitates this by outreaching Members that do not complete a mailed survey. The HSQ results risk stratifies for the assessment and care plan process. The HSQ is supplemented by patient interview that considers previous medical history and treatments, with other assessments, such as fall risk, depression and pain screening, medication review along with a discussion about medication concerns and issues. The ICT Case Manager links SNP Members with underutilized services and
programs included as part of KP Medical coverage, through Medicaid benefits and or through other community services and programs.

Following the completion of the clinical assessment, each SNP Member has a multidisciplinary review by individual case managers or providers within the ICT. Patients with complex conditions, to include unmet medical or social needs, changing or high risk stratification, or changing utilization needs are presented during case conference to develop a comprehensive care plan to include referral to KP SCAL’s Complex Case Management program. Disease-specific managers are engaged as part of this process when indicated. SNP Members are reassessed with care plan updates at least annually or upon a significant health status change.

Transition management is an integral part of the SNP Care Model to assist with identifying avoidable admissions and readmissions. The ICT has systems to alert for planned and unplanned transitions to include unplanned ED visits and admissions and discharges from Kaiser Permanente Hospitals, network hospitals and skilled nursing facilities. The ICT is also notified of planned surgical transitions to assist the member in preparation for the admission. The Case Managers contact the members to anticipate discharge needs and resolve any contributory factors for the transition. The Care Manager also provides the member or caregiver with tools and knowledge to support self-management.

This Care Model supports the CMS-identified SNP goals to improve beneficiary health outcomes and reduce hospitalizations and nursing facility placements.
MOC 1: Description of SNP Population (General Population)

Element A: Description of Overall SNP Population

The organization’s MOC description of its target SNP population must:
1. Describe how the health plan staff will determine, verify and track eligibility of SNP beneficiaries.

Eligibility Verification Process
Member enrollment processes for California are performed in Kaiser Permanente’s California Service Center (CSC). This entity maintains membership rolls and processes new members, including the newborn registry, terminations and coordination with employer groups and group enrollments, such as CMS. The CSC maintains the source record for tracking and verification of all membership and benefit information in our Foundations Systems Program, which is subsequently fed into Kaiser Permanente systems, including the electronic medical record.

In accordance with requirements outlined in Chapters 2 and 16b of the Medicare Managed Care Manual, Kaiser Foundation Health Plan verifies eligibility for the Special Needs Plan at the time of enrollment, and on a monthly basis thereafter.

Initial verification of eligibility to enroll in the Special Needs Plan is completed by the California Service Center (CSC), a national Kaiser Permanente entity that provides services related to enrollment and disenrollment to all regions and contracts. Special Needs Plan eligibility verification activities are carried out specifically by the Medicare Membership Administration department within the CSC. Verification of eligibility to enroll in the Special Needs Plan entails confirmation of an applicant’s Medicare and Medicaid status. Acceptable proof of Medicaid eligibility can be a current Medicaid card, a letter from the state agency that confirms entitlement to Medical Assistance, or verification through a systems query to a State eligibility data system. In the event that documentation of an applicant’s Medicaid status is not submitted with the enrollment application, CSC attempt to verify an applicant’s eligibility for the SNP through the use of the State Medicaid Agency web portals. If information available through the State system is inconclusive or indicates that the applicant is ineligible for the SNP, CSC staff conducts outreach to the member and offers the opportunity for the applicant to submit appropriate documentation. If the member is not able to demonstrate eligibility in response to outreach efforts, the enrollment will be denied and the applicant will receive the required notification.

On a monthly basis Management Information and Analysis Department (MIA) provides a SNP membership extract to CA-DHCS (Department of Health Care Services) via secure server. DHCS provides a return file with the dual status code for each member which is used by MIA to identify members that are no longer SNP eligible. MIA then forwards the SNP ineligible list to the CSC which reviews the file and verifies each member’s Medicaid eligibility via the state’s Medicaid eligibility portal. Once the information is verified the members are placed into the Loss of SNP Tracking Process. If a member becomes SNP eligible after being placed into Loss of SNP Tracking they are identified via the same monthly file exchange with DHCS and subsequently removed from tracking by the CSC.
SNP members who no longer qualify for the plan due to a change in their Medicaid eligibility status are granted a 4-month period of deemed eligibility, during which they are placed into the SNP Loss of Eligibility Tracking process. SNP members who re-qualify prior to the expiration of the 4-month deemed eligibility period are removed from tracking and remain enrolled in the plan; those who do not re-qualify by the end of the fourth month are involuntarily disenrolled from the SNP. Members placed into SNP Loss of Eligibility tracking receive a series of notices informing them of their status throughout the period of deemed eligibility, including a final involuntary disenrollment notice.

Once membership has been confirmed, subsequent contact for coverage and benefit information is available at the Regional Member Services Department by telephone toll-free at 1-(800) 464-4000. For members that prefer to have in person contact, each medical center has a member services department to provide assistance for navigating through coverage and care needs, to include:

- Understanding benefits and copays
- Resolving claims
- Obtaining medical record information
- Processing non-KP applications/forms (DMV placard requests, workers comp, third party liability)
- Assisting with customer service issues and complaints
- Other membership functions related to their KP coverage, such as lost Member ID cards.

The representatives receive specialized training on the concerns and needs of the elderly and prospective Medicare & Medicaid members as well as the current SNP Beneficiaries. The Member Services representatives are the first source of advocacy for SNP coverage and benefit issues for the SNP Member.
2. Describe the medical, social, cognitive and environmental factors, living conditions and co-morbidities associated with the SNP population.

Information obtained from aggregate results of the Health Risk Assessment provides opportunities to analyze the SNP Population needs and concerns for Kaiser Permanente’s Southern California SNP population. December 2013 Year End Results from Kaiser Permanente’s Health Risk Assessment (HSQ) are listed below. When available, the results indicate the proportion of the population that has been identified as Frailty High Risk.

Frailty is one of the risk stratification indicators scored by the KP SCAL’s Health Risk Assessment. The Frailty Score is the probability that the respondent will experience frailty (dependent upon others for daily care) in the next 12 months. A score greater than or equal (≥) 0.50 is flagged as high risk.

Survey responses were received from 32,638 SNP Members between January – December 2013. Demographics for this population provide risk stratification scores for the 3 risk categories. The percentage of the SNP population designated as Frailty is 18.2%, Advanced Illness Indicator (risk of death within 24 months) and Hospital Readmission Ratio (risk of hospitalization within 36 months) at 8.8%. These three categories provide guidance to the ICT Case Managers to prioritize outreach contacts and target interventions appropriately.

As indicated from results of the HRA (in the table below), KP SCAL SNPs are more likely to be female (62%), Hispanic (29%), divorced or separated (25.8%), with a grade school education (12.3%) and receive help for daily needs from spouse, child or other caregiver. This information is relatively consistent between the SNP population and the high risk frail subgroup.

Table: 2013 KP SCAL SNP Health Risk Assessment Results

<table>
<thead>
<tr>
<th>Risk Stratification</th>
<th>Count</th>
<th>Population Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frailty Score (High Risk)</td>
<td>5,955</td>
<td>18.2 %</td>
</tr>
<tr>
<td>Advanced Illness Indicator</td>
<td>8,822</td>
<td>27 %</td>
</tr>
<tr>
<td>Hospital Readmission Ratio</td>
<td>2,863</td>
<td>8.8 %</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Demographics¹</th>
<th>N Count/Percentage</th>
<th>Frailty/Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender, Race/Ethnicity, Marital Status &amp; Education Level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>11,018</td>
<td>33.8%</td>
</tr>
<tr>
<td>Female</td>
<td>20,240</td>
<td>62%</td>
</tr>
<tr>
<td>Race/Ethnicity²</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>6,724</td>
<td>20.6%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>1,642</td>
<td>5%</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>2,782</td>
<td>8.5%</td>
</tr>
<tr>
<td>Aleutian Eskimo or American Indian</td>
<td>115</td>
<td>0.4%</td>
</tr>
<tr>
<td>Other</td>
<td>5,787</td>
<td>17.7%</td>
</tr>
</tbody>
</table>
As compared to the Medicare only population, SNP members tend to have lower incomes, by virtue of means-based program eligibility for both Medicare and Medicaid benefits. A third of respondents, both in the General SNP and High Risk Frail, receive additional financial assistance from Supplemental Security Income (SSI). As expected, this correlates with a lower than average educational attainment.

Consideration of Health Literacy is necessary for this population due to multiple health conditions and complexity of managing their care. While health literacy isn’t directly measured for this population, multiple questions simulate the SNP Member’s ability to comprehend their medical treatment(s) and instructions. Those with less than a high school education or those that needed assistance with completing a health survey can serve as proxy questions for limited health literacy ability. Assistance needed to complete the Health Risk Assessment (HRA) was indicated for one-third of the general SNP respondents and 47% of the high risk frail population. Another consideration included is help needed as a result of the HRA being in a language other than English, which was 15.5% for the SNP population and 16.6% of the high risk frail group. This is representative of only those SNP Members that received the Health Risk Assessment in English and did not request an alternate document in other available languages. Six percent completed the HSQ in a primary language other than English. KP SCAL SNP programs obtain 30 – 40% of the health risk assessments by telephone which alleviates health literacy issues to a small extent as questions are clarified during the telephone interaction.

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1 Question was not answered by entire survey population
2 Currently, the HSQ is available in English, Spanish and Chinese formats.
Healthy Literacy Proxy Questions

<table>
<thead>
<tr>
<th>HRA Form Completion</th>
<th>N Count/Percentage</th>
<th>Fraility/Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistance Completing Form (Yes)</td>
<td>10,528</td>
<td>32.3%</td>
</tr>
<tr>
<td>Reason that Form was in English (Yes)</td>
<td>5,063</td>
<td>15.5%</td>
</tr>
<tr>
<td>HSQ completed in language other than English</td>
<td>1,871</td>
<td>5.73%</td>
</tr>
</tbody>
</table>

Living conditions vary for SNP members with 17% living alone, 23% live with spouse/partner and the majority live with children or another relative (37%). Generally, the SNP population reported needing some type of assistance with performing Instrumental Activities of Daily Living (IADL), with the majority of problems related to household chores, laundry, preparing meals and transportation. This is more evident in the high risk frail population for all identified IADLs.

Only a small percentage of those reporting help is needed actually receive help as indicated in the self-reported patient data for caregiver assistance, as defined in the table below. SNP Members, while managing their own health conditions, may also be responsible for providing care to another. This was reported for 1,135 of the general SNP members and for 142 of the Frail high risk population.

<table>
<thead>
<tr>
<th>Instrumental Activities of Daily Living (IADL)/Caregiver Assistance</th>
<th>N Count/Percentage</th>
<th>Fraility/Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparing Meals</td>
<td>11,577</td>
<td>35.5%</td>
</tr>
<tr>
<td>Shopping</td>
<td>14,391</td>
<td>44.1%</td>
</tr>
<tr>
<td>Household Chores</td>
<td>13,200</td>
<td>40.4%</td>
</tr>
<tr>
<td>Managing Money</td>
<td>5,592</td>
<td>17.1%</td>
</tr>
<tr>
<td>Laundry</td>
<td>11,894</td>
<td>36.4%</td>
</tr>
<tr>
<td>Taking Medications</td>
<td>6,556</td>
<td>20.1%</td>
</tr>
<tr>
<td>Transportation</td>
<td>12,780</td>
<td>39.2%</td>
</tr>
<tr>
<td>Telephone</td>
<td>2,760</td>
<td>8.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Caregiver Assistance for IADLs</th>
<th>N Count/Percentage</th>
<th>Fraility/Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/partner</td>
<td>3,327</td>
<td>10.2%</td>
</tr>
<tr>
<td>Children</td>
<td>7,173</td>
<td>22%</td>
</tr>
<tr>
<td>Other Relatives</td>
<td>3,865</td>
<td>11.8%</td>
</tr>
<tr>
<td>Friends</td>
<td>1,240</td>
<td>3.8%</td>
</tr>
<tr>
<td>Agency/hired help</td>
<td>2,998</td>
<td>9.2%</td>
</tr>
<tr>
<td>SNP is caregiver for a disabled person (Y)</td>
<td>1,135</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

This confluence of factors likely makes it difficult for these SNP members to navigate the healthcare system or to implement the treatment recommendations. This makes the assistance and coordination of the SNP program and the interdisciplinary care team, and the individual nature of the care plans all the more necessary.

3 Multiple answers were provided for the response
3. Identify and describe the health conditions impacting SNP beneficiaries

Based on information obtained both from self-reported data in the Health Risk Assessment and through patient clinical history, this population is more likely to experience disabilities more frequently than the overall Kaiser Permanente population including cognitive, intellectual, emotional or physical and are likely to have multiple chronic conditions.

Kaiser Permanente stratifies the Special Needs Plan population to identify those who are vulnerable and at risk. The SNP population is defined as those individuals who have one or more co-morbid and mentally complex chronic conditions that are substantially disabling or life threatening; have a high risk of hospitalization or other significant adverse health outcomes; and require specialized delivery systems across domains of care.

The SNP Regional Team provides a Population analysis on an annual basis to allow the Local Medical Center SNP Programs to review the data to identify the health status of SNP Members and characteristics that may impact their status. This information is used to develop appropriate staffing that can best represent the SNP Members for staffing ratio volumes and having specialized medical expertise to facilitate treatment for medical and social needs of the SNP Population.

Regardless of age, SNP members have chronic conditions. For instance, 74% have at least one chronic condition and 20% have 3 or more chronic conditions. In the over age 65 SNP population, Diabetes (27.4%), Arthritis (24.2%) and CKD (19.9%) are more prevalent than in the under age 65 population, only Asthma (9.4%) and ESRD (4.1%) are higher in the <65 age group. For Behavioral-Health diagnoses, there are higher rates in the < age 65 SNP subgroup; Anxiety, (2.7%), Major Depression (23.6%), Drug Addiction/Alcoholism (8.9%) and Schizophrenia (9.1%) are more prevalent than in the 65+ SNP. There are high rates of neurological disease and depression in the SNP population overall.

<table>
<thead>
<tr>
<th>SNP Disease Burden By Age</th>
<th>65+/Percentage</th>
<th>&lt; 65/Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>311</td>
<td>264</td>
</tr>
<tr>
<td>Arthritis</td>
<td>6,976</td>
<td>1,361</td>
</tr>
<tr>
<td>Asthma</td>
<td>1,333</td>
<td>915</td>
</tr>
<tr>
<td>Cancer</td>
<td>1,366</td>
<td>298</td>
</tr>
<tr>
<td>Chronic Kidney Disease (CKD)</td>
<td>5,733</td>
<td>827</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>2,109</td>
<td>535</td>
</tr>
<tr>
<td>Coronary Artery Disease (CAD)</td>
<td>3,330</td>
<td>481</td>
</tr>
<tr>
<td>Diabetes (DM)</td>
<td>7,901</td>
<td>1,996</td>
</tr>
<tr>
<td>Drug Addiction/Alcoholism</td>
<td>307</td>
<td>859</td>
</tr>
<tr>
<td>End Stage Renal Disease (ESRD)</td>
<td>380</td>
<td>396</td>
</tr>
<tr>
<td>Heart Failure (HF)</td>
<td>1,680</td>
<td>362</td>
</tr>
<tr>
<td>Major Depression</td>
<td>4,644</td>
<td>2,290</td>
</tr>
<tr>
<td>Neurologic Disease</td>
<td>5,933</td>
<td>2,699</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>159</td>
<td>884</td>
</tr>
</tbody>
</table>
This information guides the ICT composition towards the inclusion of internal medicine and behavioral health expertise.
4. Define the unique characteristics of the SNP population served.

Kaiser Permanente’s Southern California SNP Population is dispersed over eight counties in Southern California. There are 14 hospitals and 201 clinics with almost 6,000 physicians. The SNP population of 36,000 has steady increases each month, amounting to 1% annual net growth, in spite of deaths and disenrollment. The SNP population is 1% of Kaiser Permanente Southern California’s total membership of 3.6 million.

Kaiser Permanente enrolls only those members with full coverage for Medicare and Medicaid benefits.

**KP SCAL SNP Characteristics**

The size of this membership within an equally large health care system presents both opportunities and challenges for the SNP population. Unique characteristics and the diversity among members will have a larger presence in a population of this size. KP SCAL SNP has developed regional solutions to complement strategies employed at the Medical Center level to address these concerns. Individual Medical Centers, which have adapted to the local norms, address many of these challenges as part of their normal business processes to include:

**Geographic diversity:** Kaiser Permanente SCAL SNP’s membership is spread between urban areas that are densely populated to include Los Angeles, Anaheim and San Diego to rural areas such as Victorville, Santa Paula, Bakersfield and Mojave. Social issues, such as safety and transportation have different types of resources, strategies and interventions between the two diverse locales, with every variation in between.

**Ethnicity & Cultural diversity:** Within the Southern California area, Kaiser Permanente members represent 260 different ethnicities with more than 115 languages spoken. Ensuring that care is patient centric requires more coordination with caregivers, interpreters, family members and providers than in a smaller and homogenous SNP program.

**Socioeconomic status:** Kaiser Permanente Southern California has many very affluent neighborhoods, such as Beverly Hills, San Marino and Newport Beach which border very distressed areas, such as East Los Angeles, Watts or Compton. The higher cost of living, moderate climate and decreased, availability of affordable rentals or single resident occupancy (SRO) homes increase the area’s homelessness rate. Rural areas have even fewer housing opportunities. In densely populated areas, home and community based services may have more available options with greater demand. Conversely, in less populated areas, fewer services may be available. Either places a demand on access for services, when available. As each county in the Kaiser Permanente SNP service area has both urban and rural areas, addressing home, safety, transportation and related services creates additional preparation to ensure customized and individualized care.

**Technology diversity:** Kaiser Permanente relies on technology, specifically the electronic medical record to link medical record information between Kaiser Permanente hospitals, clinics, pharmacies and diagnostic services through the Southern California area. This provides a large network that allows the member access to their health information.
KP SCAL uses this technology to manage members through alternate sources, including telephone visits or by secure email messaging to providers. Over 1.5 million members have voluntarily registered for My Health Manager (also known as “kp.org”) as a secured, online Member website, to review their medical record, receive diagnostic test results, schedule appointments or email their physicians. SNP ICT must consider managing multiple methods to ensure that SNP members can determine their preferred method of contact.

Family Interactions: Southern California has experienced an outmigration since the 1990’s as a result of an economic downturn. This has had an impact on the extended family as the younger generation has left California, in many cases leaving older parents behind. As the parents have aged, these adult children are managing the parents’ medical and financial needs remotely, leaving day-to-day support by caregivers. Another sector of the SNP population may be estranged or abandoned by family members. Some adult children maintain a job in addition to being the SNP member’s caregiver. Kaiser Permanente’s SNP population has seen families personally providing assistance as well as those managing care needs remotely. KP SCAL’s SNP ICT adapts interventions to meet this spectrum of caregiving.
Element B: Subpopulation—Most Vulnerable Beneficiaries

The organization must have a complete description of the specially tailored services it provides to its most vulnerable members that:

1. Defines and identifies the most vulnerable beneficiaries within the SNP population and provides a complete description of specially tailored services for such beneficiaries.

KP SCAL SNP identifies the most vulnerable population through risk stratification from the Health Risk Assessment (Health Status Questionnaire/HSQ). KP SCAL SNP identifies the most vulnerable population as the SNP Member with End Stage Renal Disease (ESRD) or those identified as high risk for frailty by the HSQ.

Kaiser Permanente offers specialized case management services through Complex Case Management for those needing focused case management services for a predetermined time period.

Additionally, SNP Members with ESRD are managed by Renal Case Managers who work closely with a Nephrologist for the SNP Member’s behalf.

Members that are designated as high risk from the HSQ will be co-managed by the Complex Case Managers and the ICT Case Manager.

Frailty Methodology

As part of the clinical assessment, the HSQ, a patient self-reported survey, is collected as a Health Risk Assessment. This validated instrument has been used at Kaiser Permanente for over 20 years. The member or caregiver completes the survey, as indicated by the SNP member’s ability. The HSQ identifies members at highest risk for being frail, at risk for hospitalization and those at increased risk of dying within three years. It also provides a rich source of information provided by the member or caregiver that facilitates a personalized, member-focused approach for outreach and care management.

The Frailty Score is the probability that the respondent will experience frailty (dependent upon others for daily care) in the next 12 months. A score greater than or equal (≥) 0.50 is flagged as high risk. Advanced Illness (AII) is the respondent’s risk of death in the next 36 months. A score greater than or equal (≥) 0.175 is flagged as high risk.

Services for High Risk Frailty

The SNP Members move between a tiered level of case management, specific to individual patient needs based on changes in risk stratification or transitional activity. High Risk Frailty SNP Members are referred for Complex Case Management following the determination by the ICT that additional care is needed.

SNP Frailty High Risk

The ICT Case Manager monitors the High Risk Frailty Population for urgent intervention as indicated by having actual or projected annual hospitalizations equal to or greater than seven (7) per year which require follow up (“transition”) assessment activities for a safe return to home. The High Risk patients are initially managed by the ICT and are assessed as follows: HSQ for review with SNP member/caregiver, community benefits assessment (“Benefits Check Up”), Long Term Supports and
Services (LTSS) Assessment for Home and Community Based Services Depression screening, Assessment and Care Plan Development, Care Plan Follow Up, Medication Review, Reconciliation and management, ICT preparation and review during case conference. These SNP Members may need at least two (2) case conference reviews with the ICT multidisciplinary team in preparation for Complex Case Management referral. High risk patients receive complex case management care.

**Referral to Complex Case Management**

Complex Case Management (CCM) referral will activate additional case management activities to include additional assessments and consultation with ICT and PCP, weekly contacts over a predetermined period and close contact with caregiver or responsible parties to assist the SNP member with improved access to appropriate care to ensure that the SNP member is in the least restrictive care setting. Referrals for CCM are made by the SNP Case Manager, as part of the ICT Case Conference recommendations, by the PCP or other practitioner involved with the SNP patient care, by Hospital Discharge Planners, UM or other Hospital or Ambulatory Case Managers, or through self-referral by the SNP Member, caregiver or family member.

The CCM Program was developed using the Case Management Society of America (CMSA) care model to demonstrate the patient-centered collaborative case management activities of assessment, planning, advocacy, and implementation of the care plan across the health care continuum. The standards are consistently used in the SNP Care Model to ensure safe transition between case management programs.

The SNP ICT will coordinate with CCM upon referral to the program. The services provided by CCM include a comprehensive bio-psych-social assessment, care plan and frequent intervention with the SNP Member/caregiver until transferred back to the local ICT. During the CCM care of the SNP Member, the CCM Case Manager will provide patient updates during predetermined intervals to the ICT Case Conference.

**End Stage Renal Disease (ESRD) Methodology**

SNP members benefit from the services in place for pre-ESRD (CKD 4, CKD 5) and ESRD Patients as part of the comprehensive Medical Care in place for all Kaiser Permanente Members. PCP panels are under surveillance, based on diagnostic testing, to ensure early identification and referral for Nephrology Care. ESRD patients are referred by diagnosis and do not follow any risk stratification methodology for referral.

SNP Members with ESRD are managed by Renal Case Managers who work closely with the Nephrologist on the SNP Member’s behalf. The ICT Case Manager is involved, as needed, to assist with addressing unmet needs that would benefit the SNP Member with ESRD or pre-ESRD conditions.

**Services for End Stage Renal Disease Care Management**

The ESRD Care Management Program at Kaiser Permanente provides a comprehensive approach that assures continuity of care to renal patients. Emphasis is on the identification and management of early renal disease to delay the onset of end stage renal disease and reduce and minimize recurrent hospitalization; increase patient compliance with the plan of care; reduce fragmentation of services, care and treatment; and ensure available resources are utilized in a timely and cost effective manner to promote positive quality outcomes.
The Renal Multidisciplinary Team was created to effectively manage this patient population through advocacy, communication, education, identification of high risk candidates, rehabilitation, monitoring of patient outcomes, preventative services, and coordination and facilitation of services. Members of this team include a Permanente nephrologist, a renal nurse care manager, a renal social worker, a renal pharmacist, a renal dietitian and a Peritoneal Dialysis coordinator, where those units exist.

Renal Care Coordinators are primarily responsible for coordination of care of dialysis patients including communication between dialysis centers and the Kaiser Permanente Nephrology department, conducting education classes for patients with renal disease, submitting referrals for surgery and interventional radiology, following-up on patients with vascular access issues, orchestrating pre-kidney transplantation evaluation and testing and coordinating transportation.

The Renal care coordinators have been essential in allowing our Nephrologists to bring our ESRD members back into Kaiser Permanente for their primary care. The program focuses on the unique needs of pre-ESRD, ESRD and post renal transplant patients.
2. **Explains how the average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status, as well as other factors, affect the health outcomes of the most vulnerable beneficiaries.**

3. **Illustrates a correlation between the demographic characteristics of the most vulnerable beneficiaries and their unique clinical requirements.**

As ESRD care management is a defined program external to KP SCAL SNP, for this factor and subsequent factors under this element, only high risk frailty, that has a greater prevalence in the SNP population and crosses several medical conditions and comorbidities, will be considered for the ability to affect SNP program development.

KP SCAL SNP identifies High Risk Frailty as a vulnerable subpopulation based on the probability of increased dependencies on others in the upcoming 12 months. The SNP National Dashboard was used for medical history information to demonstrate clinical requirements. The SNP National Dashboard registered a higher rate of frailty high risk (33%) than previously reported HSQ results which can be attributed to different time frames or inclusion parameters for the Dashboard. This analysis is supplemented by patient reported available from the Health Risk Assessment aggregate data for in-home needs that was not available in the SNP National Dashboard.

Comparative results between the SNP Population and the High Risk Frail demonstrate similarities across many of the reported diseases. The High Risk Frail population have higher reported rates for CAD (+4) and Memory Loss/Cognitive (+3.6) but are lower for Cancer (-2), CKD (-5.6), Diabetes (-13.8) and Neurologic Illnesses (-8.4). Data from MOC 2, Element A, Factor 2 indicates that the High Risk Frail population is more likely to be female (69.1%), of Spanish descent (28%) and either widowed (21.2%) or divorced/separated (21.5). Consistent with the overall SNP population, the High Risk Frail has a high school or less education, however, High Risk Frail are less likely to be a high school graduate or pursue advanced education. The majority are over age 65.

<table>
<thead>
<tr>
<th>SNP SCAL Age Banding, reporting date July 2012 – June 2013</th>
<th>N/Percentage</th>
<th>Frailty/Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;65 Years Old</td>
<td>7,876</td>
<td>27.3%</td>
</tr>
<tr>
<td>65+ Years Old</td>
<td>20,967</td>
<td>72.7%</td>
</tr>
<tr>
<td>85+ Years Old</td>
<td>2,617</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SNP SCAL Disease Burden</th>
<th>N Count/Percentage</th>
<th>Frailty/Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>165</td>
<td>58</td>
</tr>
<tr>
<td>Asthma</td>
<td>58</td>
<td>19</td>
</tr>
<tr>
<td>Cancer</td>
<td>1,609</td>
<td>344</td>
</tr>
<tr>
<td>Chronic Kidney Disease</td>
<td>6,363</td>
<td>1,593</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>2,644</td>
<td>680</td>
</tr>
</tbody>
</table>

4 The age category 85+ is also included in the 65+ age grouping.

5 Frailty in the SNP Dashboard registered at a higher rate of 33%. This can be attributed to the differing time period of a rolling 12 months, ending in June 2013, and the continuous enrollment parameter used in the SNP National Dashboard.
Disease Burden (cont.)

<table>
<thead>
<tr>
<th>Disease</th>
<th>N Count/Percentage</th>
<th>Frailty/Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary Artery Disease</td>
<td>3,725</td>
<td>12.9%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>9,626</td>
<td>33.4%</td>
</tr>
<tr>
<td>End Stage Renal Disease</td>
<td>793</td>
<td>2.7%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>1,993</td>
<td>6.9%</td>
</tr>
<tr>
<td>Neurologic Disease</td>
<td>8,308</td>
<td>28.7%</td>
</tr>
<tr>
<td>Memory Loss/Cognitive</td>
<td>2,166</td>
<td>7.5%</td>
</tr>
</tbody>
</table>

Source: SNP National Dashboard, 2nd Quarter 2013, Care Management Institute.

While diseases are similar across populations, the number of treatments and medical equipment needs are disproportionate for the high risk frail subgroup. This information is based on self-reported patient data from the HRA. This infers that while disease prevalence is the same, other factors, such as comorbidities or disease progression may be more extensive in the high risk frailty subgroup.

<table>
<thead>
<tr>
<th>Treatments/Medical Equipment Needs</th>
<th>N Count/Percentage</th>
<th>Frailty/Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injections</td>
<td>3,832</td>
<td>11.7%</td>
</tr>
<tr>
<td>Oxygen</td>
<td>712</td>
<td>2.2%</td>
</tr>
<tr>
<td>Changing Bandages</td>
<td>373</td>
<td>1.1%</td>
</tr>
<tr>
<td>Tube Feedings</td>
<td>98</td>
<td>0.3%</td>
</tr>
<tr>
<td>Tracheostomy Care</td>
<td>61</td>
<td>0.2%</td>
</tr>
<tr>
<td>Ostomy Care</td>
<td>134</td>
<td>0.4%</td>
</tr>
<tr>
<td>Catheter Care</td>
<td>350</td>
<td>1.1%</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>236</td>
<td>0.7%</td>
</tr>
<tr>
<td>IV Therapy</td>
<td>292</td>
<td>0.9%</td>
</tr>
<tr>
<td>Do you need help with any of the above listed treatments? (Yes)</td>
<td>2,572</td>
<td>7.9%</td>
</tr>
<tr>
<td>Walker</td>
<td>6,519</td>
<td>20%</td>
</tr>
<tr>
<td>Cane</td>
<td>9,209</td>
<td>28.2%</td>
</tr>
<tr>
<td>Hoyer Lift</td>
<td>208</td>
<td>0.6%</td>
</tr>
<tr>
<td>Bedside Commode</td>
<td>1,187</td>
<td>3.6%</td>
</tr>
</tbody>
</table>

Source: Health Risk Assessment (HSQ), Jan – Dec 2013, Center for Health Research

Perceptions of health play a key role in determining interventions for the population. Implementation of the Health Risk Assessment provides information regarding the SNP member’s perception of health status. Over 80% felt that their current health conditions interfered with daily activities and 21% felt they need assistance with receiving treatments. Safety in the home is an issue; 28.3% indicated having fallen, either to the ground or hitting against an object, in the past twelve months.

<table>
<thead>
<tr>
<th>Perceptions of Health</th>
<th>N Count/Percentage</th>
<th>Frailty/Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compared to others your age, would you say your health is:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>2,367</td>
<td>7.3%</td>
</tr>
<tr>
<td>Good</td>
<td>13,411</td>
<td>41.1%</td>
</tr>
<tr>
<td>Fair</td>
<td>12,560</td>
<td>38.5%</td>
</tr>
<tr>
<td>Poor</td>
<td>3,699</td>
<td>11.3%</td>
</tr>
<tr>
<td>Does your health interfere with current activities? (Yes)</td>
<td>14,502</td>
<td>44.4%</td>
</tr>
</tbody>
</table>
During the past 12 months, have you fallen all the way to the ground or fallen and hit something like a chair (Yes)

<table>
<thead>
<tr>
<th>N Count/Percentage</th>
<th>Frailty/Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>5,543 17%</td>
<td>1,687 28.3%</td>
</tr>
</tbody>
</table>

Source: Health Risk Assessment (HSQ), Jan – Dec 2013, Center for Health Research

While the disease burden may be similar across the population, one consideration is that the Frailty High Risk Population may be less able to provide for their care. Based on information reported in Factor A, Element 2, the Frailty High Risk population is more likely to be widowed and less likely to have a high school education, which may affect both the ability to fully comprehend their medical condition, a concern for diminished health literacy, or share that responsibility with a spouse or partner.

They are more likely to need assistance with personal care items, also conveyed in MOC 2, Factor A, Element 2. Based on information obtained from the self-reported Health Risk Assessment, more than double the respondents in the High Risk Frailty population needed assistance with instrumental Activities of Daily Living (ADLs). Additionally, 71.1% of the High Risk Population indicated they took over 5 different prescription medications daily compared to 49.6% of the overall SNP population.

### Instrumental Activities of Daily Living (IADL)/Caregiver Assistance

<table>
<thead>
<tr>
<th>IADL</th>
<th>N Count/Percentage</th>
<th>Frailty/Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparing Meals</td>
<td>11,577 35.5%</td>
<td>5,426 91.1%</td>
</tr>
<tr>
<td>Shopping</td>
<td>14,391 44.1%</td>
<td>5,657 95%</td>
</tr>
<tr>
<td>Household Chores</td>
<td>13,200 40.4%</td>
<td>5,430 91.2%</td>
</tr>
<tr>
<td>Managing Money</td>
<td>5,592 17.1%</td>
<td>3,372 56.6%</td>
</tr>
<tr>
<td>Laundry</td>
<td>11,894 36.4%</td>
<td>5,395 90.6%</td>
</tr>
<tr>
<td>Taking Medications</td>
<td>6,556 20.1%</td>
<td>4,586 77%</td>
</tr>
<tr>
<td>• Taking 5+ different Medications daily</td>
<td>16,176 49.6%</td>
<td>2,345 71.5%</td>
</tr>
<tr>
<td>Transportation</td>
<td>12,780 39.2%</td>
<td>5,009 84.1%</td>
</tr>
<tr>
<td>Telephone</td>
<td>2,760 8.5%</td>
<td>1,923 32.3%</td>
</tr>
</tbody>
</table>

Source: Health Risk Assessment data (HSQ), Jan – Dec 2013, Center for Health Research.

Combined, these factors indicate that the High Risk Frail population has more complexity for medical care. While disease prevalence may be comparable across populations, the disease progression has impacted the High Risk Frail SNP Member’s ability to manage care without considerable assistance. Without addressing these needs, those SNP Members are more at risk for institutionalization. The ICT will be tasked with providing more coordination to assure that the care plan and interventions address these challenges.
A. Identifies and describes established relationships with partners in the community to provide needed resources

Kaiser Permanente’s integrated care model provides full medical care for its entire membership, including SNP Members. Additional programs and services were developed to ensure a complement of programs and services to address enhanced benefits offered to the SNP Member for continuity of care.

Initial Benefit Assessment

The High Risk Frailty SNP subgroup has a higher probability of dependence upon others as indicated by the risk stratification. Determining underused benefits during the SNP Assessment, combined with identifying alternate sources of support in the community is an essential part of the care plan process.

During the interview, the SNP Case Manager completes a community benefit review to determine if the SNP member has unmet needs or underutilized services beyond benefits available through their Kaiser Permanente medical coverage.

The initial source is the Benefits Check Up website that was developed by the National Council on Aging as a partner with Kaiser Permanente. Based on zip code and socioeconomic status, the website identifies other programs and resources available in the community that the beneficiary may be eligible for and request assistance to pursue. These include low cost housing, tax credits, and supplemental income sources.

A community benefits matrix that identifies other local agencies and programs is maintained either through the Medical Social Services department and supplemented with new partnerships forged with the ICT Case Managers or is developed completely by the local ICT. While available agencies vary by location, a sampling of the types of partnerships that would be of benefit for additional services to the High Risk Frailty subgroup includes:

- Adult Protective Services
- Area Agencies on Aging
- Alzheimer’s Association
- The Braille Institute
- Caregiver Resource Center
- Church groups

Through this review, the ICT Case Manager can begin to determine options and resources that would assist the SNP Member.

Community Partners

Kaiser Permanente collaborates with other health care providers and programs to create a knowledge base to assist with providing care to its members. KP promotes alignment with these programs and agencies. Examples of these programs are:

- The Health Forum at UCLA, which offers public programs featuring health leaders discussing critical issues in public health.
- The Council of Community Clinics/Coalition of Community Health Centers offers symposiums on best practices on health care delivery and clinic operations.
- The Center for Health Care Rights provides advocacy for Medicare beneficiaries
Long Term Supports and Services (LTSS)

The High Risk Frail Subgroup will benefit from long term support programs and services as these supports are designed to reduce the risk of institutionalization. These supports range from personal care assistance to housing and home repair to additional therapies. Adult Day Care, Custodial, Sub Acute and Skilled Nursing Facilities are also available to the SNP Member.

Programs and services offered through the SNP Member’s Medicaid benefit provide additional resources for SNP beneficiaries at risk for long term care institutionalization.

As part of the Coordinated Care Initiative (CCI), every SNP member will also be assessed for Long Term Supports and Services to include Long Term Care, including Community Based Adult Services (CBAS), In Home Support Services (IHSS), Multipurpose Senior Support Program (MSSP) and Home and Community Based Services (HCBS). These services are provided as part of the SNP Member’s Medicaid benefits and focus on social needs.

The ICT case managers that work with vulnerable SNP Members determine with the patient/caregiver any unmet needs which could jeopardize self-care and health stabilization. Based on patient/caregiver preferences and ability, staff will educate and instruct them to contact the identified community resource or make the referral on their behalf.

As part of providing these services, KP SCAL SNP has developed a network of community programs, agencies and resources to provide services to SNP Members. These services provide additional support to the member or responsible party to maintain the SNP member in the least restrictive setting to reduce the need for institutionalization.

Services that are included as part of LTSS are:

**Long Term Care (LTC):** Custodial and Skilled Nursing facilities that offer formal LTC services typically provide living accommodation for people who require on-site delivery of around-the-clock supervised care, including professional health services, personal care and services such as meals, laundry and housekeeping.

**Community Based Adult Services (CBAS):** Adult day care centers that offer: Nursing Services, Physical Therapy, Occupational Therapy, Speech and Cognitive Therapy, Behavioral Planning, Social/Psychological Services, Meals and Nutrition Counseling, Recreation and Social Activities, Cognitive Retraining as well as Family Counseling and Support Groups.

**In Home Supportive Services (IHSS):** Programs that provide domestic, domestic related, and personal care services for eligible Members, who are at risk of institutionalization without these services.

**Multipurpose Senior Support Program (MSSP):** Programs that assess and coordinate the following community services: Personal Care Services/Chore Services, Respite Care (in-home and out-of-home),

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6 As of 2014, CCI benefits are implemented in 6 of 8 Kaiser Permanente SNP counties with expanded implementation to remaining counties in 2015.
housing assistance, minor home repair, transportation, environmental accessibility adaptations, protective supervision, meal services – congregate/home delivered and money management.

**Home and Community Based Services (HCBS):** Other services includes personal care, chore services, respite, transportation, respite, housing assistance and protective services.

LTSS Partnerships were established through rigorous review of program requirements to include bonding of business services, credentialing of caregiver staff, background checks and license (business or professional) verification. Partnerships through contracted services were established through Kaiser Permanente’s Affiliated Provider Services under the same oversight for network adequacy and credentialing.
MOC 2: Care Coordination

Element A: SNP Staff Structure
The organization’s MOC must:
1. Describe the administrative staff’s roles and responsibilities, including oversight functions

Administrative Functions
Administrative Functions, for the purpose of this Model of Care, will focus on those entities that interact specifically with the SNP member and not those necessary for day-to-day Kaiser Permanente Health operations.

California Service Center (CSC)
Member enrollment processes for California are performed by Account Administrative Representatives (AAR) in the California Service Center. This entity maintains membership rolls and processes new members, including the newborn registry, terminations and coordination with employer groups and group enrollments, such as CMS. The CSC maintains the source record of all membership and benefit information in our Foundations Systems Program, which is subsequently fed into the Kaiser Permanente systems, including the electronic medical record.

Eligibility Verification Processes
In accordance with requirements outlined in Chapters 2 and 16b of the Medicare Managed Care Manual, Kaiser Foundation Health Plan verifies eligibility for the Special Needs Plan at the time of enrollment, and on a monthly basis thereafter.

Initial verification of eligibility to enroll in the Special Needs Plan is completed by the California Service Center (CSC), a national Kaiser Permanente entity that provides services related to enrollment and disenrollment to all regions and contracts. Special Needs Plan eligibility verification activities are carried out specifically by the Medicare Membership Administration department within the CSC. Verification of eligibility to enroll in the Special Needs plan entails confirmation of an applicant’s Medicare and Medicaid status. Acceptable proof of Medicaid eligibility can be a current Medicaid card, a letter from the state agency that confirms entitlement to Medical Assistance, or verification through a systems query to a State eligibility data system. In the event that documentation of an applicant’s Medicaid status is not submitted with the enrollment application, CSC staff attempt to verify an applicant’s eligibility for the SNP through the use of the State Medicaid Agency web portals. If information available through the State system is inconclusive or indicates that the applicant is ineligible for the SNP, CSC staff conducts outreach to the member and offers the opportunity for the applicant to submit appropriate documentation. If the member is not able to demonstrate eligibility in response to outreach efforts, the enrollment will be denied and the applicant will receive the required notification.

On a monthly basis Management Information and Analysis Department (MIA) provides a SNP membership extract to CA-DHCS (Dept of Health Care Services) via secure server. DHCS provides a return file with the dual status code for each member which is used by MIA to identify members who are no longer SNP eligible. MIA then forwards the SNP ineligible list to the CSC which reviews the file and verifies each member's Medi-Cal eligibility via the state's Medicaid eligibility portal. Once the
information is verified the members are placed into the Loss of SNP Tracking Process. If a member becomes SNP eligible after being placed into Loss of SNP Tracking they are identified via the same monthly file exchange with DHCS and subsequently removed from tracking by the CSC.

SNP members who no longer qualify for the plan due to a change in their Medicaid eligibility status are granted a 4-month period of deemed eligibility, during which they are placed into the SNP Loss of Eligibility Tracking process. SNP members who re-qualify prior to the expiration of the 4-month deemed eligibility period are removed from tracking and remain enrolled in the plan; those who do not re-qualify by the end of the fourth month are involuntarily disenrolled from the SNP. Members placed into SNP Loss of Eligibility tracking receive a series of notices informing them of their status throughout the period of deemed eligibility, including a final involuntary disenrollment notice.

**Member Services Representatives**

Once membership has been confirmed, subsequent contact for coverage and benefit information is available on a Regional level for Member Services in Pasadena by calling (800) 464-4000. For members that prefer face-to-face contact for this activity, each Medical Center also has a member services department, staffed by Health Plan Representatives, to assist members in navigating through their coverage and care needs, to include:

- Understanding benefits and copays
- Resolving claims
- Obtaining medical record information
- Processing non-KP applications/forms (DMV placard requests, workers comp, third party liability)
- Assisting with customer service issues and complaints
- Other membership functions related to their KP coverage, such as lost Member ID cards.

The representatives receive specialized training on the concerns and needs of the elderly and prospective Medicare members as well as the current SNP members.

**Payment and Claims Processing**

As Kaiser Permanente is a closed medical model, with 95% of care within its own hospitals, clinics, ancillary care, diagnostic and providers, there is less dependence on claims processing. A system for claims and/or invoice process is in place for contracted or out-of-network providers and services/ancillary care outside of the traditional medical model. This includes securing DME items or other services covered under the Medicaid benefit.

The Claims Examiners review, evaluate and screen Health Plan claim items for completeness, accuracy and conformity to established policies and procedures. They make payment or denial decisions in accordance with policy and procedures of Health Plan Claims. They authorize payment of claims in an amount based on authorization level guidelines. They review and evaluate complex claims involving Medicare, Contracts, other insurance, workers’ compensation, foreign claims and coordination of benefits.

**Medicare Compliance**

Members of the National Compliance Office (NCO) Medicare Compliance team provide compliance guidance to the SNP Program. Members of the Medicare Compliance team disseminate regulatory and
sub-regulatory guidance related to SNP, track the implementation of new regulatory requirements, participate in SNP workgroup meetings, and provide ad hoc consultation as needed. In the event of a major submission or audit, the Medicare Compliance team assists with coordination efforts and oversees any communication with CMS.

Services and programs for the SNP Beneficiary under the Kaiser Permanente SNP Coverage are represented below:

**Diagram: Oversight of the ICT for ensuring care needs of the SNP Member**

**SNP Programs**

At the Regional Level, the SNP Program is administered through the Complex Case Management for the Kaiser Foundation Health Plan/Kaiser Foundation Hospital. The Regional SNP Program is overseen by a Regional SNP Medical Director and a Director of Complex Case Management. The Regional SNP Program has oversight by the National SNP Program (Program Office).

Each Medical Center SNP has administrative oversight through their established Medical Center Leadership.

The SNP Physician Lead reports through a physician hierarchy that may include either a Quality Physician Lead or Department Physician Chief, such as Continuing Care Chief, provided that the SNP Physician Lead does not hold either of those roles. These ultimately report to the Medical Center Medical Director directly or through Assistant Medical Area Directors that oversee clinical performance and operations for specific initiatives, such as access or continuing education.
The SNP Program Manager has clinical and performance oversight for the SNP ICT. The SNP Program Manager is a Department Administrator (DA) who reports to either an Assistant Medical Center Administrator or Assistant Medical Group Administrator with reporting lines to the Medical Centers’ Chief Executive Officer for the Hospital/Health Plan, or Chief Administrative Officer for the Medical Group, and the Area Medical Director.

**Administrative Oversight**

For those departments that are not centralized at the Regional level, such as Claims Department or the California Service Center, Medical Center departments have a corresponding Regional department for oversight. Regional programs have corresponding oversight from KP’s Program Office. The Regional Departments, to include quality management, health education, member services, credentialing, etc., provide consultative support for the Medical Center Departments by reporting on performance and providing assistance as needed. These departments provide deficiency notices for departments not meeting program standards and work with the Medical Centers to improve performance.

**SNP Administrative Oversight**

Depending upon the size of the Medical Center and the proportionate size of assigned SNP membership, the SNP Program Manager may have additional program administrative staff to assist with day to day operations, to include an assistant program manager/supervisor, project manager or administrative clerk. The program oversight ensures daily operations, to include:

- Monitoring budgets to ensure payroll, schedules and staffing are in place
- Ensuring that the ICT has adequate tools to implement Model of Care activities to include training on reports and documentation tools.
- Arranging and ensuring that staff has received and completed required training in addition to the MOC training
- Providing Human Resource activities related to performance and changes to employment status
- Providing clinical consultation to assist with the Case Management process, including obligations indicated by state regulations or licensure scope
- Oversees work assignments, ensuring case mix ratios for productivity goals
- Developing program strategy to meet or exceed program requirements based on resources and other obligations.

**Staff Competency**

Staff competency is an annual mandatory program that is divided into competencies, such as age- or cultural related competencies, safety response for fire or earthquake evacuation as well as universal precautions for infectious control and hazardous materials. These are managed by the local Medical Centers and are tracked annually with a designated completion date. Managers maintain completion tracking in conjunction with Human Resources; employees that do not comply by the designated completion deadline are subject to disciplinary actions.
2. Describe the clinical staff’s roles and responsibilities, including oversight functions.

The Primary Care Physician (PCP) is responsible for primary oversight of the patient’s care.

Medical Care Acute inpatient medical care is provided through an organized medical staff at each Kaiser Permanente Hospital. Hospital Clinical Services include nursing staff, discharge planners/utilization case managers, pharmacists, social workers, respiratory therapists, RNP’s PAs in addition to technicians in radiology, laboratory and other ancillary services.

In the medical offices, in addition to physicians in both primary care and specialty areas, registered or licensed vocational nurses support the clinical health care team. Other ancillary services include health educators, dieticians, case managers, advice nurses, social workers, pharmacists, registered nurse practitioners (RNP) or physician assistants (PA), speech therapists, audiology therapists, physical therapists, occupational therapists and department specific technicians, such as orthopedic technicians, pulmonary technicians, radiology technicians or laboratory technicians. Clerks or coordinators are assigned to the various departments to assist with front office processing, scheduling and data collection. Complete Care department, with disease specific case managers, supports the PCP’s treatment plan and instruction of self-management.

Pharmacy Pharmacy consultation is provided to the SNP Members in several forums. Disease specific pharmacists are assigned to individual departments, such as oncology or heart failure. These pharmacists monitor medications associated with specific disease therapies, as indicated by the physician or upon SNP Member request. The Medication Therapy Management (MTM) pharmacists provide polypharmaceutical consultation based on specific disease/medication utilization criteria as part of the Medicare Part D initiatives. An estimated 6% of the SNP population is reviewed as part of that criterion. Pharmacists are included in the ICT and provide pharmacy consults in conjunction with the SNP Physician Lead/ICT Case Manager requests. Lastly, Pharmacists within the Kaiser Permanente retail pharmacy network provide consultations to the SNP Member.

Behavioral Health/Addiction Medicine Kaiser Permanente Southern California’s network addresses both psychiatry and addiction health care needs, based on the increased demand as indicated by the Population Assessment in MOC 1, Element A. The network includes: Psychiatrists (MD), Addiction Medicine physicians (MD), Psychologists (Ph.D./Psy.D.), Licensed Clinical Social Workers (LCSW), Licensed Marriage & Family Therapists (LMFT), Medical Social Workers (MSW), Psychiatric Clinical Nurse Specialists (CNS), Psychiatric Nurse Practitioners (NP), Physician Assistants (PA), substance abuse counselors and Psychiatric nurses (RN).

Behavioral Health Care is also provided through a variety of integrated treatment programs that involve psychiatry and/or addiction medicine specialists and other providers. As additional behavioral health services are available for SNP Members through the Medicaid benefit plan, the ICT Case Manager, the Primary Care Physician, will facilitate information and coordinate care to ensure that the SNP member has full advantage of additional program benefits and services.
SNP Interaction The ICT will interact with the health care team at the Medical Centers. SNP members also need access to a provider network that allows for in-home, and community based services such as IHSS and MSSP Independent Living Centers. Kaiser Permanente has established relationships with other organizations such as community based services and safety net providers (FQHCs, community clinics) and the county department of health services to provide assistance with meeting the strict care expectations and quality measures for serving this population.

Medical Center SNP Programs that do not have dedicated social services staff will rely on support from Medical Social Services department. The ICT benefits from the expertise of a Clinical Pharmacist for cases where patients have complex medication therapy management issues. The ICT also relies on the Behavioral Health clinician for patients with complex mental health needs. The Behavioral Health Liaison will consult with the ICT Case Managers, offer recommendations and facilitate getting the beneficiary into treatment as indicated. These practitioners participate in the ICT meetings as needed.

Clinical Oversight

License and Competency Verification

Competency The Medical Centers monitor clinical competencies to validate staff clinical proficiency with medical equipment including blood pressure machines, glucometers, pulse oximetry machines. Competency validation is administered by the staff education, Nursing Department or the individuals Department Administration. Department specific competencies are administered by the department manager annually as part of the performance appraisal and would include items regarding knowledge of disease specific indicators determined by that department’s service and target population. These include behavioral or medical concerns, to reinforce specialized training or to validate regulatory or program specific indicators.

Within the SNP departments are knowledge of treatment, services and departments that are in more frequent use by SNP members, as determined from the population analysis. ICT Case Managers are more frequently involved with Geriatric Care, Oncology Services, Behavioral Health/Addiction Medicine, Pain Management, Diabetes/Coronary Artery Disease (CAD) and would be more experienced with education, services and programs that support those treatments. Specialized education is obtained and available through Kaiser Permanente, to include continuing education programs, online education, or conferences. These contribute to the ICT Case Manager’s ability to provide coaching and self-management techniques for the SNP Member.

Licensing Staff credentialing and license verification occurs at time of initial application, reappointment, expiration and when a new privilege is requested. License renewal is the responsibility of the licensed staff to ensure good standing without expiration. Kaiser Permanente does not permit staff without current credentials to provide patient care. Licensure renewals are monitored with notification to the Medical Department Manager/Director for staff that has renewals due within a designated time frame. Upon receipt of the renewed license, the staff’s immediate supervisor obtains primary source verification and submits notice to the Human Resources Department.

7 Kaiser Permanente supports attendance at conferences developed internally by KP Education as well as sponsoring and/or attendance at external programs.
Clinical Guidelines Kaiser Permanente has developed clinical practice guidelines that are used by the physicians and other providers. Clinical Practice Guidelines (CPG) are not used for the purpose of approving, denying or modifying medical care requests. CPGs are designed to be an adjunct to clinical practice, but do not take into account individual patient characteristics, including past medical history, co-morbidities, prior response to treatment, etc. that a MD may use to determine if following the Clinical Practice Guidelines for an individual patient is the best course of medical management.

CPGs are built into the electronic medical record to facilitate ease of use and assurance for continual review by providers. Providers receive decision prompts, such as evidence based treatment or diagnostic “order sets” or best practice/health maintenance alerts based on patient specific data to guide the provider to review other medical considerations in addition to the KP Member’s presenting problem. A “hard stop” functionality requires the providers to document care in alignment with clinical practice or describing alternate care before the chart can be closed. This ensures that evidence based medicine is continually in review when determining the best care options for the SNP Member.

Care Transitions Another source of evidence based medicine used by KP SCAL’s ICT is the care transition protocols. The SNP Care Model adopted the Care Transitions Program® (Eric Coleman, MD, MPH) for its tools and processes to ensure a patient-centered, interdisciplinary intervention that addresses continuity of care across multiple settings and practitioners. The ICT Case manager serves as the point of contact to coordinate seamless transitions across healthcare settings, care providers and health services and to ensure that the SNP member will remain in the least restrictive care setting. The Case Manager supports the SNP Member prior, during and following changes in health status with techniques and strategies to support self-management of the SNP Member’ condition.
3. Describe how staff responsibilities coordinate with the job title.

The ICT is a case management model, with oversight by a Program Manager and Physician Lead, to assist the SNP Member obtain care to delay disease progression and reduce the need for institutionalization by facilitating in home care needs available through the Medicare or Medicaid benefits.

The PCP and ICT Case Managers work with SNP Members to facilitate specialty and ancillary care. The ICT Case Manager works with members to facilitate access to services they are eligible to receive in the community and Medicaid covered services, including a web based questionnaire for Benefit analysis to indicate available but underused community services benefits for that specific member. Evidence based guidelines determine necessary care items. In conjunction with an assigned Primary Care Physician, the Case Manager ensures that the beneficiary receives recommended care. As appropriate, the beneficiary and Case Manager will identify other social and medical treatment.

ICT Care Managers work with members to identify needed care and determine current patient goals to include behavioral medical or social issues. Following initial contact with the SNP member, the ICT Case Manager will as needed, discuss progress, assist with transitions in care, if applicable, and assist in reinforcing new skills and information learned from prior conversations.

KP SCAL SNP’s program has been in operation since 2010 and has established job roles in place. These have been reviewed over time with minor changes; as such, no major operational changes are anticipated for changes to staff title or position.

Identified Roles within the SNP ICT

- Physician Champion: The physician is responsible for ensuring appropriate assessment and care planning. Specific tasks of the physician champion include Clinical resource for team to oversee ICT case conference (recommended weekly or a minimum of four (4) hours per month), provide clinical consultation for complex patients, review assessments and care plans as needed, provide recommendations and direction and sign orders as appropriate. After ICT meeting, the Physician Champion coordinates care with other providers, as a liaison between team and PCP and communicate program to physicians within medical center.

- Program Manager: Provides Clinical oversight for case managers and other clinical staff. Provides clinical consult for complex patients, provides direction to staff, monitors ICT case conference agenda development and follow up.

- RN/SW Case Manager: The Case Manager is responsible for assessments and care plans for assigned members within scope of practice. The RN/SW Case Manager is the essential contact with the SNP beneficiary to ensure that the member, care giver or responsible party comprehends the SNP Member’s condition and is able to comply with necessary treatment elements. Conduct annual and transition assessments. Specific Tasks are to develop, implement and update care plans, coordinate with other team members, provide follow-up for member/caregiver calls/messages, prepare and present
cases at ICT case conferences. Following the Case Conference, the Case Managers update care plan, communicate plan of care with SNP beneficiary, caregiver or responsible party and implement changes

- Registered Nurse Practitioner, RNP (optional) – The Registered Nurse Practitioner is an optional member of the ICT. The RNP supplement care activities by providing more in-depth care management and treatment needs to support the physician activities. The RNP has been an essential component of the transition process to review discharge plans, medication orders and follow up test to ensure completeness and accuracy.

- Clerk / Coordinator / Medical Assistant/ Project Manager – These roles provide analytic, clerical and HSQ support. Duties specific to this role are collecting activity reports, such as daily transition (discharge) reports, directing inbound calls and inbasket messages, manages received HSQ reports for follow up by case managers, providing HSQ non-responder follow-up as appropriate, managing opt out, refusals and unable to reach process. This role also assists the case managers with tracking requests through the Kaiser Permanente system for referrals, appointments, educational materials, DME products, etc.

- Behavioral Health Liaison – The Behavioral Health Liaison is either an SW or RN Case Manager who works jointly with Kaiser Permanente’s Psychiatry and Addiction Medicine Specialty departments. The Behavioral Health Liaison is available to work with the ICT to assist SNP beneficiaries to facilitate care for Psychiatric or Addiction Medicine issues. The Behavioral Health Liaison attends IDT case conferences to provide consultation in the multidisciplinary team conference. Prior to IDT meeting Specific duties are to review the medical record as needed per case manager requests, coordinate care with other providers and other follow up as needed.

- Clinical Pharmacist (PharmD) – The pharmacist is an integral part of the IDT as a result of the medical complexity of these patients. The pharmacist either attends scheduled case conferences or works with the SNP Case Managers to resolve medication issues identified. The Clinical Pharmacist provides consultative expertise to the IDT Case Conference and to the Case Managers as requested.

- LTSS Coordinator– The LTSS coordinator is a SW or RN or LVN Case Manager who works with the community agencies providing LTSS services. The LTSS coordinator contributes to the discussion of the SNP Beneficiary by reviewing the existing LTSS services to determine appropriateness or for underutilization of benefits. The LTSS coordinator facilitates referrals and interacts with the SNP Member, caregivers, family and contracted LTSS vendors.

Following is the organizational chart that demonstrates the reporting structure of the ICT.
KP SCAL SNP Program Oversight

KPMMP Board of Directors

Quality & Health Improvement Committee (QMIC)

Southern California Quality Committee

Kaiser Permanente Program Office
Special Needs Program and Medicare Compliance

KP SCAL Regional SNP

Medical Center SNP ICS*

AV BP DW FN KC OC RV PC SB SD LAMLA WH

2/12/2014

*Please refer to Page 2 for Medical Center SNP ICT Operations organizational chart
4. **Describe contingency plans used to address ongoing continuity of critical staff functions.**

**Disaster Planning**
Kaiser Foundation Health Plan/Kaiser Foundation Hospitals (KFHP/KFH) and the Southern California Permanente Medical Group (SCPMG) are committed to compliance with Centers for Medicare and Medicaid Services (CMS) requirements and to ensuring that members, including Senior Advantage members, have access to necessary medical care during federal disasters or other public health emergencies.

KP SCAL coordinates with the Medical Centers to develop an Emergency plan used as a guide to manage emergencies/disasters, internal and external. The plan describes the roles and responsibilities required to support regional emergency operations as well as specific policies, procedures and resources that address hazard identification and mitigation, preparedness, response and recovery.

These emergency plans are included in new hire orientation, annual competency education updates and are practiced on an unscheduled basis throughout the year to determine staff readiness to emergency preparedness. The plan identifies coordination between Medical Office Buildings, administrative buildings and the Regional Emergency Operations to ensure appropriate care to our members.

**Communication Continuity**
The maintenance of the electronic medical record allows for continuity of staff function across the organization by ensuring that any involved clinician is up to date on member health status as needed.

Emergency plans have been developed for planned or unplanned “downtime” to ensure that patient information and subsequent documentation is maintained during software upgrades, system outages or external influences, such as a natural disaster.

All KP staff revert to “downtime” processes for the electronic medical record and maintain in this mode until resolution as indicated by the Command Center.

**Staffing**
At the Plan Level, a SNP Regional Team has been established to oversee the KP SCAL SNP Program. Core responsibilities for consulting activities are shared between the Regional Director of Complex Case Management and a Manager of Seniors & Persons with Disabilities (SPD) and Complex Case Management. Critical job functions are shared between the two roles. In the event of a long term leave, whether planned or unplanned, job roles will be shifted to the other person with a transition plan to identify upcoming efforts or major deadlines.

At the Medical Center level, Managers or other supervisory staff provides coverage for each other across departments to ensure operational continuity for short and long term absences.

Kaiser Permanente considers the member’s care team collectively responsible for assuring timely and appropriate care. However, the IDT Care Manager is the key team member to both assure all follow-up
is scheduled and performed and to monitor the outcomes of care provided. Special consideration is used to ensure there is no disruption evident for the member.

For Case Management staff, the continuity plan is dependent upon the length of leave. For holiday or short term vacation leave, coverage is coordinated by other ICT Case Managers to address immediate telephone requests or manage transition contacts. For longer term leaves, to include medical leaves or job changes, the SNP Program Manager will monitor caseloads, reallocate as needed, to ascertain if coverage can be maintained until the staff member returns or is replaced. As appropriate, the SNP Program Manager will arrange for temporary staffing or the hiring of additional staff to meet program demands. This provides a contingency plan to ensure critical staff operations to the SNP Member will continue independently of short or long term staff vacancy.
5. Describe how the organization conducts initial and annual MOC training for its employed and contracted staff

Model of Care Training
The Model of Care training is available online as part of new hire orientation and annual update as well as during any significant program change that is the result of benefit or program changes. The MOC is housed on Kaiser Permanente’s online training website KPLEARN.

KP Learn is available to employees, physicians and contingent workers through an intranet website.

Example: KP Learn Log On webpage

While ICT Core Staff are autoenrolled into the training, other stakeholders can directly register for this course by using the search function in the learnings catalogue. Both the employee and direct supervisor can monitor status and progress for training completion.

Example: KP Learn – Staff Scheduled Enrollments

The MOC is reviewed annually for revision by the four (4) SNP KP Regions to ensure program consistency. The MOC training provides information on services and programs available to the SNP Member and defines how the Service Area ICT completes program elements to support improved member health outcomes.
Objectives for the SNP Model of Care Training
- Define the SNP Model of Care
- Identify the proper Steps for Assessment and Care Planning
- Identify the required elements for the SNP Model of Care
- Define Key Measurable Goals
- Identify SNP Care Management Roles and Staff Structure
- Define the Provider Network
- Define Data Collection, Analysis and Reporting
- Identify the SNP Communication Network
- Identify Contact Information for the region

The Model of Care training addresses specific elements required by CMS and defines how the SNP KP Regions implement standards to address those elements.

- Program Goals and Performance
  - SNP Members Health Outcomes
- Role of the Interdisciplinary Care Team
- Use of the Health Risk Assessment
- Clinical Assessments and the Individualized Care Plan
- Regulatory and Quality Reporting

Example: SNP MOC Training Content

SNP Model of Care
In This Course You Will Learn To:

- Define the SNP Model of Care
- Identify the proper Steps for Assessment and Care Planning
- Identify the required elements for the SNP Model of Care
- Define Key Measurable Goals
- Identify SNP Care Management Roles and Staff Structure
- Define the Provider Network
- Define Data Collection, Analysis and Reporting
- Identify the SNP Communication Network
- Identify Contact Information for your region

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Measurable Goals

- **Goals of the Model of Care**

To Improve:

- Access to medical, mental health, social services & affordable care
- Coordination of care through an identified point of contact
- Transitions of care across healthcare settings & providers
- Access to preventive health services
- Beneficiary health outcomes
  - (e.g.) Reduce hospitalizations & Skilled Nursing Facility placements

To Ensure:

- Appropriate utilization of services
- Cost-effective service delivery

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Data Collection & Analysis

- **Plans must collect data on**

  - **Beneficiary health outcomes** such as:
    - reduced hospitalizations & SNF placements
    - improved self-management & independence

  - **Quality indices** such as:
    - improved access to affordable medical care & mental health/social services
    - coordination of care through a single point of care management

  - **MOC structure or processes** such as:
    - improved coordination of care through the use of an individualized care plan
    - utilization of services by identifying & stratifying health risks
Regular teleconferences are held with SNP Program Managers, SNP Physician Champions, ICT Case Managers to reinforce the established standards, performance against the standards and to devise strategies to improve performance.

**Supplemental Training**
The ICT core staff receives additional supplemental educational programs to increase proficiency in topics relevant to SNP Member management. Additional training may include new program requirements as updated by CMS. Program content is determined from recommendations by SNP Program Managers and includes behavioral health issues, Medicare/Medicaid benefits, quality programs, addressing special clinical patient needs and Care Management standards. Other specialized training may focus on technical needs such as reports related to risk stratification and membership, electronic medical record tools, or regulatory requirements.

Other topic needs are determined by monitored quality metrics, such as end of life planning, changes in workflows or systems, or suggestions by ICT members for issues encountered during SNP Member management such as “Motivational Interviewing” or “Available Community Based Programs.” All training is provided through face-to-face meetings, web based instruction and/or telephone conferences. The complexity of the SNP program elements require additional updates within the ICT Core Team to ensure that the new hire has full comprehension. Subsequent follow up trainings help reinforce key learnings.

Webinar is the preferred method for training as it provides a recording feature that allows for new hires or those that missed the initial schedule to replay as needed. This also allows SNP Program Managers to continue daily operations without an impact on staffing. Training materials provided to attendees are maintained on Kaiser Permanente’s intranet for all ICT members.

The annual training schedule is developed, implemented and maintained by the SNP Regional Program staff.
6. Describe how the organization documents and maintains training records as evidence that employees and contracted staff completed MOC training.

Model of Care Training for the ICT staff follows the process for other trainings that are established in KP Learn. This online educational website specifically tracks enrollment and transcripts for required trainings.

KP SCAL SNP has little reliance on contracted staff but would follow the same process for this employment category.

**Annual Updates – Model of Care Training**

All related SNP Regional staff and ICT staff are preregistered for the Annual SNP Model of Care Training. The class registration will be listed on the individual staff enrollment page to notify of required trainings as part of the required training enrollments. Staff is provided adequate time during working hours to complete the anticipated one-hour training in advance of the training deadline.

**New Hire – Model of Care Training**

The SNP Program Manager registers new ICT staff for the Model of Care training on KP Learn. The new hire is required to complete the online training within the first month of employment. Staff will be provided adequate time during working hours to complete the anticipated one-hour training. In the subsequent year, staff are added in the “established” staff roster, as defined above, to allow for the autoenrollment feature.

Verification of completion of the online training is documented in KP Learn and with a printed completion certificate as additional verification. Additionally, the completed training is included as part of the employee’s individual transcript of all educational offerings attempted and/or completed.

**Example: KP Learn - Staff Transcript**

<table>
<thead>
<tr>
<th>Transcripts</th>
<th>Title</th>
<th>Learner Name</th>
<th>Course Id</th>
<th>Start Date</th>
<th>End Date</th>
<th>Date Marked Complete</th>
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<td>Medicare Advantage: Grievances, Organization Deter...</td>
<td>CPL/NACPL MED MAGOD 2013</td>
<td></td>
<td>06/28/2013</td>
<td></td>
<td></td>
<td>Successful Print Certificate of Completion</td>
<td>Web Based Training</td>
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<tr>
<td>Annual Compliance Training 2013</td>
<td>CPL/NACPL ACT 2013</td>
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<td>06/10/2013</td>
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<td></td>
<td></td>
<td>Successful Print Certificate of Completion</td>
<td>Web Based Training</td>
<td></td>
</tr>
</tbody>
</table>

Sixty days prior to the established deadline for annual training, the Regional SNP Program will compile a list of those ICT employees who have not completed training to date. This provides a reminder to allow the SNP Program Managers to prompt ICT staff to dedicate time in advance of the deadline to complete the training. This process repeats at 30 days and 10 days prior to training until all staff are completed.

**Example: SNP Manager/Stakeholder Reminder notification**
Hello,

This attachment contains the names of those who have not yet completed the 2013 SNP Model of Care training. We will be discussing this list during tomorrow's meeting. Please let me know if you have any questions or issues. Thank you.

SNP_MOC_Training_Outstanding_List_12.4.13.xlsx

[Name]
Special Needs Program/Utilization Management
Walnut Center
7. **Describe actions the organization takes if staff do not complete the required MOC training.**

The individual’s direct supervisor provides notice of the training requirement with reminder prompts and time on the job to complete training; the intent is to provide opportunities that allow the ICT to be successful for training completion.

Anticipation MOC training noncompliance starts 90 days prior to the identified deadline. SNP Program Managers are notified of those staff that has not completed training. SNP Program Managers have the responsibility for notifying individual staff and providing the time during regular scheduled work hours to complete the training. The Regional SNP Program Team monitors completions and provides subsequent notices are presented on a monthly basis until the deadline has been met or until all staff has completed training. Staff that is on HR-defined leave, including family or medical leave, will be deferred from completion until the return to work has commenced.

Noncompliance with required training is reportable to the individual’s direct supervisor. Failure to complete required training will result in progressive disciplinary action initiated by the SNP Program Manager as defined by KP Human Resource policy.
Element B: Health Risk Assessment Tool (HRAT)
The organization’s MOC includes a clear and detailed description of the policies and procedures for completing the HRAT that addresses:

1. How the organization uses the HRAT to develop and update the Individualized Care Plan (ICP) for each beneficiary (Element 2C).

The HRAT initiates the Care Planning Process for the KP SCAL ICT.

The Health Risk Assessment Tool for Kaiser Permanente Southern California is the Health Status Questionnaire (HSQ) implemented by a Kaiser Permanente affiliated organization, the Center for Health Research (CHR). The CHR manages receipt of the patient collected data that is transferred to the SNP ICT through the electronic medical record. When the HSQ is not received by the mailed process, the ICT staff will outreach to members to obtain the HRA information over the telephone to ensure that the patient information and subsequent risk scores are included in the care plan development.

When not obtained by mail, the ICT staff uses outreach lists, either created by tracking reports within the CHR website or by other alerts, such as reports on transitional activity, new member enrollment or reassessment anniversary dates. Upon review of the HSQ results, the ICT Case Manager contacts the SNP Member or designated responsible party to initiate the clinical assessment.

The SNP Member drives the development of the care plan; the case manager may prompt areas to consider but ultimately, the SNP Member determines content of the treatment goals. The Individual Care Plan is reviewed and shared with the SNP Member and the Health Care Team, headed by the ICT Team and the Primary Care Physician. A Care Plan letter is sent to the SNP Member and attached to that encounter in the electronic medical record.

Elements that are incorporated into the plan of care include goals and objectives, results from the health assessment, care preferences, medication review, add-on benefits and services, end of life discussion, fall risk, review of underutilization of eligible services or benefits, and as appropriate, education on complications associated with specific diseases the SNP Member may be experiencing.

Care Plan Development is based on completion of the Special Needs Program Assessment Questionnaire. The Questionnaire is stored as a flowsheet in the electronic medical record which allows for retrieval and response trending. The assessment is completed by using a series of other screening tools and assessments, including a PHQ2/PHQ9 Depression Questionnaire, past hospitalization review, Mental Health/Mental Illness/Substance Abuse History, Medication Adherence and Drugs to Avoid list, benefits assessments, Pain screening/management plan, psycho-social review including a screening for potential neglect. IADL and ADL functional status, cognitive issues and additional assessment tools may be used, such as the CAGE Questionnaire for Alcohol Use or the Katz assessment for ADL status.

Other add on benefits needs are determined as part of the assessment process. These include educational needs which would allow for referrals to classes in member health education. Additionally, the community benefit review provides needs assessments of services available either free or as part of the Medicaid benefit package, to include other home and community based services. A Community
Benefits Matrix of available programs and services is in use from cross over work with the Medical Social Services Department. Another source is the Benefits Check Up website that was developed by the National Council on Aging as a partner with Kaiser Permanente. Based on zip code and socioeconomic status, the website identifies other programs and resources available in the community that the beneficiary may be eligible for and request assistance to pursue. These include low cost housing, tax credits, and supplemental income sources.

The ICT Care Manager will document the specific goal(s) on the SNP Care Plan questionnaire in the electronic medical record, The ICT Case Manager will also update the status of each goal within 12 months or upon a significant change in health status.
2. How the organization disseminates the HRAT information to the Interdisciplinary Care Team (ICT) and how the ICT uses that information (Element 2D).

As the Center for Healthcare Research (CHR) receives the completed HSQ, SNP Member response data and risk scores are automatically uploaded into the electronic medical record. This generates a system notification to the ICT notifying them that the HSQ survey results are available as part of an inbasket message by Medical Center within the electronic medical record.

The inbasket message is sent to a group mailbox that allows the ICT to prioritize case manager workloads based on the incoming message volume. Once the message has been read and accepted by a single user, it removes the message from the group mailbox; it is merely a notification that the results are now available in the SNP Member’s medical record. This indication of a received HSQ provides a trigger for the ICT staff to triage the active surveys for ICT Case Manager Care plan development.

Completed HSQs that do not trigger the automated notice are sent to the Regional SNP Program Team to provide Medical Center notifications. The volume of missed automated notices is limited and is typically the result of demographic mismatch. These typically are <10 per month and the result of address change mismatch or name change that has not transmitted between systems in enough time to update the membership eligibility lists.
3. How the organization conducts the initial HRAT and annual reassessment for each beneficiary

The HRAT drives the clinical assessment and care plan process for KP SCAL’s SNP program.

Nationally, KP uses an automated mail survey process to conduct initial and annual assessments for SNP members using the Health Status Questionnaire (HSQ). The HSQ is a 45 question validated instrument that addresses the required domains and assesses frailty (probability the member will be dependent on others for daily care within next 12 months), hospital readmission (probability of hospital readmission within next 24 months) and advanced illness (probability of death within next 36 months).

Between the 1st and 10th of each month, regional SNP membership files are automatically created and uploaded to a secure website that is accessed by Center for Health Research (CHR), a KP affiliated research company, that developed and administers the HSQ. Business rules outlining when HSQs should be mailed are developed by KP SNP Program Office staff and provided to CHR at the close of each year for the upcoming year. These rules include, but are not limited, to the following:

- New SNP members are mailed a HSQ the month they first appear on the monthly SNP membership file ensuring members are aware of and engaged in the assessment process within 90 days of enrollment in SNP.
- SNP members who complete a HSQ are mailed another HSQ nine months after the month of the completed HSQ to address the requirement for re-assessment within one year of the initial or prior assessment.
- SNP members who do not return a HSQ in a given year are mailed at the start of the following year.

CHR programs the business rules and runs the rules against the monthly membership file and their HSQ tracking system (houses historical member level HSQ data including mail dates, completion dates and respondent data) to identify which members in the monthly membership file are due for a HSQ mailing that month. The resulting mail file is uploaded to the fulfillment and mail house for processing.

Two weeks after the HSQ is mailed, a reminder postcard is sent encouraging members to complete and return the survey. If two months after the HSQ was mailed a completed survey has not been received, a second survey is mailed.

The completed surveys are returned to CHR where response data is scanned into their system and member level risk scores for frailty, advanced illness and hospital readmission are computed.

The National HSQ website tracks the nonresponders for the mailed survey. This is one way for the local teams to target SNP Members for outreach. The ICT also targets member reassessment anniversary dates independently of the HSQ nonresponder list.
The ICT staff calls the SNP Member and arranges to obtain the survey results over the telephone. As part of this process, the ICT Case Manager explains the HRA process, conducts the SNP Member interview, initiates other assessments to begin the care plan development.

The ICT strives for 100% completion of HRAT for its membership, but acknowledges that members may opt out of participation are cannot be reached. Following the CHR mailing of the HSQ, as members are placed on that nonresponder list, the Medical Center ICT assumes responsibility to collect the HSQ by telephone. A member of the ICT makes three (3) subsequent call attempts to the member to obtain the HSQ. If the member is reached, the ICT will collect the responses, unless the member requests a mailed HSQ. This information is relayed to CHR to begin the mailing process again. More often, SNP Member agrees to participate and HSQ responses obtained by telephone are entered into the website.

If the member has not been reached, the ICT will send a letter, call one (1) more time, and wait up to two (2) weeks before identifying the Member as “unable to reach” (UTR) and alternate methods are used. Member that are designated as UTR receive continued attempts to outreach to the SNP member to complete the care plan. These include member contact during clinic appointments or enlisting the Primary Care Physician to assist with establishing contact. The ICT Case Manager will provide closer monitoring of transitional contacts as these may signal a change in the SNP Member’s condition that may necessitate additional in home needs available through the SNP benefits.
4. The detailed plan and rationale for reviewing, analyzing and stratifying (if applicable), the HRA results.

KP SCAL SNP uses two sources to risk stratify SNP Members for prioritizing patient contact. These are the Health Risk Questionnaire (HSQ) and the Diagnostic Cost Grouping (DXCG). The process to risk stratify occurs on an individual basis to provide information that will target high risk patients for immediate contact and to guide the interaction to anticipate interventions.

The HSQ is a self-reported assessment survey developed by the Center for Healthcare Research (CHR) as a Kaiser Permanente affiliated research organization. The HSQ has multiple areas of inquiry, to cover cognitive, medical functional and psychosocial elements. The HSQ assesses perceptions of general health, self-care, medical care and remaining independent. Kaiser Permanente has used the HSQ since 1995 and its use as a study tool has been validated as a reliable predictor of hospitalization and end of life risk.

The HSQ provides three risk scores based on question mapping to obtain these results. The three scores are obtained for:

1) The Frailty Score is the probability that the respondent will experience frailty (dependent upon others for daily care) in the next 12 months. A score greater than or equal (≥) 0.50 is flagged as high risk.

2) Hospital Readmission (HRAD) the respondent’s risk of hospital readmission in the next 24 months. A score greater than or equal (≥) 0.50 is flagged as high risk.

3) Advanced Illness (AII) is the respondent’s risk of death in the next 36 months. A score greater than or equal (≥) 0.175 is flagged as high risk.

In the absence of, or to complement the HSQ, existing KP Members with SNP coverage are also risk stratified by Diagnostic Cost Grouping (DXCG). This is beneficial for those cases in which an intervention has been initiated prior to obtaining the HSQ, such as notification of an inpatient hospitalization within the initial weeks of SNP enrollment.

The DXCG model uses medical data to assign a member’s risk score indicative of the relative risk of future medical resource consumption. Scores range from 0-100. A score equal to or greater than (≥) 15 is considered high risk. The monthly DxCG report also flags SNP members whose risk score moved from less than (<) 15 equal to (≥) 15 or more.

In the scenario described above, the DxCG in absence of the HSQ provides prioritization for patient contact during daily transition case assignments with the indication of future resource needs.

As HSQs are completed and scored by the CHR, they are delivered to the designated ICT electronic medical record inbasket, based on geographic location. HSQ scores provide triaging direction for ICT Case Manager assignment. This allows the ICT Case Manager to determine urgency for specific outreach attempts to focus on high risk member contact.
HSQ scores are trended in the SNP Member’s medical record; this provides the ICT Case Manager with the opportunity to assess risk score changes over time. Interventions are developed from individual analysis of the SNP member’s condition based on changes in the risk scoring.

Risk Stratification assessment is also evident in the KP SCAL SNP’s CMS Quality Improvement Project (QIP). SNP Members presented for escalated case conference review are typically identified from increased utilization or discovered from unmet needs arising from assessment or transition contact. KP SCAL SNP’s QIP provides a complementary process by using risk stratification scores from HSQ or DxCG, without active presenting needs, to proactively assess the member’s needs during case conference review. The intent is to develop a safety net plan should the SNP Member’s situation abruptly change. This is an anticipatory planning process that works equally well for SNP Members who actively participate in the process as well as those SNP Members who opt-out of the assessment process or are unable to be reached.
Element C: Individualized Care Plan (ICP)

The description of the organization’s ICP must include:

1. The essential components of the ICP.

A care plan is developed based on the information obtained from the health risk assessment, comprehensive SNP Member interview which lead to other clinical assessments, the patient determination of key priorities, and review of past clinical history in the members’ medical chart, if available. Initial Care planning is initiated upon receipt of the Health Risk Assessment from Kaiser Permanente’s Health Risk Questionnaire (HSQ).

The Individualized Care Plan includes results of the Clinical Assessment, review of Community Benefits and Services, a minimum of 1 – 3 patient prioritized goals, barrier assessment, interventions and follow-up plan/schedule.

Clinical Assessment
The initial assessment includes, as applicable, the following evaluation components:

- Current health status and specific health conditions and co-morbidities
- Clinical history including the onset of illness, key events such as acute phase or inpatient stay, treatment history and procedures; past and current medications. The case manager may refer to the “problem list” in the electronic medical record to gather information about the member’s clinical history and onset of illness
- Review of any pertinent diagnostic procedures
- Functional status including Activities of Daily Living (ADL), and Instrumental Activities of Daily Living (IADL)
- Psychosocial factors such as alcohol use and smoking, living arrangement, highest level of education achieved, and support system
- Mental Health status, including cognitive function and Depression screening with Patient Health Questionnaire (PHQ–9)
- Life planning which address end of life decisions, Advance Directives, Health Care Power of Attorney.
- Cultural and dietary preferences, as applicable, religious affiliations, cultural or family traditions related to illness, death and dying; any spiritual beliefs that discourages treatment and procedures; ability to understand and/or speak English and need for interpreter
- Visual and hearing impairment; preferred communication device(s), and ability to communicate
- Quality of life assessment relative to self-perception of health compared to same age group.

Community Benefits and Services
The ICT Case Manager reviews the benefits and services that the member is currently receiving against available services that may be underutilized. The ICT Case Manager will facilitate application to services
to ensure that the member’s Medicare and Medicaid benefits are coordinated. The SNP Member is assessed for items, such as:

- Community resources the member is currently receiving as well as a review of potential underutilized services
- Evaluation of benefits including secondary plan and dual enrollment (Medicare/Medicaid) and pertinent financial information that may impact the delivery of services
- Need for current and future Long Term Supports and Services (LTSS)
- Caregiver assessment including type of assistance provided to the member, involvement with decision-making, and need for care giving training or supportive services

**Goal Planning**
The case manager prioritizes the goals based on member’s or caregiver’s prioritized health concerns, preferences and desired level of involvement in the care management plan and for which the member agrees. SNP Member Goal Planning includes, as indicated:

- Identified problems based on the member’s prioritized health concerns
- Mutually agreed upon goals by priority with targeted achievement date
- Member’s identified tasks, such as:
  - Maintaining prescribed diet
  - Self-monitoring of blood sugar, blood pressure or weight management
  - Recording and reporting blood sugar readings or blood pressure readings
  - Self-administration of medication or refill management
  - Behavior modification, such as smoking cessation, dietary changes or weight management
  - Management, replacement and reordering of DME and supplies

**Barrier Assessment**
The ICT Case Manager assesses barriers to meeting goals and plan of care such as knowledge deficits about disease process, medications, treatment or self-care management. The Member or caregiver’s physical ability, financial or transportation problems are included as limitations affecting participation in care. The Barrier Assessment also involves a readiness assessment to include motivational factors or readiness to change. The SNP Case Managers employ techniques of Motivational Interviewing to determine the member’s readiness to engage in the process.

**Interventions**
The SNP Member and ICT Case Manager collaboratively determine strategies to help achieve defined goals, taking into consideration items identified from the Barrier Assessment. The resulting interventions provide a plan of action to assist the SNP member achieve defined goals.

Case management interventions include these activities, as indicated:

- Education on disease entity and self-care techniques, supported with education materials and self-care action plan
- Coaching on self-care management procedures
- Communications with MD, community agencies, and other members of the health care team and follow-up
- Discussion with the SNP Member or Caregiver to resolve barriers
• Access to immediate MD appointment
• Proactive coordination of care which includes but is not limited to the following
  o Referrals to community agencies
  o Access to health care services and community resources

Follow Up Plan/Schedule
Reassessment of goals progress, evaluation of effectiveness of interventions and referred services will occur either upon a time schedule established collaboratively between the Member/Caregiver and ICT Case Manager agree. As the plan is individualized to the SNP Member, it may include referrals to services, consults with Physician or Pharmacist, and other care options, to include external benefits to KP, such as Medicaid or community services. The primary purpose of the follow up schedule is to evaluate goal progress and to determine the need to modify the intervention. If no progress is made, the ICT Case Manager may reassess, as needed:

• Readiness to learn or to change behavior
• Adherence with treatment regimen including follow-up appointments
• Knowledge of condition and treatment plan
• Ability to sustain learned self-care skills
• Stability of support systems
• Ability to access care at the appropriate level
• Evaluation of member’s ability to follow-through with directions, referrals, or agreed upon self-care management plan. When a caregiver is involved, this activity includes an evaluation of the caregiver.
• Evaluation of member’s or caregiver’s ability to follow-through with self-care action plan
• Response to interventions

The care plan is agreed upon by the member and the ICT Case Manager mails a copy for the member’s reference. The SNP Member’s care plan is attached to the SNP Member’s medical record. The ICT Case Manager send a copy of the care plan for the PCP’s review with alerts when there are immediate SNP Member concerns. The care plan is also routed to ICT members as appropriate. The PCP’s care concerns are integrated in to the case management plan as indicated.
2. The process to develop the ICP, including how often the ICP is modified as beneficiaries’ health care needs change.

The ICT Case Manager develops the ICP after a thorough review of the SNP Member’s clinical history, including a review of the past medical history, the health risk assessment and an interview with the SNP Member, Family Member or Caregiver to create a comprehensive clinical assessment.

Initial Care planning is initiated upon receipt of the HRA and completed within 90 days of new enrollment. Annual Care planning update is part of the reassessment that occurs prior to the anniversary date of the previous assessment. The Care Plan is developed in conjunction with the SNP Member or caregiver/responsible party. The SNP Member or caregiver provides information essential to the care plan development, including a determination of goals that hold value to the SNP Member, available or needed resources to achieve the goals, and what measures will be used to deem the goal successfully completed with an identified timeframe. The ICT Case Manager also completes an evaluation of SNP member’s/caregiver’s/responsible party’s ability to follow-through with directions, referrals, or agreed upon self-care management plan.

Reassessment of goals progression and evaluation of effectiveness of interventions and referred services will occur per agreed upon timeframes, upon a significant health status change or at least annually. Reassessments that are initiated during significant health status change, with a subsequent care plan update or revision, are based on the clinical judgment of the ICT Case Manager. Transitions are a key source to indicate health status changes, however, the reason for the admission is assessed to determine if the change was significant. For example, an ED visit may signal that a significant health change occurred, however, if it is determined that the visit resulted from care that could have been provided in the ambulatory setting, the ICT Case Manager may offer assistance to arrange future visits, the transition contact was noted without updating the care plan.

Care Plans may be updated independent of the scheduled assessments. Examples include prearranged follow up contacts to check goal progress or during adhoc contact to address SNP Member requests.

Care planning is within the domain of the ICT Case Managers to include Social Workers, Registered Nurse, Pharmacists or Registered Nurse Practitioners. The SNP Physician Lead may also update the Care Plan.

ICT Case Managers are licensed consistent with industry practices to ensure that each clinical practitioner is qualified in accordance with applicable professional or industry standards and laws. This process for clinical or administrative oversight to ensure competency proficiency and licensing is described in MOC A, Factors 1 and 2.
3. The personnel responsible for development of the ICP, including how the beneficiary and/or caregiver(s) are involved

The Case Manager is the key contact for the SNP Member for Care Plan Development. The Case Manager can be a Registered Nurse and/or a Medical Social Worker, or Nurse Practitioner (NP) Case Managers. As part of the Care Plan development, the Case Manager works in partnership with the SNP Member to develop a comprehensive care plan and coordinates care across the continuum, including specialty care and services. Case managers review pharmacy, ED and hospital utilization for appropriateness and consult with others on issues related to psychosocial concerns, pharmaceutical issues and medication adherence, mental health and drug/alcohol related problems. The ICT Case Manager uses KP’s clinical practice guidelines to educate and support members on self-management techniques.

As part of the Care plan development, a Pharmacist is also a part of the ICT when indicated for polypharmaceutical management consults. The Pharmacist provides Medication Therapy Management (MTM) as indicated for targeted SNP Members as part of the Medicare Part D services.

A Behavioral Health Liaison is either a Mental Health Professional or Psychiatric RN Case Manager or Social Worker that provides assistance for SNP Member needs in psychiatry and addiction medicine. The Behavioral Health Liaison will facilitate care requests including appointment facilitation or referrals for KP psychiatric evaluations.

For members who receive Long Term Supports and Services (LTSS), the LTSS coordinator will participate in ICP development. LTSS includes MSSP, In Home Supportive Services (IHSS), Community Based Adult Services (CBAS), Home and Community Based Services (HCBS) or Long Term Care (LTC).

The SNP Physician Lead provides clinical oversight and leadership of the ICT to include mentoring and clinical oversight of the Case Management staff. The Physician Lead oversees case conference to review of complex or problem-prone cases. The Physician Lead also interacts with the SNP Member’s PCP to resolve issues identified for follow up.

The Primary Care Physician reviews, approves and contributes, as indicated, to the SNP Member’s individualized care plan.

The SNP Member is an active part of Care Plan development. If the SNP member is not competent, following approved consent for health care needs, the ICT Case Manager will work with the designated person, such as a family member/care giver/appointed guardian.

For SNP Members that are in Hospice, Palliative Care or Skilled or Long Term Care Facilities, SNP Members receive their assessment and care plan by those designated Case Managers.

For escalated case conference review, it is not possible to have the beneficiary physically present. ICT Case Managers involve the SNP Member before and after the Case Conference.
4. How the ICP is documented, updated and where it is maintained.

The ICP is documented as part of the patient encounter within Kaiser Permanente’s electronic medical record. Updated activities within these encounters can be linked in a series, which allows for easier review by ICT members or other providers. The Care Plan presents as a hyperlink within the encounter and can be reviewed for trending or for updating. The report viewer will provide all dated updates to the Care Plan in a single report.

The Care Planning Template prompts for long and short term goals creation, with interventional goals and a success measure. Results of the care plan can be trended over time as progress against stated goals.

Care plan status is reviewed at every SNP Member contact, whether scheduled or unscheduled. Scheduled contacts occur during annual reassessments, transitional activity contact and during case manager scheduled follow up. Unscheduled contacts occur whenever the SNP Member contacts the ICT Care Manager for a specific request or inquiry.

Updates to the individualized care plan are documented in encounters that link to the original episode within the SNP Member’s chart. They are available to all KP SCAL providers as part of the electronic medical record.

A copy of the care plan is sent to the SNP member, caregiver, family member or responsible party within two days care plan development with the member. This information is available in the SNP members medical record and routed to the Primary Care Physician for review, as needed.
5. How updates and modifications to the ICP are communicated to the beneficiary and other stakeholders.

The components of the ICP, health risk assessment, clinical assessment and care plan are available in the electronic medical record for all KP providers and affiliated provider review and the ICT Case Managers and core team. The plan of care summarizes treatment goals that the beneficiary has identified with the ICT Case Manager (RNP/RN/SW) along with resources and additional information requested as part of the contact.

All communication between the health team regarding care plans, updated care plans and follow-up is documented in the member’s medical chart. Members are contacted by the ICT team either by telephone and/or in writing regarding the recommendations of the ICT.

The ICT Case Manager alerts the PCP for SNP Members who have significant health changes or outstanding care needs from the PCP recommended treatment, when known, by routing the member’s care plan with these items called out. The ICT Case Manager will work with the PCP to ensure that the alerted items are resolved.

A copy of the Care Plan is mailed to the SNP Member following completion of the development process. Updates to the Care Plan are not sent unless significant changes are made, such as addressing a significant health status change.

Other personnel and stakeholders have access to the care plan either through direct access to the electronic medical record or through KP Providers that work with those stakeholders. An example of the latter are custodial facilities where KP Physician round on the SNP Member. The KP Physician has access to the SNP Member’s medical record; pertinent details are relayed to the facility’s staff by the physician.
Element D: Interdisciplinary Care Team (ICT)
The organization’s MOC must describe the critical components of the ICT, including:

1. How the organization determines the composition of ICT membership.

Expertise is demonstrated by board certification or accreditation, specialized training, or experience within a specific discipline, such as geriatrics, palliative care, or addiction medicine, etc. The SNP Interdisciplinary Care Team has demonstrated expertise in general medicine, both psychiatry and addiction medicine.

Information obtained from the most recent SNP National Dashboard indicates that within the SNP population, 74% had at least one chronic condition with 20% having at least 3. At least one-third had a behavioral health diagnosis.

The medical center in each service area has an ICT. The ICT will include, at a minimum, a lead SCPMG physician, at least one Care Manager, as a RN, Social Worker or Nurse Practitioner, a Clinical Pharmacist, an LTSS Coordinator and a Behavioral Health Liaison. As indicated by the population review prior to the program start up in 2010, and validated by the recent population analysis, there is predominant need for internal medicine specialties with a focus on multiple chronic conditions, behavioral health or end of life needs.

Members of the SNP ICT include Providers with specialized skills in Geriatrics/Senior Care, Hospice, Home Health or Palliative Care or with specialized skill in disease management, such as complex care to include diabetes, hyperlipidemia or heart failure as those diseases are more prevalent in this population. Behavioral Health are included on the ICT for their expertise in managing members with complex conditions that are compounded with a psychiatric or substance abuse disorder.

- **Physician Champion**: The physician is responsible for ensuring appropriate assessment and care planning. Specific tasks of the physician champion are Clinical resource for team are to oversee ICT case conference (recommended weekly or a minimum of four (4) hours per month), review assessments and care plans as needed, provide recommendations and direction and sign orders as appropriate. After the ICTT meeting, coordinates care with other providers-liaison between team and PCP and communicate program to physicians within medical center.

- **Program Manager**: The SNP Program Manager provides managerial oversight for day to day operations, strategic oversight with the analytic/project support and clinical oversight for the ICT Case Managers. The SNP Program Manager, along with the SNP Physician Champion, makes case assignments and monitors staffing to ensure that Medical Center program operations are in alignment with the regionally defined standards for the SNP MOC.

- **RN / SW Case Manager**: The Case Manager is responsible for assessments and care plans for assigned members within scope of practice. The RN/SW Case Manager is the essential contact with the SNP beneficiary to ensure that the member, care giver or responsible party comprehends the SNP Member’s condition and is able to comply with necessary treatment elements. Conduct annual and transition assessments. Specific Tasks are to develop,
implement and update care plans, coordinate with other team members, provide follow-up for member/caregiver calls/messages, prepare and present cases at IDT case conferences, implement cases. After ICT meeting, update care plan, communicate plan of care with SNP beneficiary, caregiver or responsible party and implement changes

- **Registered Nurse Practitioner, RNP** (optional) – The Registered Nurse Practitioner is an optional member of the SNP Team. The RNP supplement care activities by providing more indepth care management and treatment needs to support the physician activities. The RNP has been an essential component of the transition process to review discharge plans, medication orders and follow up test to ensure completeness and accuracy close to discharge.

- **LTSS Coordinator** – Those members that receive Long Term Supports and Services (LTSS) will have their LTSS case manager as part of the ICP development. This would include MSSP, In Home Supportive Services (IHSS), Community Based Adult Services (CBAS), Home and Community Based Services (HCBS) or Long Term Care (LTC).

- **Clerk / Coordinator / Medical Assistant/ Project Manager** – These roles provide analytic, clerical and HSQ support. Duties specific to this role are collecting activity reports, such as daily transition (discharge) reports, direct inbound calls and inbasket messages, manages received HSQ reports for follow up by case managers, provide HSQ non-responder follow-up as appropriate, manages opt out, refusals and unable to reach process, This role also assists the care managers with tracking requests through the Kaiser Permanente system for referrals, appointments, educational materials, DME products, etc.

- **Behavioral Health Liaison** – The Behavioral Health Liaison is an SW, MFT or RN Case Manager that works jointly with Kaiser Permanente’s Psychiatry and Addiction Medicine Specialty departments. The Behavioral Health Liaison is available to work with the IDT to assist SNP beneficiaries to facilitate care for Psychiatric or Addiction Medicine issues. The Behavioral Health Liaison attends IDT case conferences to provide consultation in the multidisciplinary team conference. Prior to IDT meeting specific duties are to chart review as needed per care manager requests, coordinate care with other providers and other follow up as needed.

- **Clinical Pharmacist (PharmD)** – The pharmacist is an integral part of the IDT as a result of the medical complexity of these patients. The pharmacist either attends scheduled case conferences or works with the SNP Case Managers to resolve medication issues identified. The Clinical Pharmacist provides consultative expertise to the IDT Case Conference and to the Case Managers as requested.

The Interdisciplinary Care Team may change to include additional adhoc medical expertise after evaluation of the individual SNP Member’s needs, to include results from the HRAT, patient interview or a review of past medical history. Based on specific needs of the SNP Members, to include results from the HRAT, patient interview, review of or past medical history, additional medical specialty providers are included in the case conference review to assist the SNP Member meet defined goals. The ICT Case Manager reviews outcomes of the SNP Members goals, along with a review of the care needs identified from health outcome goals from the care management summary sheet to determine if goal revision
needs to occur. Barrier review, additional coaching of self-management techniques are added as interventions.

There is an ongoing effort to ensure that the staffing composition meets the diversity of the population served.

As part of a patient centric model, the SNP Member is the center of the ICT. The Care Plan is developed based on the needs assessment identified during the Health Risk Assessment, and supplemented with a clinical assessment. Patient goals are identified based on the SNP Member’s top three prioritized concerns. Additionally, the ICT Case Manager may include other health care outcomes in addition to the prioritized concerns. The ICT Case Manager’s subsequent contact with the SNP Member provides progress review on the health outcomes, as part of the PCP overall treatment plan. The care plan uses a readiness assessment to ascertain the SNP Member’s motivation towards completing goals. Obstacles that the SNP Member faces are considered so that the care plan is individualized to the SNP Member. If goals are not met, the ICT Case Manager includes other strategies to revise the goal into achievable and actionable tasks. Strategies may include performing another barrier analysis, coaching on actionable tasks or educating self-management techniques.

It is not always possible to include the SNP Member during the actual case conference. The ICT Case Manager engages the SNP Member or caregiver prior to and following the case conference and following to implement the identified recommendations. In rare occasions, the ICT case conference establishes a follow up meeting to involve the SNP Member to implement recommendations, but this has usually been the result when the SNP Member has a completely opposite viewpoint from those expressed by the Caregiver, Family and ICT.

As indicated, the SNP Member may defer to a caregiver/family who participates at the consent of the SNP Member.
2. How the roles and responsibilities of the ICT members (including beneficiaries and/or caregiver[s]) contribute to the development and implementation of an effective interdisciplinary care process.

3. How ICT members contribute to improving the health status of SNP beneficiaries

The SNP ICT is a multidisciplinary care model with providers who jointly consult on the SNP Member’s behalf as part of the ICT process. The multidisciplinary review provides an effective vehicle to examine the SNP Member’s circumstances through a variety of disciplines. In a group setting of the case conference, the review provides for a brainstorming opportunity to consider alternate options that may not be evident in a single person review.

In the case conference, the ICT reviews escalated cases for SNP Members with unmet needs, unusual utilization trends or high risk stratification scores for issue resolution that may be a barrier to care plan development.

Members of the SNP ICT include Providers with specialized skills in Geriatrics/Senior Care, Hospice, Home Health or Palliative Care or with specialized skill in disease management, such as complex care to include diabetes, hyperlipidemia or heart failure as those diseases are more prevalent in this population. To meet the specialized social needs or institutional experience of this population, individual expertise having community agencies or with inpatient hospital background are included in the ICT.

Behavioral Health liaisons were selected for their expertise in managing members with complex conditions that are compounded with a psychiatric, behavioral health or substance abuse disorder. The SNP ICT benefits from the expertise of a Clinical Pharmacist for cases where patients have complex medication therapy management issues. A Long Term Supports and Services (LTSS) Coordinator participates for SNP Members who are currently receiving, or would benefit from, in home support services (IHSS), Community Based Adult Services (CBAS) or home and community based services (HCBS).

The intent of the case conference review is to simultaneously discuss and assess the SNP Member’s situation in a problem solving mode. Recommendations build on the expertise of the represented disciplines to develop solutions that address urgent concerns brought forth by the ICT Case Manager.

All ICT Case Managers identify cases for case conference review. The presenting ICT Case Manager provides a SBAR review of the case, and identifies, when it can be determined, the objective to be resolved. As part of this review process, each of the other disciplines present, discusses concerns and options from that perspective. As needed, the PCP and other physicians are notified of the agenda discussion in advance. The SNP Physician Lead assesses issues presented and provides recommendations. The status of the case and all follow up activities are recorded and tracked for resolution. The ICT Case Manager contacts the SNP Member to implement the recommendations and provides a summary to the PCP in the SNP Member’s medical record.
4. How the SNP’s communication plan to exchange beneficiary information occurs regularly within the ICT, including evidence of ongoing information exchange.

Several methods are used for regular exchange of SNP Member information between disciplines and departments.

Use of Electronic Medical Record for Communication between providers
Kaiser Permanente’s electronic medical record is used to coordinate care and deliver primary care, specialty care, acute inpatient and long term care to provide emergency, diagnostic and, pharmacy services. Care needs are communicated to all stakeholders through the use of electronic medical record by forwarding messages to the primary care provider, the SNP ICT and the SNP physician. The electronic medical record is used to order specialty services. The SNP ICT sets up electronic reminders to assure that follow up is completed as ordered and that appointments have been booked for specialty services. The electronic medical record allows caregivers and support staff to understand and track the member care across the care continuum.

For the SNP Beneficiaries or Responsible Parties
SNP members receive communication regarding their care needs through individual contact with the ICT Case Managers/Care Team, outreach efforts through specific departments or programs, through direct mailings regarding services or benefits, interactive Kaiser Permanente online resources and by their Kaiser Permanente Primary Care Physician.

Kaiser Permanente ensures that patient education and Member notices consider health literacy. Documents are assessed against readability standards at the 6th grade reading level.

Kaiser Permanente provides no cost interpretation services 24/7/365 at every point of contact for members/patients who speak a language other than English. Interpretation services are provided for all languages including Sign Languages through qualified bilingual staff and contracted in-person and over-the-phone interpreters. Staff can be qualified in nine languages: Spanish, Armenian, Cantonese, Mandarin, Vietnamese, Farsi, Russian, Tagalog and Korean. Interpretation services through the over-the-phone vendors are available in 200 languages.

In order for staff to be deemed “qualified” to provide interpretation services, employees must pass a language assessment and complete required training. The language assessment has been validated through a third party and is a thorough evaluation of interpreting skills which assesses the employees’ spoken proficiency in both English and other identified language and the ability to do a basic Sight Translation. The training provides techniques and strategies to work effectively as an interpreter. Likewise, any organization contracted to provide professional interpreter services to KP members/patients must have processes in place to ensure the proficiency of the interpreters and the quality of the interpreter services provided.

In addition to the interpretation services, telephone-based services are available for the deaf and hard of hearing, or speech impaired, that can be used to make appointments, get advice, communicate with
care providers etc. Members can call one of KP’s TTY phone numbers and staff will respond using a TTY telephone.

Language assistance services are offered at every encounter to patients/members who have identified a preferred spoken language other than English. Use of language assistance/interpreter services and type of service/interpreter is documented in the member’s medical record or health plan file. If the member refuses language assistance services, documentation of the refusal is made in the medical record including the reason for refusal.

KP adheres to several state and federal laws and regulations requiring Health Plan to translate member informing/vital documents into threshold languages. KP’s integrated process ensures that all members/patients receive the same quality level of translated materials for effective communication. The organization adheres to the threshold languages denoted under the provision of Medicaid enrollees as identified at the county level to include the following in Southern California: Arabic, Armenian, Cantonese, Farsi, Khmer (Cambodian), Korean, Mandarin, Russian, Spanish, Tagalog, Vietnamese.

In addition to the translation of documents into other languages, KP provides materials in other formats to accommodate individual needs such as, i.e., large text, audio cd, accessible formats, Braille.

Every SNP beneficiary has been assigned an individual ICT Case Manager or Care Management team. Each local Medical Center based SNP Program has established a dedicated toll free “800” telephone line to promote ease of contact. The telephone line provides after business hours consult by telephone advice nurses through the KP-on-call system.

For ICT Case Conference Communication

Each ICT meets regularly in Case Conference, as frequently as weekly or a minimum of four (4) hours/month. Agendas with case review of SNP members needing additional consult and follow up are prepared for each Case Conference. Each medical center maintains a record of each meeting, which includes attendees (both in person and telephone), actions taken and planned follow up as a formal document.

Discussion of members during Case Conference is documented in the electronic medical record). The PCP notes from prior encounters will be included in the Case Conference discussion. As indicated, information is documented/updated in the patient’s electronic medical record that is available across disciplines throughout the thirteen (13) Service Areas throughout Southern California. It is available for immediate review by the Primary Care Physician simultaneously to the ICT Case Manager closing the notes within the electronic medical record

SNP Members are engaged prior and post to the meeting by a telephone encounter based on needs assessment and care plan follow up.

As needed, the ICT Physician may contact the PCP real time to solicit additional information during the Case Conference discussion. A copy of the documentation, including the updated care plan, is sent to
the PCP. When there is a specific urgent concern requiring immediate action, a staff message is sent to the physician electronically for immediate action.

All communication between the health team regarding care plans, updated care plans and follow-up is documented in the member’s medical chart. Conference agendas and minutes that delineate follow up actions are stored securely following the conclusion of use, consistent with KP Policies and Procedures for maintaining Protected Health Information (PHI).
Element E: Care Transition Protocols

The organization’s MOC describes the following care transition protocols:

1. How the organization uses care transition protocols to maintain continuity of care for SNP beneficiaries.

The SNP Care Model adopted the Care Transitions Program® (Eric Coleman, MD, MPH) for a patient-centered, interdisciplinary intervention that addresses continuity of care across multiple settings and practitioners. The SNP Case manager serves as the point of contact to coordinate seamless transitions across healthcare settings, care providers and health services. These ensure that the SNP member will remain in the least restrictive care setting. The Case Manager supports the SNP Member prior, during and following changes in health status with tools and knowledge to support self-management of the SNP Member’s condition. While admitted, SNP member contact is performed only when such contact would not interfere with current treatment. The SNP Case Manager defers to usual care provided by the facility but interacts with the facility providers or case manages as is warranted.

Transition management occurs post discharge and prior to planned admissions to identify and resolve any potential risk for complications or rehospitalization. Upon notification of an unplanned transition, by scheduled transition reports, census review or notification from another program, the SNP Case managers contacts the SNP Member within two business days to conduct a comprehensive assessment. The SNP Member and/or caregiver is interviewed to ascertain the SNP Member’s understanding of the reason for the admission, the discharge plan and follow up activities. The ICT Case Manager will ensure that the SNP Member is aware of indicators that the treatment plan is successful or red flags that signal a worsening of the condition with contingency plan.

Discharge from Hospital/Skilled Nursing to Home

When discharged from Hospital/Skilled Nursing to home, the SNP Members are reviewed initially by the SNP Case Manager for outstanding issues or unmet needs that may be a contributory factor for a potential readmission. The SNP Case Manager works with the SNP Member, Caregiver/responsible party to resolve contributory issues. Additional case management reviews are made, dependent upon complexity determined from the initial SNP Case Manager review for Interdisciplinary Team Case Conference or to Complex Case Management

Discharge from Hospital to Skilled Nursing, other acute facilities or in-home Hospice

SNP Members who transition from KFH to long term care, home hospice, inpatient psychiatry or acute rehabilitation is assisted by the Hospital’s case manager. Communication between transporting facilities is provided by the attending physician, nurse and case manager.

Admissions at other non-KP facilities are notified to the Emergency Prospective Review Process (EPRP) and Outside Medical departments until the SNP Member can be repatriated to a Kaiser Permanente Hospital. EPRP Physicians document patient information obtained from the non-KP provider in the Member’s electronic medical record.

Upon transition to home, the ICT Case Manager will resume case management services. The ICT Case Manager will follow the expectations defined in “Discharge from Hospital/Skilled Nursing to Home.”

ICT Case Manager coordinate care with other clinicians in Chronic Disease Management or Complex Case Management by providing information obtained through previous assessments and SNP member interactions.
2. **The personnel responsible for coordinating the care transition process**

The personnel used to coordinate the care transition process is determined by the Medical Center’s SNP Program Manager for the ICT. The ICT Case Manager completes transition management, or new and annual assessments or both activities. The ICT Case Manager manages the overall case and care coordination of the member’s health needs and works in partnership with other KP SCAL health care disciplines during all care transitions to meet the member’s needs.

The SNP Program Managers determine staff assignments based on a variety of factors, to include, patient acuity available staffing mix and case load assignments. The SNP Program Manager may assign SNP Member contact to a specific ICT Case Manager based on individual circumstances of the SNP Member.

It is the responsibility of the ICT Case Manager to resolve any issues identified during the transition contact. This includes confirming understanding of the discharge plan, confirming or arranging follow up visits, monitoring receipt of identified medical equipment, as indicated, and assessing for other care needs that may result from the transition activity.
3. How the organization transfers elements of the beneficiary's ICP between health care settings when the beneficiary experiences an applicable transition in care.

Kaiser Permanente SCAL is an integrated health network with hospitals, ambulatory clinics, pharmacy and diagnostic services provided in a single network. In most instances, Patients are connected to primary, diagnostic and specialty care on a single campus. The majority of care is provided in network using an electronic medical record to transmit patient information between 13 Service Areas throughout Southern California. This interconnectivity allows for the SNP Member Care plan to be communicated instantaneously upon documentation.

**Before Transition Activity**

The ICT Case Manager reviews the SNP Member’s medical activity occurring in the ambulatory setting, to include the Physician plan of care, along with diagnostic testing and orders are available in the chart pending admission. Providers across disciplines within the Kaiser Permanente health care system use the electronic medical record to transfer information about additional diagnostic or treatment needs for the SNP member. Following a review of elements of the care plan, the ICT Case Manager contacts SNP Members prior to elective surgery to assess the SNP Member’s ability to understand care needs prior to the surgery and post-surgery. The ICT Case Manager updates the Care Plan and assists the SNP Member in obtaining any needs identified during the assessment process. The ICT Case Manager will provide updates to the Case Managers/Nurses and/or LTSS Coordinator to support the SNP Member.

**During a Care Transition**

All providers, both in the inpatient and ambulatory setting, have access to the SNP Member’s medical information while admitted. The electronic medical record updates provider notes automatically upon completion. Care Plan elements are continually updated during the admission. There is an ability to “route” any member’s chart to any KP provider and/or communicate with staff through electronic messaging (“inbasket messaging”) which provides ease of access to the individual SNP member’s chart for instant review, including care plan, all inpatient or ED encounters, specialist physician consultation notes to include those by KP Physicians in Hospice, Palliative, Skilled Nursing Rounding Teams, diagnostic tests (current or trended), and communication between member and providers.

While admitted, the ICT Case Manager defers to usual care provided by the attending physician and nursing team. The ICT Case Manager resumes care of the SNP Member upon discharge, using information provided in the electronic medical record to guide the update to the SNP Care Plan and transition assessment.

**After a Care Transition**

ICT Case Managers review recent hospital or Emergency Department activity during post discharge contacts. The ICT Case Managers use information from the physician notes, discharge plan, after visit summaries to gauge the SNP Member’s understanding of the reason for admission to determine a plan for self-management with contingency of red-flag warning signs. When the SNP Member experiences a significant change in health status, the ICT Case Manager reassesses the SNP Member beyond the discharge transition process to determine if the care plan is maintained or is substantially modified.
When Members are admitted to non-KP facilities, information is transmitted into the electronic medical record to provide a better picture of the SNP Member’s health conditions. When SNP Members reside in skilled or custodial care, as KP Physicians round on those patients, documentation for care member needs are included in the electronic medical record. The KP Physician documents additional information in the facility chart, as needed, to provide continuity between the two records. The ICT Case Manager is able to review the KP Physician’s rounding note during the annual reassessment and incorporate elements of the facility’s care plan during the assessment process.

For out of network facilities the ICT Case Manager may not be notified of the transition as this relies on manual notification between facilities or through the claims process. This information process is facilitated between KP’s Emergency Prospective Review Process (EPRP) and Outside Utilization Resource Services (OURS) programs. Upon notification by a non-plan hospital of a KP member admission/ED visit (as required per AB1203), the EPRP Physician updates the SNP Member’s electronic medical record with information provided by the non-KP physician. As this patient information is entered into the electronic medical record, the ICT Case Manager will use elements of the care plan to update the care plan and assess for additional services.

KP staff work closely with the non-KP facility to ensure care coordination including providing 24/7 access to a member’s medical record; coordination of medical transfers; and appropriate discharge planning to allow KP to continue oversight and manage member care. A copy of the patient’s transfer summary/orders accompany patient at time of transfer is provided within one business day by either the KP or non-KP as the sending facility.
4. **How beneficiaries have access to personal health information to facilitate communication with providers in other healthcare settings.**

Kaiser Permanente provides multiple methods for the SNP Members, to obtain their personal health information (PHI). In accordance with HIPAA requirements and as outlined in the KP Access to PHI by Members and Patients policy (# NATL.NCO.PRIV.1), members have the right to request and receive copies of their protected health information (PHI), and request that such information be transmitted directly to a third party, including external providers.

Additionally, as described in the KP Communicating with Family Members Involved in Care and With Disaster Relief Entities policy (#NATL.NCO.PRIV.17), patient protected health information (PHI) may be disclosed to family members and other persons involved in the care of a member. This includes instances in which information about a member's care was disclosed to communicate with providers in other settings or otherwise external to KP.

Methods that KP SCAL uses to provide information to KP Members include:

- Following every hospital, emergency or ambulatory encounter, the [SNP] Member is provided with a follow up record, or “After Visit Summary” (AVS). The AVS confirms the diagnosis, vital signs collected and any available test results from that encounter along with the treatment plan, instructions and follow up schedule. Patient education information is included for easy reference. Also included on the AVS are any scheduled appointments, unrelated to the current visit, or reminders to schedule follow up care, such as screening tests. The Physician or Clinic Assistant will review information with the [SNP] Member so that questions or concerns are resolved prior to leaving the clinic. This AVS selects information directly from the Medical Record, so it is valuable for the SNP Member to relay to any caregivers or other healthcare providers in absence of the actual chart documentation.

- Members have access to the Kaiser Permanente member website, “My Health Manager”. My Health Manager is a secure and password protected member website that provides information regarding laboratory and diagnostic test results, encounter information, upcoming appointments, health education class schedules, important telephone numbers, including the ability to request appointments as well as providing physician and clinic information. This information can be printed by the SNP Member or caregiver/responsible party to communicate with healthcare providers in other settings.

- For SNP members without computer access, this information is also available by telephone through special information telephone lines such as KP Notification System, a secured message system, (KPNS - toll free at 1-888- 4KP-TEST or 1-888-457-8378) for results or through individual departments, such as the Call Center, Membership Services or their individual PCP offices.

- In the event that a SNP Member receives care at an outside provider facility, or otherwise needs copies of medical information, such as consultation notes, diagnostic
results, etc., information will be provided upon authorization by the SNP Member and in compliance with Kaiser Permanente policies and procedures.
5. How beneficiary and/or caregiver(s) will be educated about the beneficiary’s health status to foster appropriate self-management activities

Care Managers will refer SNP members to applicable KP SCAL care delivery and/or care management programs, wellness programs, or community programs as guided by medical necessity, social support requirements and member preferences.

ICT Case Managers seek to teach skills to the individual member or caregiver—whether for management of chronic conditions, or lifestyle management—to ensure that the member, as appropriate:

- Understands his/her condition(s)
- Understands the context of the situation
- Takes an active role and works with his/her health care provider(s) to ensure that communication flows both ways, relaying his/her preferences and values
- Uses effective self-management support strategies that include goal setting, planning, problem solving, and follow-up
- Has a support infrastructure to effectively manage his/her condition(s)

The Case Manager supports the SNP Member prior, during and following changes in health status with tools and knowledge to support self-management of the SNP Member’s condition. As part of the transition management, the SNP Member and/or caregiver is interviewed to ascertain the SNP Member understands of the reason for the admission, the discharge plan and follow up activities. The ICT Case Manager will ensure that the SNP Member is aware of indicators that the treatment plan is successful or red flags that signal a worsening of the condition with contingency plan. The contingency plan includes confirmation that the SNP Member has emergency contact information available and understands when to call the PCP, Emergency services and the ICT Case Manager.

Follow up activities support self-management. This includes a schedule for continuity of care such as referred services, consults with Physician or Pharmacist, and other care options, to include external benefits to KP, such as Medi or community services. The ICT Case Manager will discuss and arrange, as needed, the resources to be used to achieve the goals, such as home health care, DME, rehabilitation therapies, LTSS, community resources, transportation services, or public assistance programs The follow up also includes a reassessment of goals progress and an evaluation of effectiveness of interventions and referred services.

Follow up will occur per agreed upon timeframes, upon a significant health status change or at least annually.
6. How the beneficiary and/or caregiver(s) are informed about the point of contact throughout the transition process.

During transition contact, the SNP Member receives information about their ICT Case Manager with teach-back reinforcement on when to call the PCP and when to contact the SNP Program. Other methods used to notify the SNP Member or caregiver of their SNP point of contact:

- Annually, each beneficiary is mailed a SNP Explanation of Coverage (EOC) that outlines benefits and coverage.

- A guidebook for their local medical center, based on geographic zip location, is mailed annually to the SNP Members.

- KP SCAL SNP focuses on new member engagement by contacting members well in advance of the 90 day standard to foster the relationship and transfer care from other health care plans, as needed. The ICT establishes the point of contact and follow up with information about the SNP Program are key Medical Center information

**Example: New Member Notice**

Kaiser Permanente
SENIOR ADVANTAGE MEDICARE
Medi-Cal Plan (HMO) Members

When you have questions about your health care, it's important that you know who to call to get the answers you need. You should continue to make appointments as you always have and contact your doctor as usual. The following services are also available to help you. Please use this guide to find the right number to call for your questions.

**Want to know how Your Care Manager can assist you?**

Your Care Manager at (facility name):
- phone number (TTY for the hearing/speech impaired)
- days and hours of operation

Your Care Manager can help you:
- Improve your health
- Obtain the care you need
- Understand the annual questionnaire
- Meet your health care goals

**Questions about your copays and benefits?**

Need to change your address?

Call our Member Service Call Center:
- phone number (TTY for the hearing/speech impaired)
- days and hours of operation

Call with questions about:
- Benefits and coverage
- Copays

**Want to learn more about classes that you can take?**

Health Education / Healthy Living Classes:
- phone number (TTY for the hearing/speech impaired)
- days and hours of operation

Call with questions about the availability, location, and times of classes.

Kaiser Permanente is a health plan with a Medicare contract.
• Existing SNP beneficiaries receive updated information on assigned SNP case management staff or units/departments as part of the care plan development process. SNP Beneficiaries are provided with a care plan summary within two (2) days of completion that confirms name, location and telephone number of the dedicated case manager.

• Annually, as part of the Health Risk Assessment (HSQ) process, the SNP Beneficiary receives a letter to explain of the case management services available as part of their Kaiser Permanente Medical Coverage. Local Medical Centers provide a SNP dedicated toll free 1-800 telephone number to assist SNP beneficiaries with ease of contact to their local ICT.
MOC 3: Provider Network

Element A: Specialized Expertise
The organization must establish a provider network with specialized expertise that describes the following components of the network:

1. How providers with specialized expertise correspond to the target population identified in MOC 1.

Kaiser Permanente Southern California has a commitment for quality health care to all members throughout our integrated system. Services and processes that are in place for all members also apply to SNP members.

The majority of medical care is within Kaiser Permanente owned and licensed hospitals and medical facilities. If needed medical care is not available in plan, or the member needs to transition to an alternate level of care outside of plan, the contracting department has oversight for arranging and managing contracts, i.e., Community Based Adult Services (CBAS)

Network adequacy reports are monitored annually to ensure that physicians and services are adequate to meet membership demands. As needed, the Health Plan contracts with hospitals, dialysis facilities, and specialists who provide the needed care to all Kaiser Permanente members. The Regional Contracting department arranges and monitors contracts for physicians and services to ensure that demand is maintained.

Our integrated health services delivery system is comprehensive and spans both the ambulatory and hospital settings; including 14 Medical Centers (hospitals), and 209 ambulatory Medical Office Buildings, plus an extensive network of contracted agencies and facilities to meet our member’s needs. Our network of physicians comprises over 6,000 physicians representing all specialties.

In the ambulatory facilities, in addition to physicians in both primary care and specialty care, registered or licensed vocational nurses support the clinic health care team. Other ancillary services include health educators, dieticians, case managers, advice nurses, social workers, pharmacists, registered nurse practitioners (RNP) and physician assistants (PA), speech therapists, audiology therapists, physical therapists, occupational therapists and department specific technicians, such as orthopedic technicians, pulmonary technicians, radiology technicians or laboratory technicians. Clerks or coordinators are assigned to the various departments to assist with front office processing, scheduling and data collection.

The primary care physicians have access to, and seek consultation from, as appropriate, specialty physicians including board certified geriatricians, palliative care and End of Life experts. The KP SCAL SNP Population analysis indicates a targeted need for specific specialty care to manage prevalent KP SCAL SNP medical conditions. (See MOC 1, Element A, Factors 2 & 3 for detailed information.) Kaiser Permanente is well represented by medical specialties indicated in the analysis to include Endocrinology, Gastroenterology, Hematology, Nephrology, Neurology, Oncology, Pulmonary, Pain Management, Rheumatology, Psychiatry, Otolaryngology, Allergy, Orthopedics, and Urgent Care/Emergency Medicine.
In addition, the physicians are supported by a broad array of high quality clinical teams in hospice, palliative care, pharmacy, disease management, care/case management, long term care, and skilled nursing, prevention, and member services. The Kaiser Permanente electronic medical record serves as the communication tool for integration of services, as well as tracking of members. Use of the electronic medical record provides instant access to health information between hospital, clinics, diagnostic facilities and providers simultaneously with updates noted upon completed documentation.

The Kaiser Permanente network addresses both psychiatry and addiction health care needs. The network includes: Psychiatrists (MD), Addiction Medicine physicians (MD), Psychologists (Ph.D./Psy.D.), Licensed Clinical Social Workers (LCSW), Licensed Marriage & Family Therapists (LMFT), Medical Social Workers (MSW), Psychiatric Clinical Nurse Specialists (CNS), Psychiatric Nurse Practitioners (NP), Physician Assistants (PA), substance abuse counselors and Psychiatric nurses (RN). The network addresses levels of care including:

- Acute Psychiatric Inpatient
- Inpatient Detoxification
- 23 hour Observation Beds
- Partial Hospital
- Day Treatment
- Intensive Outpatient
- Outpatient Services

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

- Individual Therapy
- Group Therapy
- Medication evaluation/monitoring
- Case management

Behavioral Health Care is also provided through a variety of integrated treatment programs that involve psychiatry and/or addiction medicine specialists and other providers. The ICT Behavioral Health liaison facilitates information and treatment options for our SNP members who may need behavioral healthcare.

The medical center in each service area has an Interdisciplinary Care Team (ICT). The Interdisciplinary Care Team has representation with demonstrated expertise in medical, mental health, both psychiatry and addiction medicine, pharmacy and social service disciplines that assist and manage the specific needs of the population based on the targeted needs identified by the population analysis. Expertise is demonstrated by board certification or accreditation, specialized training, or experience within a specific discipline, such as geriatrics, palliative care, addiction medicine, behavioral health/psychiatry, social medicine, etc.
2. How the SNP oversees its provider network facilities and oversees that its providers are competent and have active licenses.

The existing network includes sufficient specialists to fully meet the special needs of the SNP populations in each region. KPSC monitors the adequacy of the practitioner/provider availability through a semiannual measurement and analysis (Geoaccess) at the Regional and Service Area Levels. It includes an analysis of Primary Care, Specialty Care, Behavioral Health providers against member ratios and time and distance to facilities, including ED, SNF, Behavioral Health facilities, ambulatory clinics, surgery centers and mammography/radiology clinics.

Competency of the licensed provider and clinical staff is evaluated in the local service area by the respective department clinical managers. Providers must have three (3) peer references to attest to the applicant’s competency in the specific practice setting. Proctoring is in place for newly appointed practitioners to evaluate their competency. Licensed clinical staff competency is department specific and addressed on an annual basis.

Kaiser Permanente’s credentialing system is designed to ensure that all health care practitioners delivering care to SNP members are appropriately educated, trained and competent and that health care is delivered in accordance with prevailing standards of care and appropriate applicable state and federal regulatory agency guidelines. The credentialing process follows applicable standard accreditation agency guidelines, such as those set forth by the National Committee for Quality Assurance (NCQA). The credentials (current license, insurance, good standing with Medicare, accreditation and/or site visit) must be confirmed during the initial application process and be re-confirmed at least every three (3) years to ensure good standing. Administrative oversight is conducted in the local service area with accountability to Regional Kaiser Permanente offices. Staff credentialing and license verification occurs at time of initial application, reappointment, expiration and when a new privilege is requested.

Licensure renewal is the responsibility of the licensed staff to ensure good standing without expiry. Kaiser Permanente does not permit staff without current credentials to provide patient care. Please refer to MOC 3A, Element 3 p 74 for the complete license process.
3. **How the SNP documents, updates and maintains accurate provider credentialing information**

For Service Areas/Medical Centers in which a Kaiser Foundation Hospital is located, the process of collecting, verifying, and evaluating licenses and credentials will be integrated for the purposes of participation and privileges in KPSC and Kaiser Foundation Hospital Professional Staff membership and/or privileges even though the ultimate approval by KPSC and Kaiser Foundation Hospitals are separate and independent.

**Credentialing:** The credentialing and recredentialing process is initiated by receipt of a completed application. Competency to provide specialized care includes written and verbal verification to include letter from a primary source, report transmitted from electronic databases that are maintained by the primary source, internet reports from approved databases or a documented review of cumulative reports released by a primary source of credentials data.

Credentials and Privileges are evaluated initially and based on setting as stated: (a) Hospital setting: at least every twenty-four (24) month; and (b) Ambulatory (medical office) setting: at least every thirty-six (36) months.

The Credentialing and Privileging Committee may review any provider’s practice at any time, including between recredentialing cycles, to consider additional information relevant to that practice. The Committee may decide at any time to take action regarding a provider’s credentialing. Such action or decision may include, but is not limited to, the suspension, termination, limitation or revocation of credentialing. Written notification of such decision of action will be made to the provider.

**Licensing:**

All Providers must have a current, valid and unrestricted California license, registration, certification and/or other authorization to practice from the appropriate licensing board. Kaiser Permanente obtains notification from the licensing agency that it performs primary source verification of education and training.

Licensing is monitored daily. For State licenses, DEA licensures, Board Certification, Radio/Fluoro permits, Malpractice insurance and life support certifications (ACLS, BLS, PALS). Email notifications are sent for initial notification to Providers at least 30 days in advance as a reminder to provide updated licenses. The Local Medical Centers work with a Regional Credentialing Department to resolve issues, such as suspensions or other related issues.

Kaiser Permanente Southern California accesses routine reports on a monthly basis of licensing board sanctions to detect restrictions. These are used to trigger the Credentialing and Privileging Committee review, as described above.
**Provider Directory**

All Kaiser Permanente physicians accept both Medicare and Medicaid coverage – there is not a separate directory for SNP Members.

KP’s online member website, “My Health Manager” is the primary source for Kaiser Permanente’s Provider Director. My Health Manager links the KP Member with information about Kaiser Permanente, at each of the KP Regions, with access to their medical record.

The Physician Directory allows members to compare physicians on criteria, including language, gender, education and specialty certifications. In addition to specialized training, the Physician Director lists the physician biography which includes a “mission statement” that each KP Provider created.

**Example: My Health Manager website**

![My Health Manager Website](image)
Example: Physician Directory Search

Meet Our Doctors

Whether you’re already a member or thinking of becoming one, browse our doctor profiles to see everything you need to know to find the right doctor for you.

California: Southern

**Important:** If you think you’re having a medical or psychiatric emergency, call 911 or go to the nearest hospital. Do not attempt to access emergency care through this website.

Example: Individual Physician Information

All KP Members are encouraged to sign up for this secure website to conveniently manage their care needs. Those members that elect not to use My Health Manager are directed to Member Services to obtain this information.
4. **How providers collaborate with the ICT and contribute to a beneficiary’s ICP to provide necessary specialized services.**

Kaiser Permanente’s integrated delivery model provides care coordination to deliver needed primary and specialty services to SNP Members.

Kaiser Permanente’s electronic medical record is the primary internal communication tool to coordinate care and deliver primary care, specialty care, emergency, diagnostic and, pharmacy services. Care needs are communicated to all stakeholders through the use of the electronic medical record by forwarding messages to the primary care provider, the SNP ICT and SNP physician. The electronic medical record is used to order specialty services for members. The SNP ICT sets up electronic reminders to assure that follow up has been completed as ordered and that appointments have been booked for specialty services. The electronic medical record allows caregivers and support staff to understand and track the member care across the care continuum.

Kaiser Permanente considers the members care team collectively responsible for assuring timely and appropriate care. However, the ICT Case Manager is the key team member to both assure all follow-up is scheduled and performed, as well as the monitoring the outcome/care needs after receiving specialized care. ICT Case Managers use various tracking tools to monitor appropriate delivery of care. Methods include, but are not limited to, monitoring the receipt and resulting action of care team messaging within the electronic medical record and reports tracking care referrals for patient action and completion.

The PCP and ICT Case Manager work with members to facilitate specialty and ancillary care. The ICT Case Manager works with members to facilitate access to community and Medicaid covered services they are eligible to receive in the community and Medicaid covered services. A web based questionnaire used for Benefit analysis to indicate available but underused community services benefits for that specific member. Evidence based guidelines determine necessary care. In conjunction with an assigned Primary Care Physician, the ICT Case Manager will facilitate the provision to the SNP Member recommended care. As appropriate, the member and Case Manager will identify other social and medical treatment. Provided below are examples of how care navigation within the Kaiser Permanente system works.

**Example 1:** A 62 year old female with Type 2 Diabetes and history of a recent fall with Carpal Tunnel syndrome was identified as part of the ICT Case Conference as taking medications not commonly offered to someone her age due to increased fall risk. This information is relayed to her physician through a staff message in the medical record from the ICT Case Manager. The PCP reviews the chart, contacts the ICT Case Manager for additional information and confirmed with the patient her preference for continuing with the medication. Once medication preference was confirmed, the physician ordered a physical therapy evaluation for proper equipment such as a trough or cradle for the patient’s walker to assist her with stability during ambulation. The patient was also offered and accepted a referral to a fall prevention clinic.

**Example 2:** A 70 year old female with lung cancer was identified by their home health provider as experiencing severe depression through the HRA review by the ICT Case Manager. After talking with the
member, her family, her primary care provider and oncologist it was determined that she should see a mental health provider. Kaiser Permanente’s Behavioral Health care team was engaged, and determined the mental health status of the patient warranted the care of a state mental health facility. Upon making this decision, a three way call was initiated between the member, a Kaiser Permanente care manager and the state mental health facility to schedule an appointment for the member.
Element B: Use of Clinical Practice Guidelines and Care Transition Protocols

The organization must oversee how network providers use evidence-based medicine, when appropriate, by:

1. Explaining the processes for monitoring how network providers utilize appropriate clinical practice guidelines and nationally recognized protocols.

Kaiser Permanente has developed clinical practice guidelines that are used by the physicians and other care givers. Clinical Practice Guidelines are intended for those who provide medical care in our medical offices and hospitals. There Clinical Practice Guidelines are not used for the purpose of approving, denying or modifying medical care requests.

New and revised guidelines are disseminated to all physicians, residents, physician assistants, nurse practitioners, certified nurse midwives, and other health care professionals. To support implementation efforts, guidelines are also distributed to Department Administrators, Associate/Assistant Medical Directors, Care Managers, Drug Education Coordinators, Operation Managers, Formulary Specialists, Health Education Administrators, Health Plan and Hospital Executive Leaders and Administrative Teams, Regional Quality Improvement Directors, Directors of Medical Education, Physician Educators, Utilization Managers, Benefits Managers, Professional Education, Regional Laboratory, and selected clinicians and staff in other Kaiser Permanente Regions.

The following is a list of guideline distribution methods:

- E-Mail: Notices related to new and updated guidelines are distributed via e-mail to practitioners and other relevant staff.

- Clinical Library Intranet Web Site: The Southern California Clinical Library website contains the most recent versions of all new and revised guidelines. From this web site, physicians and other health care professionals can search for, read and print or download CPGs (in HTML and/or PDF format) for their own use. New and revised guidelines are posted following approval from relevant physician groups.


Clinical Guidelines are also shared in the form of continuing provider education. Providers at the Medical Centers participate in Quality Improvement (QI) meetings, specific to the department’s specialty, where projects and performance, based on quality improvement and evidence based guidelines are reviewed. Each Kaiser Permanente Medical Center has a QI Committee that reports progress towards Quality Goals to the Regional Quality Committee (Southern California Quality Committee or SQCQ).

Kaiser Permanente’s Committee establishes the quality strategy for KP SCAL to include quality of care and service.
2. Identifying and documenting instances where the use of clinical practice guidelines and nationally recognized protocols need to be modified or are inappropriate for specific vulnerable SNP beneficiaries

3. Providing details regarding how decisions to modify clinical practice guidelines or nationally recognized protocols are made, incorporated into the ICP, communicated to the ICT and acted upon by the ICT.

The Physician ultimately determines treatment and the best plan of care for the member.

Clinical Practice Guidelines are designed to be an adjunct to clinical practice, but do not take into account individual patient characteristics, including past medical history, co-morbidities, prior response to treatment, etc. that a Physician may use to determine if following Clinical Practice Guideline for an individual patient is the best course of medical management.

The complexity of medical conditions of the KP SCAL SNP Member may require modification of Clinical Practice Guidelines to obtain better outcomes for the member. Within the electronic medical record, decision support tools, based on Clinical Practice Guidelines, offer recommended treatment modalities, such as evidence based order sets and health maintenance alerts for recommended screenings. The KP Physician documents when treatment is modified from the CPG-recommended care, using the individual patient characteristics to support changes.

Information is relayed to all members of the ICT as soon as chart documentation is completed within the electronic medical record. Changes to the Clinical Practice Guidelines as part of the medical record, are validated with the SNP Member as part of the care plan development.

For other providers, Clinical Practice Guidelines are built as decision support tools in a reference sheet for use by non-physician providers. Use of these tools is monitored and reported for the ICT Case Managers.

Adherence to Clinical Practice Guideline adherence as related to preventative care, is measured indirectly through HEDIS preventive services measures and/or clinical strategic goals performance.
4. **Describing how SNP providers maintain continuity of care using the care transition protocols outlined in MOC 2, Element E.**

KP SCAL uses the electronic medical record to transfer information for transitions to ensure continuity of care. Member information is transmitted between the 14 Kaiser Permanente Hospitals throughout Southern California; this ensures that when a SNP Member accesses care at any of the Kaiser Permanente facilities, information is readily available regarding that visit.

When members have care at non-KP facilities, to include out of network emergency rooms, KP physicians are notified of the admission. These are coordinated through the Emergency Prospective Review Process (EPRP) and Outside Medical departments by SCPMG physicians until the SNP Member can be repatriated to a Kaiser Permanente Hospital. Members that are admitted to contracted Skilled Nursing or Custodial facilities have regular rounding schedules by KP physicians. Patient information is documented in the electronic medical record which adds to care continuity when Members are in non-KP facilities.

The ICT receives automated alerts for admissions that occur in KP facilities and for discharges occurring in both KP and non-KP Hospitals. Discharges from Skilled Nursing or Custodial Facilities are based on manual notification between providers, such as telephone or use of extraneous databases. KP SCAL IT is implementing software to the existing medical record that offers alternatives to eliminate manual notification in 2014.

Upon notification of discharge, either through reports or manual notification, the ICT Case Manager collects information included in the medical record, including reason for visit, discharge plan, follow up visits, diagnostic results and ordered procedures or medications. Following a review of the chart documentation in the electronic medical record, the ICT Case Manager contacts the SNP Member to initiate the care transition protocols.
Element C: MOC Training for the Provider Network

The organization’s description of oversight of provider network training on the MOC must include:

1. Requiring initial and annual training for network providers and out-of-network providers seen by beneficiaries on a routine basis.

Physicians that provide care to SNP Members receive Model of Care (MOC) training that is available online through the KP Physician portal. Kaiser Permanente’s integrated network and electronic medical record provides a ready source of communication between providers.

Example: Physician Portal with Task Monitor Training Reminder

SNP Model of Care (MOC) Training is provided for those physicians that are identified as the member’s PCP, to include internal medicine and related subspecialties, such as Endocrinology, Nephrology, Continuing Care or Obstetrics. KP SCAL identified these as physicians that are primarily responsible for the care of the SNP member and should be knowledgeable of the enhanced SNP benefits prior to specialty care referral. Subsequent referrals to specialties would not alter treatment recommendations based on SNP benefit knowledge; the majority of work-up, using this benefit information, has been provided by the PCP, in conjunction with the ICT Case Manager.

Annually, the Regional SNP Program Team reviews the listing of medical staff departments to confirm included specialties. Included specialties are those whose treatment recommendations would be altered from usual Kaiser Permanente Medical care by the SNP benefits package. Permanente Human Resources registers these physicians for training on their physician portal. The training registration is noted on their active classes and remain until the training is completed at the designated due date.

There is little reliance on non-network physicians to provide care to SNP members; MOC training is not provided for non-network physicians.
2. Documenting evidence that network providers receive MOC training

KP SCAL Physicians are autoenrolled for the Model of Care (MOC) training through the Physician Portal that compiles all physician required training. MOC Training completions for Physician is tracked through the registration feature in the Physician Portal. The portal collects the results of completed trainings on the individual physician level and compiles results for Permanente Human Resources for tracking. The Regional SNP Program receives quarterly updates for physician training completions.

Example: Notification of Physician MOC training registration (partial view)

![Notification of Physician MOC training registration](image_url)

Permanente Human Resources tracks noncompletions and provides notifications to the individual physician and to the physician’s supervising chief of medicine. These notifications are made in advance of the training completion deadline to ensure adequate time for the physician(s) to comply.
3. Explaining challenges associated with the completion of MOC training for network providers.
4. Taking action when the required MOC training is deficient or has not been completed.

Managing training requirements for a large organization presents unique challenges to ensure completion to standards. Kaiser Permanente Southern California uses web based training to minimize challenges experienced for scheduling logistics and tracking completions.

SCPMG physicians are provided with paid educational time in their weekly schedule as continued medical education is required to maintain license and credentials status. Educational time (ET) is used to attend CME lectures or conferences or to complete mandatory training. The SNP MOC training would be completed during ET time.

Other programs have equally important mandatory training. As physicians and staff have multiple training requirements from the regulatory programs managed by Kaiser Permanente Southern California, it is important that the volume of information dispensed does not impact the value of information; the key learnings are internalized and not learned by rote.

Physician training is tracked on a quarterly basis by Permanente Human Resources with reports to the Regional SNP Program.

Physician MOC training is tracked through online registration. Training completion is proactively managed by Human Resources to ensure completion. Anticipation of projected noncompliance starts 90 days prior to the identified deadline. PHR initiates subsequent notices on a monthly basis until the deadline has been met or that all have completed training. Physicians that are on HR-defined leave, including family or medical leave, will be deferred from completion until the return to work has commenced.

Noncompliance of required training is managed through Permanente Human Resources and is reportable to the individual’s physician supervisor. Failure to complete required training will result in disciplinary action as defined by Permanente Human Resource policy.
MOC 4: MOC Quality Measurement and Performance Improvement

Element A: MOC Quality Performance Improvement Plan

The organization must develop a MOC quality performance improvement plan that:

1. Describes the overall quality improvement plan and how the organization delivers or provides for appropriate services to SNP beneficiaries, based on their unique needs.

SNP Quality Improvement efforts are accomplished through a systematic, integrated approach to planning, designing, measuring, assessing, and improving the quality of care and service provided to the SNP members. Quality, utilization, process, and demographic information is collected, analyzed, and reported by using established internal and/or external targets or benchmarks. Evaluation of program effectiveness for the model of care occurs at the National Level between the three other KP SNP Regions in Northern California, Georgia and Colorado. Regular communication among the Program Managers in each SNP Region provides the opportunity to share program information for the common measures to stimulate performance improvement opportunities.

Each SNP region will use the results to make adjustments and improvements on programs within their area. This process is also replicated at the Regional level for improvements at the local Medical Center SNP Programs.

SNP performance is trended and analyzed with results distributed on a set schedule on monthly Program Dashboards. In addition to distribution at the Regional level to Departments that support SNP Clinical Oversight, the dashboards are sent to individual Medical Center SNP Program Manager/Physician Champion, as well as to other stakeholders to include Hospital and Medical Group Executive Leadership, UM Directors and Quality Directors. Outlier performance at the Medical Center level serves as an indicator whether individual needs for beneficiary health outcomes are being met.

The SNP Regional Program team facilitates discussions between Medical Center SNP Programs to identify best practices that drive improved performance. Best practices are shared with lower performing Medical Center programs for implementation. Programs that do not meet standards are placed under stricter scrutiny by the KP SCAL’s Regional Office until performance improves.

KP SCAL SNP reports performance internally through an annual Workplan that identifies annual program goals, success measures and objectives to support the goals. Simultaneously, KP SCAL SNP Regional Project Team completes an annual evaluation of the previous year’s performance, based on findings and analysis from end of year reports, to KP’s Southern California Quality Committee (SCQC) and ultimately reporting to Kaiser Foundation Health Plan’s Board of Directors through its delegated Quality review committee, Quality and Health Improvement Committee (QHIC).
The Annual SNP Program Evaluation and the corresponding Workplan addresses quality, utilization management (UM), service performance, member satisfaction, prevention, population-based care, and health outcomes. Compliance to internal and external review standards is also monitored. Improvement opportunities and Medical Center deficiency notices are noted with periodic progress reports to the appropriate oversight bodies to ensure implementation and effectiveness in improvement.
2. Describes specific data sources and performance and outcome measures used to continuously analyze, evaluate and report MOC quality performance

Kaiser Permanente utilizes a national dashboard with clinical, utilization, quality and select process measures for the four Kaiser Permanente SNP regions to compare and contrast performance and to identify opportunities for improvement within and across regions. Each region also has a region specific dashboard to monitor and manage regional priorities for performance measurement and health outcomes.

The National SNP Dashboard reports data derived from 9 data marts plus self-reported data from HSQ. SNP quality performance data is sourced from internal encounters as well as outside medical claims. Internal encounters represent patient visits with a Kaiser Permanente clinician and/or facility. Outside medical claims (CMS-1500 (HCFA) and UB-92) are submitted to Kaiser Permanente based on patient visits with a non-Kaiser Permanente clinician and/or facility.

The internal encounters and outside medical claims data are loaded into Oracle data marts which represent the middleware used for data extraction and analysis. Internal encounters and outside medical claims are loaded into Oracle data marts with identical data architecture so that the analytic process for data extraction is not stratified by data source. Business rules are applied to internal encounters so that procedure and diagnosis codes are industry-standard values.

Apart from utilization information, other data silos utilized for quality reporting are also loaded into Oracle data marts. These include survey data (i.e., Health Status Questionnaire) and membership records (i.e., enrollment start/end dates, product line assignment, Kaiser Permanente Region).

The SNP National Dashboard is an interregional, quarterly dashboard focused on SNP utilization and quality of care measures. The dashboard includes data for each of the four KP SNP regions with rates trended over time. KP SCAL and NCAL regions also have metrics reported by medical center. Quarterly reported SNP-specific metrics include:

**Quarterly SNP Metrics**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Metric</th>
<th>Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Inpt Admissions Per 1,000</td>
<td>Care Plan Completion Rate</td>
<td>CDC, Eye Exam</td>
</tr>
<tr>
<td>Acute Inpt Average Length of Stay</td>
<td>Cervical Cancer Screening</td>
<td>CDC, Nephropathy Monitoring</td>
</tr>
<tr>
<td>Acute Inpt Admissions in Last Six Months to Death</td>
<td>Cholesterol Mgmt for Coronary Conditions, LDL-C &lt; 100</td>
<td>Death Rate</td>
</tr>
<tr>
<td>ALOS Among Acute Inpt Admissions in Last Six Months to Death</td>
<td>Cholesterol Mgmt for Coronary Conditions, LDL-C Screening</td>
<td>Decedents with 1+ Palliative Care Consult</td>
</tr>
<tr>
<td>All-Cause 30 Day Readmits</td>
<td>Colorectal Cancer Screening</td>
<td>Emergency Room Visits Per 1,000</td>
</tr>
<tr>
<td>Antidepressant Med Management, Acute Phase Treatment</td>
<td>CDC, LDL-C &lt; 100</td>
<td>Emergency Room Visits in Last Six Months to Death</td>
</tr>
<tr>
<td>Antidepressant Med Management, Continuation Phase Treatment</td>
<td>CDC, LDL-C Screening</td>
<td>HSQ Completion Rate</td>
</tr>
<tr>
<td>Avg Total Cost Per Member</td>
<td>CDC, BP &lt; 140/90</td>
<td>Mental Health Inpt Admissions Per 1,000</td>
</tr>
<tr>
<td>Avg Total Cost Per Member in Last</td>
<td>CDC, HbA1c Poor Control</td>
<td>Persistence of Beta Blocker</td>
</tr>
</tbody>
</table>
Six Months to Death | Treatment After Heart Attack
---|---
Breast Cancer Screening | CDC, HbA1c Screening

In addition, users can segment the SNP population based on any combination of 1, 2 or 3 conditions selected from the list of diagnoses, risk scores, age and/or segments listed below. Once the segment is defined, the dashboard provides summary level statistics and drill down capability into member level data to facilitate further review, analysis and/or operational interventions.

<table>
<thead>
<tr>
<th>Diagnostic Filters</th>
<th>Risk Scores and Self Reported Data</th>
<th>Age Bands</th>
<th>Segments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acute Leukemias</td>
<td>• HSQ Adv Illness Index &gt;= .175</td>
<td>• Age 85+</td>
<td>• All Advanced Frailty Members</td>
</tr>
<tr>
<td>• Anxiety</td>
<td>• HSQ Frailty Score &gt;= 0.50</td>
<td>• Age 65+</td>
<td>• All Major Physical Members</td>
</tr>
<tr>
<td>• Arthritis</td>
<td>• HSQ Reported Poor Health</td>
<td>• Age &lt; 65</td>
<td>• All Major Mental Members</td>
</tr>
<tr>
<td>• Asthma</td>
<td>• HSQ Reported Severe Memory Problems</td>
<td></td>
<td>• Healthy</td>
</tr>
<tr>
<td>• Cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Chronic Kidney Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Chronic Obstructive Pulmonary Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Coronary Artery Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Dementia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Drug/Alcohol Abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• End Stage Liver Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• End Stage Renal Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Heart Failure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hepatic Coma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Liver Transplant Complications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Major Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Neurological</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Palliative Care Consult</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Schizophrenia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Secondary Cancers Except Lymph Node/Disseminated Cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Secondary Lymph Node Cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Official HEDIS data, where available for SNP product line, is reported for each relevant metric by reporting year by region. Program-wide SNP performance (four SNP regions consolidated) and KP Medicare performance are also reported.
### HEDIS Metrics

<table>
<thead>
<tr>
<th>Metric Description</th>
<th>Performance Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Monitoring for Patients on Persistent Medications: ACE or ARB</td>
<td>Dispensed a Systemic Corticosteroid Within 14 Days of COPD Exacerbation</td>
</tr>
<tr>
<td>Annual Monitoring for Patients on Persistent Medications: Digoxin</td>
<td>Follow-Up Within 7 Days of Discharge After Hospitalization for Mental Illness</td>
</tr>
<tr>
<td>Annual Monitoring for Patients on Persistent Medications: All Medications</td>
<td>Follow-Up Within 30 Days of Discharge After Hospitalization for Mental Illness</td>
</tr>
<tr>
<td>Annual Monitoring for Patients on Persistent Medications: Anticonvulsants</td>
<td>Glaucoma Screening in Older Adults</td>
</tr>
<tr>
<td>Annual Monitoring for Patients on Persistent Medications: Diuretics</td>
<td>Medication Reconciliation Post-Discharge</td>
</tr>
<tr>
<td>Antidepressant Medication Management: Effective Acute Phase Treatment</td>
<td>Osteoporosis Management in Women Who Had a Fracture</td>
</tr>
<tr>
<td>Antidepressant Medication Management: Effective Continuation Phase Treatment</td>
<td>Persistence of Beta-Blocker Treatment After a Heart Attack</td>
</tr>
<tr>
<td>Care for Older Adults: Advance Care Planning</td>
<td>Potentially Harmful Drug-Disease Interaction in Elderly: All Symptoms</td>
</tr>
<tr>
<td>Care for Older Adults: Medication Review</td>
<td>Potentially Harmful Drug-Disease Interaction in Elderly: Chronic Renal Failure</td>
</tr>
<tr>
<td>Care for Older Adults: Functional Status Assessment</td>
<td>Potentially Harmful Drug-Disease Interaction in Elderly: Dementia</td>
</tr>
<tr>
<td>Care for Older Adults: Pain Screening</td>
<td>Potentially Harmful Drug-Disease Interaction in Elderly: History of Falls</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>Use 1+ High-Risk Medications in the Elderly</td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td>Use 2+ High-Risk Medications in the Elderly</td>
</tr>
<tr>
<td>Dispensed a Bronchodilator Within 30 Days of COPD Exacerbation</td>
<td>Use of Spirometry Testing in Assessment, Diagnosis of COPD</td>
</tr>
</tbody>
</table>

### Regional Dashboard

The Regional SNP Program Team reviews and reports on Medical Center SNP performance for continuous improvement opportunities. During telephone contacts with the SNP Member, the ICT Case Manager collects data and enters the data into a SNP-specific data collection tool within the electronic medical record. This tool ensures that information collected are in reportable fields that can be trended over time for the SNP Member’s medical history as well as compiled for performance and regulatory reporting.

Metrics are identified from SNP-specific program targets, HEDIS measures, Medicare 5 star measures and utilization performance. The performance is presented in a monthly Dashboard with individual Medical Center SNP Performance, Regional targets and Regional performance averages. This is supplemented with patient-level data to allow for local teams to audit against recorded performance.

Data for the Dashboard is maintained by KP’s Management and Information Analysis (MIA) and KP’s Clinical Analysis Departments. These departments report SNP performance for Quality to HEDIS or CMS and for Regulatory Compliance for NCQA and/or Department of Health Services.

The Regional SNP Dashboard is reviewed annually for additions to the performance metrics. Measures that have sustained performance above benchmark are removed and placed under surveillance.
Regional SNP Dashboard is reserved for metrics that are targeted for rapid improvement; it does not represent the total performance monitored for the SNP population. At a minimum, the Regional Dashboard includes:

**Utilization Metrics**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Performance Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Utilization</td>
<td>Performance is continually reviewed for downward trends.</td>
</tr>
<tr>
<td>Patient Day Rate</td>
<td>Benchmarks have not been established as the population is too small and subject to outlier performance to affect a true rate</td>
</tr>
<tr>
<td>Discharge Rate</td>
<td>2014: 1% reduction from 2013 rate or 222 with 2015: 1% additional reduction from 2014 rate or 220</td>
</tr>
<tr>
<td>HEDIS O/E Readmission Ratio (QIP Goal)</td>
<td>85% (11) Medical Centers performing at &lt;.92 5% reduction (.87) from Regional Average of Jan 13 baseline of .92</td>
</tr>
</tbody>
</table>

**Quality Measures**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Performance Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal Cancer Screening</td>
<td>82.0%</td>
</tr>
<tr>
<td>HbA1c &lt; 9 mg/dL</td>
<td>84.0%</td>
</tr>
<tr>
<td>High Blood Pressure Control</td>
<td>87.0%</td>
</tr>
<tr>
<td>LDL &lt; 100 mg/dL (CCIP Goal)</td>
<td>80.5%</td>
</tr>
<tr>
<td>High Risk Drug Rate (at least one medication)\1↓</td>
<td>9.0%</td>
</tr>
<tr>
<td>Dangerous Drug Interactions 8 ↓ – History of Falls</td>
<td>10.6%</td>
</tr>
<tr>
<td>Dangerous Drug Interactions 1 ↓ – Dementia Diagnosis</td>
<td>17.4%</td>
</tr>
<tr>
<td>Osteoporosis Management Post Fracture</td>
<td>85.0%</td>
</tr>
<tr>
<td>Care of the Older Adult – Functional Status</td>
<td>As technical specifications regarding thresholds change for these metrics, the Performance Target is to meet Medicare 5 star status</td>
</tr>
<tr>
<td>Care of the Older Adult – Pain Screening</td>
<td></td>
</tr>
<tr>
<td>Care of the Older Adult – Medication Review</td>
<td></td>
</tr>
<tr>
<td>Advance Care Planning – Advance Directive of Physician Orders for Life Sustaining Treatment</td>
<td>5% improvement (18.7) over 2Q13 performance (17.8%)</td>
</tr>
</tbody>
</table>

**SNP Process Measures**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Performance Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessments Completed within 365 days</td>
<td>85%</td>
</tr>
<tr>
<td>Assessments Completed current year</td>
<td>Prorated performance = month x 0.92</td>
</tr>
<tr>
<td>Benefit Review</td>
<td>85%</td>
</tr>
<tr>
<td>Care Plan/Goal(s) Completion Rate</td>
<td>85%</td>
</tr>
</tbody>
</table>

\1 This metric has a changing drug list; while performance decreases, as new drugs are introduced onto the list, the performance rate will increase.
<table>
<thead>
<tr>
<th>Metric</th>
<th>Performance Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Member Assessments within 90 days</td>
<td>85%</td>
</tr>
<tr>
<td>Transition Completed Rate</td>
<td>85%</td>
</tr>
</tbody>
</table>
3. Describes how its leadership, management groups, other SNP personnel and stakeholders are involved with the internal quality performance process.

Evaluation of the effectiveness of the model of care is conducted in conjunction with the other three Kaiser Permanente SNP regions – Northern California, Georgia and Colorado.

A national workgroup consisting of regional SNP MD clinical leads, regional SNP program leads and staff from KP’s Care Management Institute meet quarterly to discuss quality performance. Stakeholders from compliance and quality areas are also invited. These meetings include a review of the quarterly national dashboard, status updates on national MOC analyses and identification of areas for further performance measurement evaluation and analysis. The regions provide updates on region specific performance initiatives and outcomes.

The Southern California Regional SNP Program Team and other content experts are responsible for facilitating meeting discussions where the program data will be analyzed and summarized into recommendations for strategic program direction. These recommendations will be shared with local Medical Center SNP leadership who are then responsible for implementation.

Within KP SCAL’s SNP Program, primary oversight for SNP Program operations is shared between the Regional SNP Medical Director and the Regional Director for Complex Case Management (CCM). Additionally, the departments of Clinical Analysis and Management Information Analysis (MIA) manage clinical quality and regulatory reporting for CMS, NCQA and HEDIS.

Key personnel that participate in SNP Oversight are the SNP Regional Medical Director and Regional Director of Complex Case Management (CCM), along with the CCM Project Management group that supports reporting needs defined by SNP Regional Leadership. The SNP Regional Medical Director and the Regional Director of CCM make determinations and provide direction on SNP Performance activities for the Medical Center ICT. Data Consultants and Managers from these two departments provide consultative support to the Regional SNP Program, working closely with the CCM Project Management Team, to ensure that projected, interim and final reports accurately reflect KP SCAL SNP performance.

MIA and Clinical Analysis work with the SNP Regional Team to discuss objectives necessary to develop reports, determine programming logic, validate with data audits and provide ongoing reports for distribution.

Data consultation is provided for the SNP HEDIS measures, the Medicare 5 star Care of the Older Adult measures, SNP Utilization Performance, POLST & Advance Directive Performance, SNP Dashboard Process Measures, DXCG Membership report (monthly) and DXCG Utilization report (quarterly).

The Regional SNP Program Team reviews, analyzes and provides reports, based on the predetermined frequency, to the Medical Centers SNP Program Manager and SNP Physician Lead to assess program performance for continuous improvement opportunities.
4. Describes how SNP-specific measurable goals and health outcomes objectives are integrated in the overall performance improvement plan, as described in MOC 4, Element B.

The overall performance improvement plan consists of nationally identified measures (acute inpatient utilization/1000 and acute inpatient utilization within 180 days from care plan completion) and region specific measures. The National SNP Dashboard provides a comparative analysis between regional SNP plans and between program-wide SNP and Medicare Advantage plans and is used to identify opportunities regionally and/or nationally. The National SNP Dashboard is provided on a quarterly basis.

The Regional SNP Dashboard highlights select metrics from HEDIS, CMS and NCQA reporting. KP SCAL provides monthly performance updates on projected results on KP intranet websites. These are used as a proxy to indicate whether ICT Case Manager activities have implemented effective interventions or need to implement program refinements.

While HEDIS and CMS data is supplied on an annual basis, projected results are provided more regularly for program performance analysis. Monthly and bimonthly results provide opportunities for Regional SNP and Medical Center ICT to review current processes, identify opportunities and apply interventions in a rapid improvement model.

ICT Case Manager Activities have a direct impact on improving SNP Member health outcomes by focusing on the Care Plan needs. Care Planning is monitored on the Regional SNP Dashboard as “SNP Process Measures.” These activities promote early new member engagement in the process, timely reassessment timeframes, review of unmet care needs, assessing barriers and obstacles, promoting self-management techniques, ensuring transition management and identifying a plan for follow up.
Element B: Measureable Goals and Health Outcomes for the MOC

The organization must identify and clearly define measureable goals and health outcomes for the MOC and:

1. Identify and define the measureable goals and health outcomes used to improve the health care needs of SNP beneficiaries.

Improvements in the coordination of care and appropriate delivery of services will be measured by decreased hospital discharge rates as impacted by completed care plans. Hospital 30 day readmission HEDIS Expected/Observed ratio will also be monitored as care plan completion should also impact this rate. This data is sourced from internal encounters as well as outside medical claims. Internal encounters represent patient visits with a Kaiser Permanente clinician and/or facility. Outside medical claims (CMS-1500 (HCFA) and UB-92) are submitted to Kaiser Permanente based on patient visits with a non-Kaiser Permanente clinician and/or facility.

This is an important quality performance measure for KP SCAL because effective proactive medical management and care coordination of beneficiaries with complex, chronic and co-morbid conditions can lead to better health outcomes and more cost-effective use of services by reducing acute hospitalizations.

Results from the National SNP study indicate a decreased risk of inpatient admissions in the 180 days following care plan development. KP SCAL SNPs care plan completion rate contributes to reducing this risk. The measureable goal is a monitoring of care plan development activities. This includes monitoring transition activity, ensuring that preventive care needs are arranged, completing assessments on new members and reassessments on existing members in a timely fashion.

KP SCAL SNP’s Care Plan development has a direct correlation to the engagement of the SNP member by aligning the perceptions of health care needs through the HRAT and the ICT’s use of that information to assess for other health care needs into the development of a patient-centered Care Plan. Care Plans are initiated during the assessment process and are monitored during other contacts, to include transition activity, such as post hospitalization discharge or preparing for an elective surgery.

Affordability and Access

Affordability and Access are also directly correlated to Care Plan activities by providing the right care at the right time. The ICT Case Manager attempts to shift inappropriate care from Emergency to ambulatory setting by educating on the need for preventive care or arranging convenient appointments with the PCP. Self-Management coaching with a contingency plan discussion for “red flags” during transition contacts provides education on the discharge plan. Follow up needs, including Home and
Community Based Services are arranged to support the member in home, instead of alternate institutional settings. The goal addressing affordability and access by improving the care transition process are reducing the 30 day readmission rate through the Quality Improvement Project (QIP) efforts and reducing the discharge rate through care planning activities.

**Alignment of HRAT, ICT and ICT**
The HRAT risk stratification, along with other predictive modeling sources used by KP, guides the ICT Case Manager for the frequency and intensity of contacts. The ICT Case Manager prioritizes interventions that will assess for underutilized services, providing coaching on treatment therapies, and will arrange for care needs, to include current laboratory and other screening tests, immunizations, and disease-specific treatments, such as foot, hearing and vision exams. Care Plans are updated at every patient contact which shows consistency among contacts and supports tighter case management that contributes to improving goal performance with better health outcomes.

**National SNP Benchmark**
Since this measure is not publicly reported, KPSCAL SNP uses an internal benchmark of performance during the most recent six month interval: January through June 2012. During this interval, the KP SCAL SNP regions achieved a 21% decreased risk of acute inpatient admission in 180 days after completed care plan when compared against usual care:

The time interval for remeasurement will be acute inpatient hospitalizations within 180 days of care plan completion date for the interval July 2014 through December 2014 with data analysis completed in October 2015.

For acute inpatient utilization/1000 members, KP’s SNP continue to outperform the industry benchmark (CY2012 is the most current data available) reported by the SNP Alliance:

- CY2012 SNP Alliance DSNPs = 385
- CY2012 KP NCal SNP = 269
- CY2012 KP SCal SNP = 273
- CY2012 KP CO SNP = 296
- CY2012 KP GA SNP = 276

**KP SCAL SNP Targets**
Targets and Benchmarks are established for Kaiser Permanente Southern California by the KP SCAL and Executive Leadership. Projected performance is provided monthly, based on a rolling 12 month period, with HEDIS reporting dates based on the annual April submission date. Projected performance reinforces KP SCAL’s Executive Leaders and Medical Center Leadership expectations that HEDIS targets
and benchmarks have continuous improvement, if goals are not met. Monthly projected rates provide opportunities for rapid change cycles to influence performance.

Benchmarks for these measures are identified on an annual basis and based on the prevailing external 90th percentile of all health plan performance.

KP SCAL has made significant improvements from the initial data supplied in CY 2012 as a result of subsequent Care Plan activities by ICT Case Managers, showing a 17.9% reduction from CY 2012. The majority of improvement may have been realized in the initial program start-up period; it may not be reasonable to expect the same performance improvement rate. The identified goal is a 1% reduction from CY 2013 of 222 discharge rate. This will be reviewed in 2014 for a subsequent 1% reduction from CY 2014 or 220.

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<tr>
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</thead>
<tbody>
<tr>
<td>Discharge Rate (per 1000 Member/12 months)</td>
<td>385</td>
<td>273</td>
<td>224</td>
<td>222</td>
<td>220</td>
</tr>
<tr>
<td>Reduction from 2012 performance</td>
<td>-17.9%</td>
<td>1%</td>
<td>1%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source data: KP Management Information and Analysis (MIA) July 1, 2013 – December 31, 2013

The goal is to meet or exceed a reduction in acute inpatient admissions during the July 2015 through December 2015 interval.

**KP SCAL SNP Measureable Goals**

The target for Regional SNP Performance is to meet or exceed the National Benchmark for each of the SNP HEDIS Measures. For the Medicare 5 Star Measure, as these thresholds are determined by CMS, the target for Regional SNP Performance is to achieve 5 star performances for the four metrics. (Please refer to MOC4A, Factor 2, pp. 90-91 for HEDIS and Medicare performance goals.) The SNP goals from the CMS Chronic Conditions Improvement Project (CCIP) and the Quality Improvement Project (QIP)

The QIP and the CCIP contribute to reducing the likelihood of hospitalization by ensuring that members are adherent to recommended treatment therapies for healthy hearts or anticipating underutilized services on risk-stratified population to affect avoidable admissions.

The CCIP Goal is a 5% improvement on LDL-C Control performance in the SNP CAD Population from November 2012 baseline of 76.7%

The QIP Goal is a 5% reduction in the SNP HEDIS Observed/Expected 30 Day Readmission Rate from November 2012 baseline of .92.
2. Identify specific beneficiary health outcome measures used to measure overall SNP population health outcomes.

KP National Dashboard

Overall SNP population health outcomes are determined by inpatient utilization, specifically acute inpatient utilization/1000 members. SNP quality performance data is sourced from internal encounters as well as outside medical claims. Internal encounters represent patient visits with a Kaiser Permanente clinician and/or facility. Outside medical claims (CMS-1500 (HCFA) and UB-92) are submitted to Kaiser Permanente based on patient visits with a non-Kaiser Permanente clinician and/or facility.

If goals are not achieved, the next step is to conduct an analysis following completion in October 2015 to determine why and structure interventions based on the findings.

KP SCAL SNP Regional Dashboard

Data for KP SCAL SNP performance is collected in the electronic medical record from SNP Member interaction with the ICT Case Manager, other Kaiser Permanente Providers, and utilization performance from both within KP Hospitals as well as claims data from non KP facilities.

Data from the electronic medical record that is for reporting includes inpatient and ambulatory encounter records, KP provider clinical documentation, laboratory, pharmacy and radiology information.

To support reporting for SNP activities, specialized data collection tools were built to collect information to support quality and regulatory activities as part of the clinical assessment or transition contact. The specialized data collection tools also ensure that the conditions of functional, cognitive, medical and psychosocial domains are met. Data elements are collected in reportable fields instead of free text progress notes; this provides the ability to collect information for current reporting needs as well as the opportunity to expand for other report development.

The health outcomes of the SNP Member are reported on a monthly basis. As this population has a steady influx of new enrollments as well as terminations from death or disenrollments, a rolling 12 month report for SNP-HEDIS measures keep constant focus on achieving performance goals. The Regional SNP Project Team reviews program performance with the Medical Center SNP Program Leads following release of the monthly results. The Medical Center Leads provide status against meeting year end goals to include obstacle identification and plans to resolve those barriers.

While each Medical Center ICT work towards meeting health outcomes on a monthly basis, the December Year End report is most critical as that projected performance most closely mirrors the HEDIS submission.
3. Describe how the SNP establishes methods to assess and track the MOC’s impact on SNP beneficiaries’ health outcomes.

KP National SNP

The impact of the SNP care plan on follow-up utilization has been quantitatively evaluated by Kaiser Permanente in 2012 and a similar analysis will be performed in 2015. The follow-up utilization reviewed was acute inpatient hospitalizations in 180 days after care plan completion date.

The SNP care plan group criterion will be:
• SNP member in Kaiser Permanente Northern California, Southern California, Colorado or Georgia Region and
• Continuously enrolled in SNP from July 2014 through June 2015 and
• Completed a care plan between 7/1/2014 and 12/31/2014

The comparison group criterion will be:
• Member in Kaiser Permanente Northern California, Southern California, Colorado or Georgia Region and
• Continuously enrolled in Kaiser Permanente from July 2014 through June 2015 and
• Medicaid member if age less than 65 years as of 7/1/2014 and
• Medicare Risk member if age 65 years or older as of 7/1/2014

Additionally, the comparison group will be matched on a one-to-one basis with a SNP care plan group based on DxCG concurrent risk score as of 10/1/2014, average census income ranges, diagnosis of depression, diagnosis of diabetes, diagnosis of congestive heart failure and diagnosis of schizophrenia. Logistic Regression propensity score matching will be used to match the groups.

Lastly, the SNP care plan group and non-SNP matched comparison group will be more closely aligned by adjusting for the remaining variances between the groups in the following attributes:
• Age
• Sex
• DxCG concurrent risk score
• Prior inpatient admission (prior six months)
• Prior emergency department visit (prior six months)
• Diagnosis of cancer
• Diagnosis of congestive heart failure
• Diagnosis of coronary artery disease
• Diagnosis of depression
• Diagnosis of diabetes
• Diagnosis of asthma
• Diagnosis of drug/alcohol abuse
• Diagnosis of schizophrenia
• Average census block income

These two groups will then be compared via logistic regression model to ascertain completion of the SNP care plan’s impact on follow-up utilization in acute inpatient admissions in 180 days. The 180 day follow-up period for SNP group is care plan completion date to 180 days after care plan completion date. The 180 day follow-up period for comparison group is 10/1/2014 (midpoint of SNP care plan completion date range) to 180 days after 10/1/2014.

KP SCAL SNP Beneficiary Outcomes

KP SCAL SNP uses HEDIS and CMS Improvement Projects to support improved beneficiary health outcomes for reducing avoidable hospitalizations as part of the care plan process. As part of a vulnerable population, select SNP quality metrics were determined as outliers from Commercial or Medicare performance for the same metrics. These were selected from the HEDIS metrics and are typically included as health concerns within the individual SNP Member’s care plan. The HEDIS Observed/Expected Readmission Ratio is also used to monitor avoidable hospitalizations. Additionally, the CMS Chronic Conditions Improvement Project (CCIP) and the Quality Improvement Project (QIP) have specific goals and objectives designed to delay disease progression or reduce the likelihood of institutionalization.

The tracked items are included in the Regional SNP Dashboard that is distributed monthly. The specific measures, with performance targets are listed in MOC 4, Element B, Factor 1. The Regional SNP Dashboard provides a summary of Quality, Utilization and Care Planning Activities (SNP Process Measures) to assess Medical Center ICT performance against identified targets as well as comparing performance against peer ICT Programs.

The KP SCAL SNP 30 Day Readmission Ratio is calculated using the HEDIS Observed/Expected Ratio to determine performance improvement for utilization. The Observed rate is determined by the Count of Actual 30-Day Readmissions as compared to the Count of Index Hospital Stays. The Expected Rate is determined by the Count of Probable 30-Day Readmissions as compared to the Count of Index Hospital Stays. The ratio is determined by dividing the Observed Rate by the Expected Rate. A ratio of 1.0 indicates that the readmissions are at the expected rate; a ratio of less than 1.0 indicates that the performance is better than the expected rate.
4. Describe the processes and procedures the SNP will use to determine if health outcome goals are met.

KP SCAL SNP is monitoring SNP discharge rates per 1000 members to determine if the goal of a 1% reduction to 222 has been met as of CY 2014, with subsequent determination if goal will be reduced to 220 in CY2015. Unless otherwise specified, goals are met if the overall Regional average meets or exceeds the defined goal.

To support achieving that goal, contributory activities that support care plan development will be monitored on a monthly basis as new dashboards are released, during monthly meetings discussions with the Medical Center SNP Program Manager/Physician Champion Dashboard performance is reviewed at the Year End strategy meetings and learnings that impact improved performance are shared with the Medical Center SNP Programs.

Status on goals is assessed on the Regional SNP monthly Dashboard; metrics are color coded as “meeting target,” “within target range” or “not meeting target.” These provide a quick reference to determine if performance is on track to meet identified goals.

**Example: Goal Status - Regional SNP Dashboard (partial view)**
5. Describe the steps the SNP will take if goals are not met in the expected time frame.

Kaiser Permanente Program Office will perform a deep dive analysis of the data identify specific cohorts or other factors that contributed disproportionately to the underperformance for this measure. This information will be provided to the KP SCAL SNP to develop interventions in response to these findings.

For KP SCAL SNP, the SNP Regional Dashboard’s color monitoring of identified goals allows the Regional SNP Team to identify outlier performance when goals are not met. The Regional SNP Program Team will work with the identified Medical Center ICT staff to analyze performance deficiencies. This can include comparison of Medical Center stated performance against standard reports, chart audits or a review of other contributory factors. These may include chart documentation errors, retraining on core program elements or productivity analysis. A barrier analysis is provided to the SNP Program Manager to determine if barriers can be resolved within a specified time frame, typically 60 days.

If there is no resolution within the designated time frame, the Regional SNP team will provide notice of program deficiencies to the Medical Center’s SNP Program Manager, SNP Physician Champion, and those that provide direct oversight to those two Medical Center Program Leads.
Element C: Measuring Patient Experience of Care (SNP Member Satisfaction)

The organization’s MOC must address the process of measuring SNP member satisfaction by:

1. Describing the specific SNP survey used.

To collect feedback and measure satisfaction of the patients experience with the SNP program, KP SCAL SNP mails out member satisfaction surveys. The SNP Program Team manages the frequency, time and population to receive the patient survey. A mailing list of the target population is generated monthly from the Clarity database and member satisfaction surveys are mailed out with a self-addressed return envelope and logged for tracking purposes. SNP members receive the survey letter in the language that they identified as their preferred language during the completion of the SNP assessment.

The target population includes SNP members with a SNP effective date within the previous calendar month and had an assessment completed within that month. The annual estimated population is 7,500 new members. The entire KP SCAL SNP new member population is eligible to receive a survey if they meet the target population criteria; no sampling methodology is required. The targeted population has a completed assessment and care plan; this provides evidence of contact with the ICT Case Manager.

Sample survey:
Responses to the surveys are mailed back to the SNP Program Team in the self-addressed envelopes. Results are compiled, analyzed and feedback is provided to the SNP Leadership for use by the ICT for performance improvement opportunities.
2. **Explaining the rationale for the selection of a specific tool.**

Due to technical challenges and resources, The SCAL SNP Program Team selected a mailing method to survey SNP member satisfaction. This methodology allows the SNP Program Team to easily track and manage surveys via the SNP Member Satisfaction Log. Clarity, which is linked with members’ electronic medical record, is a database refreshed daily which allows SNP assessment completion data available and surveys to be mailed out no later than one month after it was completed to reach the member while the experience is still fresh in their memory.
3. Describing how results of patient experience surveys are integrated into the overall MOC performance improvement plan.

KP SCAL SNP receives feedback from both the New Member Satisfaction Surveys and Inquiries Grievances and Appeals process to identify improvement opportunities for the SNP Model of Care.

Inquiries, Grievances and Appeals

Results obtained from member surveys, inquiries, complaints and grievances are compiled by Health Plan Regulatory Reporting (HPRR) to identify trends. HPRR reviews plan performance for SNP as compare to overall Kaiser Permanente membership. This collects SNP Member concerns for all touchpoints for their Kaiser Permanente medical care. Types of inquiries, complaints and grievances are categorized for Access to Care, Attitude and Services, Billing and Financial Issues and Quality of Care. This process provides for long range review of plan performance. This information is shared with the Regional SNP Department to determine improvement opportunities, within the KP SCAL influence, which is reported to the Member Concerns Committee (MCC) who has program oversight. Trends that involve stakeholder external to SNP, such as billing and Finance, or are universal across the reporting plans are addressed on a larger scale with interventions recommended by MCC.

Items are prioritized for urgency and impact, and whether the intervention can be implemented by the Regional SNP Project Team or by the Medical Center ICT. The opportunities are assessed for implementation and shared during SNP Program Managers/SNP Physician Champions twice annual strategy meetings for project formulation. Prior opportunities have resulted in educational trainings or job aides to improve communications or awareness of complementary programs.

Pre and Post-intervention data with the ICT case managers have provided an indication of improved proficiency, which will ultimately affect the quality of care provided. An example of a survey metric recently implemented for Durable Medical Equipment ordering has provided for ICT Case Manager access to the DME order system to track orders and an escalation process to facilitate DME order processing.

Workgroups are established with ICT related staff to assist with implementation. Interim monthly teleconference meetings are held with SNP Program Managers/SNP Physician Champions and other Medical Center Stakeholders to provide status on implementation.
4. **Describing steps taken by the SNP to address issues identified in survey responses.**

Results of the SNP New Member Patient Satisfaction Survey are analyzed with the final report indicating opportunities and issues. This report is provided to the SNP Leadership at the Medical Centers; trends are shared at the Medical Center level. The SNP Regional Program will trend responses that are less than Agree/Strongly Agree to specific questions, Medical Centers or Case Managers for resolution.

Issues are trended to determine outlier performance with specific activities or within specific Medical Centers. If trends persist over subsequent reporting campaigns, patient response IDs will be uncloaked to perform chart reviews to ascertain contributory factors. Results will be shared with the Medical Center Leads as appropriate. For areas with less than satisfactory results, the specific ICT will provide an action plan to indicate next steps to resolve identified issues.

Annual results are compiled and presented to the Member Concerns Committee (MCC)
Element D: Ongoing Performance Improvement Evaluation of the MOC

The organization’s MOC description must describe:

1. How the organization will use the results of the quality performance indicators and measures to support ongoing improvement of the MOC.
2. How the organization will use the results of the quality performance indicators and measures to continually assess and evaluate quality.
3. The organization’s ability for timely improvement of mechanisms for interpreting and responding to lessons learned through the MOC performance evaluation.
4. How the performance improvement evaluation of the MOC will be documented and shared with key stakeholders.

Evaluation of the effectiveness of the model of care is conducted in conjunction with the other three (3) Kaiser Permanente SNP regions – Northern California, Georgia and Colorado.

Quality, utilization, process, and demographic information is being collected, analyzed, reported and compared on a quarterly and annual basis at both the individual SNP regional level and jointly among all the Kaiser Permanente SNP regions with common measures. Quality measures include SNP HEDIS measures with comparison to Medicare HEDIS where applicable and Medicaid HEDIS where applicable.

Annually, the Regional SNP Program Team develops goals to support local SNP operations. The goals identify improvements for program operations. Utilization measures will include readmissions within 30 days, inpatient days, and emergency department utilization. Process measures where comparable will be used such as completion of care plans and assessments. Demographic information will be compared using KP data and results of the HSQ assessment. Once data is collected and analyzed, discussions will occur between all regions to understand the operational processes affecting the results.

The SCAL SNP Program Team identifies a minimum of 3 - 5 goals to include in the Utilization Management Annual Workplan. Goals are directly attributable to Model of Care operations and are defined with threshold, target and stretch metrics with defined benchmarks for each level. The workplan also specifies activities and strategies to push performance and includes monitoring activities. The workplan is reviewed annually; target dates for completion are defined for that specific year.

The Regional SNP Program Team involves the Medical Center SNP Leads in this process. Learnings from previous years determined that engagement in this process helps unveil potential barriers and promotes local ownership of the identified goals.

An example of workplan goal:

<table>
<thead>
<tr>
<th>Performance Goal:</th>
<th>CCIP: To improve the % of SNP patients in the POINT CAD registry with LDL &lt;100 mg/dL with a Care Manager statin reminder intervention as part of the assessment &amp; transition call process.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Success Measure:</td>
<td>The target goal is to improve the LDL control rate of SNP CAD population from</td>
</tr>
</tbody>
</table>
the August reported rate of 77% by 5%.

<table>
<thead>
<tr>
<th>Performance Improvement Activities</th>
<th>Threshold: Targeted patient lists provided to Medical Center Teams by March 31, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Target: Obtain Medical Center processes to implement CCIP as part of SNP processes</td>
</tr>
<tr>
<td></td>
<td>Stretch: Initial results provided to Medical Centers by end of 2nd Quarter 2013.</td>
</tr>
</tbody>
</table>

The workplan is evaluated for the previous year’s performance against stated goals. The Evaluation assesses each goal, provides a qualitative and quantitative analysis that includes a barrier analysis. For goals that do not meet identified targets, next steps are included and the goal may repeat for the subsequent.

Information regarding MOC program operations, quality metrics, and performance goals for the SNP program is included in the Annual SNP Quality/UM Workplan. The Workplan is developed by the Regional SNP Medial Director and Complex Case Management Regional Director using initiatives developed from HEDIS Quality Measures, NCQA Regulatory indicators and CMS programs to include items from the Medicare Manual, CCIP or QIP programs. Workplan goals are reviewed for approval and then included in the Regional Utilization Management workplan.

The Regional Director of Continuing Care Quality Management includes the annual review of SNP’s evaluation for the previous year’s workplan, along with the goals developed for the upcoming year’s workplan for review by Regional Southern California Quality Committee (SCQC). The information is compiled for reporting to the Quality and Health Improvement Committee (QHIC), who has authority by Kaiser Foundation Hospital/Kaiser Foundation Health Plan Board of Directors for quality oversight.

The Workplan is used to guide program development at the ICT programs at the local Medical Centers. SNP Regional Dashboard activity guides learnings that are shared at the SNP Leaders’ teleconferences and meetings, with guidance provided to the ICT Case Managers through their structure department updates.
Element E: Dissemination of SNP Quality Performance Related to the MOC

The organization must address the process for communicating its quality improvement performance by:

1. Describing how performance results and other pertinent information are shared with multiple stakeholders.
2. Stating the scheduled frequency of communications with stakeholders.
3. Describing the methods for ad hoc communication with stakeholders.
4. Identifying the individuals responsible for communicating performance updates in a timely manner.

1. Stakeholder Review
Quality Performance
Kaiser Permanente SCAL

Quality Measures for Kaiser Permanente, of which KP SCAL SNP contributes, are reported to the general public through a variety of sources, including The Leapfrog Group for hospital excellence in quality and safety, or surveys completed through Consumer Assessment of Healthcare Providers and Systems (CAHPS). Kaiser Permanente also provides notification to members, Healthcare Partners and the general public for NCQA, Medicare or HEDIS performance as updates are provided. KP SCAL SNP does not report quality measures independently of Kaiser Permanente to the general public, members or caregivers.

Kaiser Permanente’s Management Information and Analysis (MIA) and the Clinical Analysis Departments share reporting responsibilities for Kaiser Permanente. MIA provides regulatory updates to NCQA based on a NCQA-defined schedule; Clinical Analysis provides quality data to CMS or HEDIS on a similarly defined schedule. These annual reports have include performance and are distributed to the SNP ICT to guide performance improvement activities.

KP SCAL SNP
The SNP HEDIS Measures and the Medicare 5 Star performance are web-based on the KP SCAL intranet. MIA and Clinical Analysis notify a comprehensive list of stakeholders by email of updates to the web based reports.

The Regional SNP Project Team identifies the tracked metrics to include on a monthly dashboard for easier reference of program initiatives. Tracked Metrics include SNP Process Measures for volume and timeliness of task activities, utilization measures and quality goals. These are monthly projected performance, based on Medical Center activity, of annually reported metrics.

The Regional Director of Continuing Care Quality Management includes the annual review of SNP’s evaluation for the previous year’s workplan, along with the goals developed for the upcoming year’s
workplan for review by Regional Southern California Quality Committee (SCQC). The information is compiled for reporting to the Quality and Health Improvement Committee (QHIC), who has authority for quality oversight by Kaiser Foundation Hospital/Kaiser Foundation Health Plan Board of Directors.

For HEDIS and Medicare 5 start metrics, Clinical Analysis posts reports to the KP intranet webpage and notifies the Regional SNP Project Team when new data is available.

MIA provides direct notification by email to the Regional SNP Project Team when new data is available.

The Regional SNP Project Team collects information from these sources to compile the Regional SNP Dashboard and/or provides direct notification to the SNP stakeholders when source data is available.

Inquiries, Grievances and Appeals Reporting
Kaiser Permanente’s Department of Regulatory Relations & Performance Assessment reports and analyzes data collected for inquiries, grievances and appeals. This data is shared with the Regional SNP Project Team to determine trends and identify opportunities.

The Regional SNP Project Team creates an implementation plan and determines success measures that are reported with the analysis to the Regional Member Concerns Committee (MCC) on an annual basis. The progress is evaluated by the MCC who makes recommendations to the Regional SNP Project Team.

Results of these activities are ultimately reported to the responsible Stakeholder groups that include the Board of Directors, Regional Program Directors, Senior Leadership as well as Medical Center Management, and direct personnel involved with the various programs. The Regional SNP Program Team provides updates of this information on an annual basis during the monthly SNP Leadership Teleconferences.

For patient satisfaction surveys collected on SNP New members for case management effectiveness, reporting updates are provided on a quarterly basis during the monthly SNP Leadership conferences.

2. Communication Frequency
The SNP Regional Dashboard is a monthly snapshot of SNP activity that includes regionally tracked utilization measures, projected HEDIS and Medicare 5 star measures and projected activity on SNP process measures, such as care plans completed on new members within 90 days and on existing members within 365 days. The Regional SNP Dashboard is distributed by email to a comprehensive list of stakeholders that extends beyond the ICT Leadership to include Medical Center Executive Leadership and local Quality Committeess /Departments. The Dashboard is archived on the SNP Shared Drive.

Data sources used for the SNP Regional Dashboard, such as the SNP HEDIS Measures, maintain the original document. These are initially emailed, according to the reporting schedule (monthly, quarterly
or annually), to the SNP Regional Project Team and are posted on an internal website that hosts other quality measures, such as the Medicare 5 star performance and HEDIS performance by Medical Center.

3. **Adhoc Communication**

In addition to scheduled monthly teleconferences, both the Regional SNP Project Team and Local Medical Centers ICT arrange for presentations at regularly scheduled staff meetings.

The Regional SNP Project Team will engages with stakeholders during implementation of improvements or to assist with program knowledge awareness.

Ad hoc communication can occur in person during regularly scheduled meetings or through webinar teleconferences. Best practices can be shared across large distances by initiating a webinar request and multiple attendees can participate simultaneously. This facilitates more rapid information sharing between large groups.

4. **Program Communication Responsibility**

The Regional SNP Program Team is responsible for communicating the SNP Regional Dashboard on a regular schedule. The Regional SNP Project Team monitors receipt of reports and will contact the data reporting entity, as necessary, when reports are not delivered timely.

The Regional SNP Program Team also communicates SNP program information to meet all required and requested program updates, to both internal and external stakeholders, to include CMS, NCQA and other regulatory and reporting agencies.
2017 Home Care/Continuing Care Quality Program Description Annual Work Plan and Evaluation

Kaiser Foundation SCAL Region Home Care/Continuing Care

Approved by the Kaiser Foundation Regional Home Care SCQC Committee on _________________ (Date)
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Section 1 – Quality Program Overview

**Purpose**

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

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

The foundational elements of all quality and patient safety initiatives and activities provide a framework that also supports quality improvement processes at KFH SCAL Regional Home Care/Continuing Care. They are:

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

**Mission, Vision, Values**

**Mission:**
Our mission is to provide quality health care and service to our patients at an affordable cost.

**Vision:**
Our vision is to help patients optimize their health by providing access to outstanding, compassionate primary and specialty services. We will promote our communities through outreach and educational programs.

**Values:**

**Guiding Principles:**

- Principle#1: Quality Assurance and Performance improvement will play a role as we monitor the accuracy of reported billing via our Sarbanes-Oxley (SOX) review program.

- Principle#2: Regional quality team will use the Quality Assurance and Performance Improvement program as a means to improve clinical operations and sustained quality of care to our members.
HOME CARE/CONTINUING CARE QUALITY
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- Principle#3: QAPI means providing the member and the family unit the best clinical and non-clinical care, services and satisfaction throughout the Continuum of Care; including across Southern California, Medical Centers, Departments, Disciplines, every time without fail. Our members are why we exist.
- Principle#4: Our QAPI program will focus on systems and processes, rather than individuals. The emphasis is on identifying system gaps rather than on blaming individuals.
- Principle#5: Kaiser Permanente bases decisions on data, which includes input from all stakeholders including the voice of the members.
- Principle#6: KP set goals for performance and measures progress toward those goals. The methodology for measurement is through Evidence Based Practice (EBP) and Plan-Do-Study-Act (PDSA).
- Principle#7: KP supports quality assurance and performance improvement by encouraging staff to support each other and to be accountable for their own professional performance and practice.
- Principle#8: KP has a culture that encourages, rather than punishes, employees who speak up to identify errors or system breakdowns.
Program Oversight, Authority, and Home Care Governance Structure

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

AUTHORITY AND STRUCTURE

Kaiser Foundation Hospitals Board of Directors
Quality Health and Improvement Committee (QHIC)

Southern California Quality Committee (SCQC)

Southern California Continuing Care Committee, Quality Evaluation and Support Team (QUEST) and Southern California Quality Committee (SCQC)

Kaiser Foundation Hospitals Board of Directors:
Kaiser Foundation Hospitals is a California non-profit, public benefit corporation that owns and operates general acute care hospitals in California, Hawaii, and Oregon. Each hospital is licensed by the state in which it is located, certified by CMS and accredited by The Joint Commission. The Board of Directors of Kaiser Foundation Hospitals, the governing body, through its Quality and Health Improvement Committee (“QHIC”), oversees each home care agency’s Quality and Patient Safety Program (“Program”). The QHIC assures each home care agency’s executive and Professional Staff leadership develops the Home care Agency’s program consistent with the Home Care’s mission, vision and values. The Agency’s executive leadership is accountable to the QHIC to assure the planning and implementation, including establishing priorities for KFH - SCAL Regional Home Care/Continuing Care Quality
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and Patient Safety Program with respect to the delivery of existing services and the implementation of new home care services.

**Governing Structure:**
The Governance of the Home Health Agency is vested in the Governing Body and the Medical Center Administrative Team. This governance is made up of four bodies, The Kaiser Foundation Governing Board, Regional Home Care Governance Committee, Regional Operational Partners and Medical Centers Partners.

**Purpose of the Governing Body:**
The Governing Body provides National leadership oversight. The President of the Region for Operations and the Executive Director of Home Health and Hospice provides Regional leadership. The Medical Center SVP/Area Manager oversees the Kaiser Foundation Hospitals (KFH) and Kaiser Foundation Health Plan (KPHP) function. The Medical Center SVP/Area Manager communicates directives and inquires with the Home Health and Hospice Area Administrator also collaborating with the Executive Director of Home Health and Hospice and the Regional Home Care Operations Director. Agency level requests of the Medical Center Administrative Team, Regional Leadership and the Governing Body are made through this established chain of command.

**Purpose of the Home Care Governance Committee:**
Kaiser Permanente Southern California (KPSC) Regional Governance Committee will oversee the state of agency administration as outlined in local Professional Advisory Committees (PAC).
Medicare Conditions of Participation outline the requirement for a governing body to assume full legal authority and responsibility for the operation of home health and hospice agency.
Further, a hospice’s governing body is responsible for ensuring an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually.
The federal *Conditions of Participation (COP)* mandate a group of multi-disciplinary professional personnel establish and annually review the agency’s policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation.
KPSC Home Care agencies fulfill this by conducting meetings at least three times per year with the Professional Advisory Committee (PAC) or the Agency fulfills this by conducting an annual review meeting. PAC minutes and supporting documentation will reflect evidence of compliance with regulations.

**Role & Activities of the Committee:**
Oversee accountability for the quality of care and financial performance
Guide/consult strategic plans, including the development of new programs and services
Provide direction to the business, property, affairs, and funds of the entity
Ensure that the entity functions in the most effective and efficient manner consistent with KP’s mission and values
Ensure alignment & integration of Home Care Services across the continuum of care & overall KP goals & strategies.

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

**Medical Center**
The Kaiser Foundation Hospital Board of Directors has designated each Medical Center’s
SVP/Area Manager as the Governing Body of the local Home Health Agency and as such has delegated decision-making authority for Agency operations to the Executive Director. Such authority includes:

- **Accountability** – Approves policies, oversees management of fiscal affairs, including budgets, and appoints Administrators for home health agencies and hospice services within the Medical Center’s service area.
- **Monitors** Home Health operations and quality performance.

Orientation may include orientation to his/her role as the Area Administrator of Home Health and Hospice. Orientation includes written materials and information regarding Home Health services and the role and responsibilities of the Governing Body members to the agencies.

The Area Administrator of Home Health and Hospice annually approves the list of indicators that measure the quality of care and service delivered, appropriateness of the service, and regulatory readiness. Indicators are selected based on regulatory requirements, high risk or problem prone areas or significant trends identified in data collection results. These indicators will provide the basis for the quality program at each Home Health agency and reflect the means to report on the aggregate status of all agencies throughout the Region.

### Home Care Leadership:

The Home Care/Continuing Care leadership team focuses its efforts on home care operations and strategic priorities. KFH - SCAL Regional Home Care/Continuing Care is managed by the Regional Executive Director for Home Care who serves as the home care administrator. In collaboration with the Regional Quality Continuing Care Director, and the Regional Continuing Care Medical Director, Leadership is responsible for providing a framework for the delivery of quality care and services provided by the agencies based on the home care’s mission, Board of Directors’ QHIC initiatives, and home care identified opportunities for improvement. Leadership is also responsible for developing and implementing an effective planning process that allows for defining timely and clear goals.

The Regional Executive Director for Home Care, the Regional Quality Continuing Care Director, and the Regional Continuing Care Medical Director, collaborate with other members of the leadership team including the Regional Director of Operations for Home Care, the Regional Director of Clinical Service for Home Care, and the local Home Care Agency leadership and the quality leaders on implementing the Quality and Patient Safety Program.

The Regional Executive Director for Home Care is responsible for the operations of Home Care Services and is accountable to the governing body for the management of the Home Care Agency.

Kaiser Foundation SCAL Regional Home Care/Continuing Care Leadership is responsible for:

- Ensuring collaboration with community leaders and organizations to design services to be provided by the hospital that are appropriate to the scope and level of care required by the population served;
- Ensuring communication of the organization’s mission, vision, values, goals, objectives and strategies across the facility;
- Utilizing situational leadership behaviors to provide appropriate direction and management for all services and/or departments;
- Ensuring uniform delivery of patient care services provided throughout the hospital;
- Ensuring that systems are in place to promote the integration of services, and to support the patient beyond the hospital walls;
- Appointing committees, work groups, performance improvement teams and other forums to ensure multidisciplinary and interdepartmental collaboration on issues of mutual concern;
- Establishing structures and processes that focus on safety and quality, improving the health care safety of patients, and reducing preventable adverse patient events;
- Implementing changes in existing processes to improve the quality of the care provided;
- Establishing quality of care and patient safety metrics, which can be monitored through the hospital’s plan;
Establishing a learning environment where employee development and continuing education opportunities serve to promote retention of staff and to foster excellence in the delivery of care and support services;

Providing ongoing patient safety training for physicians, nurses and hospital staff;

Promoting a “Just Culture” that recognizes human beings make mistakes, supports reporting, advocates fair treatment, and has intolerance for reckless behavior;

Ensuring that staffing resources are available, trained and competent to appropriately meet the needs of the patients served;

Ensuring the Medical Executive Committee submits reports to the Board of Directors’ QHIC regularly and as requested; and

Providing routine reporting and special reports as requested to the Board of Directors’ QHIC.

**Agency Management**

Home Health Management Team Role/Responsibilities - The daily operation of the Home Health agency is vested in the Management Team who collectively and individually assume daily responsibility for Agency operations, staff performance and patient care outcomes. The Agency Management Team includes the Area Administrator of Home Health and Hospice and middle managers and may also include individuals who perform operational coordination roles. Each member of the Management Team is carefully selected and qualified through credentialing, education and experience for their level of supervision and managerial leadership.

The following describes the Management Team:

1. **Area Administrator of Home Health and Hospice** - the Area Administrator of Home Health and Hospice is the person who is appointed in writing by the Medical Center SVP/Area Manager as delegated by the governing body of the HH Agency to organize and direct the services and ongoing functions of the Agency. (See Home Health Policy 4-006.1)

2. **Regional Quality Manager** - The Regional Quality Manager designated for each agency for quality program oversight assumes responsibility for the quality management program through participation in the development of the quality plan, designing tools for problem identification/resolution, compliance monitoring, standards development, inter-rater reliability (IRR) and recommendation and collaboration with corrective action plans. The Regional Quality Manager works with the Leadership teams and Quality staff in each agency on all aspects of the Quality Program including performance improvement, quality outcomes, regulatory compliance, and service.

3. **Director of Patient Care Services** - the Director of Patient Care Services (DPCS) collaborates with other departments within KFH and KFHP, other KP Home Health agencies, external community resources and Home Care Agencies within this broad range of activities. The management team coordinates and integrates Home Care into the functions of the organization.

4. **Clinical Supervisors, Agency Supervisors/Managers and Team Leaders** - These positions exist for the management/supervision of the direct patient care functions and agency operations.

5. **Professional Advisory Committee (PAC)** - See below - III Quality Oversight

6. **Medical Staff** - The Southern California Permanente Medical Group is directed and administered as a separate entity from KFH and the Kaiser Foundation Health Plan.

   **Regional Level** - The Medical Directors of SCPMG are responsible for the executive level decisions made regarding SCPMG issues.

   **Facility Based Medical Staff Positions:**

   **Home Health Medical Director** - The HH Medical Director provides consultation and acts as a liaison to the area Medical Director and Regional Departments. The responsibilities of the Medical Director shall include but are not limited to:
HOME CARE/CONTINUING CARE QUALITY
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a) Availability to the HH management/staff members by direct access; Participation in standards approval, quality management, utilization review, PAC Meetings and assistance in dealing with conflict resolution; Provision of direct medical home care; Designation of alternative MD in his/her absence.

b) Attending Physician - Patients admitted to HH are attended by their primary physician. The following are the responsibilities of the attending physician: authorize and sign the plan of care in a timely manner; review and modify the plan of care as required; participant with the Home Health interdisciplinary team; and provide necessary medical examination and care.

Medical Executive Committee (MEC): The Medical Executive Committee is responsible to ensure the proper functioning of all departments, committees and other activities of the Professional Staff and to monitor the effectiveness of Professional Staff activities. The MEC has oversight of the quality of care and patient safety provided to patients and their families. The MEC is responsible for the organization of the performance improvement and patient safety activities of the Professional Staff as well as the mechanisms used to conduct, evaluate and revise such activities.

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

The committee facilitates the preparation of reports related to the hospital’s quality assurance, performance improvement, and patient safety activities to be submitted to the Board of Directors’ QHIC through the Medical Executive Committee on an ongoing basis and as requested.

Other committees: Coordination and integration of the QM activities occurs through formal relationships at the medical center, regional and program levels. This includes other Professional Staff Committees, departmental committees, and specifically focused committees and work groups have been given, by leadership, the responsibility to develop, implement, and monitor performance effectiveness for the services and processes within their scope. These committees and work groups report up through the quality structure.

Section 2 – Performance Improvement

Performance Measure Overview

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

The Board of Directors’ QHIC has set an expectation that the home care administrator in partnership with the Continuing Care Medical Director will identify, prioritize and remedy quality and safe patient care issues as they occur, consistent with the parameters of the quality plan. This is accomplished in part through the collaboration of the home care administrator and the hospital Medical Executive Committee. Home Care leadership shall report these issues and their remediation on an annual basis in the Agency’s annual quality and patient safety evaluation.

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

Quality Oversight & Scope:
Home Health Agencies use the concepts of Quality Management (QM) in the development of a systematic Quality Management practice model. Organizational and clinical functions are designed, measured, assessed and improved on an ongoing basis to meet professional, regulatory and accreditation standards.

Medical Center Quality Committee - The Medical Center quality committee has oversight responsibility for the quality activity in the Home Health Agency. The Medical Center quality committee will review and approve the HH Program Descriptions as well as the agency’s Annual HH Work Plan and HH Program Evaluation. The Area Administrator of Home Health and Hospice or designee reports to the Medical Center Quality Committee. Frequency of reporting is determined by the Medical Center Quality Committee. The Medical Center Quality Committee reviews all key quality monitors.

Professional Advisory Committee (PAC) - Each HH Agency has at minimum a PAC Committee and may also have a Quality Committee.

PAC and/or Quality Function: The PAC is a group of professional personnel who are available to meet at a minimum of three times a year, or more frequently, if needed, to advise the HH Agency on professional issues. The PAC participates in the evaluation of the Agency's program and assists the Agency in maintaining liaison with other Health Care providers in the community and with the Agency's community information program.

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

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

These committees will address quality issues, monitor agency performance for improvement activities, and track progress on action plans. This committee, under the leadership of the Quality Manager or designee analyzes data, evaluates results of analysis and institutes QI activities as needed and ensures follow-up as appropriate.

Home Care Area Administrators Committee - The Area Administrators of Home Health and Hospice meet at least 9 times per year and are responsible for overseeing the following QM activities:
(a) structure, process and outcome standards development;
(b) compliance monitoring of structure, processes, outcome standards and aggregate collation of area statistics;
(c) overseeing the development of data sources for problem identification, as well as resolution and monitoring the effectiveness of problem identification methods;
(d) identifying opportunities for improving systems, programs and patient care; and
(e) identifying teams to pursue corrective action and improvement activities.

Home Health and Hospice Quality Committee - The Home Health and Hospice designated Quality Manager from each Agency meet at least 9 times per year. The QM Committee directs the quality assessment and quality improvement efforts for Home Care and coordinates QM activities for each agency. This committee exists to identify opportunities for improvement and consistency, and to conduct benchmark among the agencies. The committee coordinates and implements improvement initiatives, best practice opportunities and consistent education and training with the agency leaders and quality management staff.

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

QAPI Goals:
- The regional QAPI program will address compliance measures outlined by regulatory metrics from Center for Medicare & Medicaid Services (CMS).
- The regional QAPI program will collect, monitor, review, compare, and interpret data from various sources-CASPER, Home Health Compare, HHCAHPS and Hospice CAHPS, HHQI, vendors, and chart audits, etc.
- The overall goal is to always ensure safe, effective, appropriate and affordable care as we manage through efficacy, availability, timeliness, continuity, safety, respect and caring.

Program Activities and Scope:
- QAPI Program will gather input from focus groups, process mapping to identify areas of improvements. It will consolidate, and prioritize, considering if the area is a high risk problem versus an opportunity for improvement. The program will look for alignment to other current quality indicators that measure outcomes and key indicator to determine if standards have been met.
- The focus will be on high-risk, high volume, or problem prone areas of service, considering the incidence, prevalence, and severity of problems in those areas. The goal is to correct any immediate problem that directly or potentially threatens the health and safety of our members.
- The program will track and analyze unusual occurrences and complaints utilizing Midas so that the agency can implement preventative actions and sustainable measures.
- The program will use Root Cause Analysis (RCA) or Inter rater Reliability (IRR) to identify contributing causal factors that leads to variations in performance.
- The program will refer to any regulatory and clinical performance standards to identify deviations; implement changes or corrective actions that will result in improvement, testing small pilots before rolling out to entire region; review QAPI plan every year (continuing to show improvement)
HOME CARE/CONTINUING CARE QUALITY
HOME HEALTH PROGRAM DESCRIPTION

- The program will access online QAPI courses in HHQI University to stay versed in HH QAPI, topic specific courses related to Acute Care Hospitalization, Medication Management, and Cardiovascular Health.
- The program will support Standards and policy development
- The program will support patient and family surveys and complaint monitoring
- The program will support monitoring of contracted services
- The program will support monitoring of publicly reported data and performance improvement

Methodology for Improving Performance:

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

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

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

D. Regional Quality Team Committee
The regional quality team will be a standing committee with ad hoc members that meets monthly to review trends, regulatory compliance issues, set regional policy and procedures. This group will meet the second Tuesday of each month in a designated agency each month. This group will include the Regional Director of Continuing Care, Regional Clinical Director for HH & HO, Regional Quality Managers and an Agency Quality Coordinator. Ad Hoc or Subject Matter Experts (SME) will be invited as needed.

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

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

Annually, responsible home care and Professional Staff leaders evaluate each component of the Quality and Patient Safety Program, evaluate performance against targets and develop work plans for the ensuing year. The evaluation specifically:

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

The Home Health Agency has a system of assessing and improving the quality of services. Components of the HH Quality Plan include:

- Continuing education
- Professional credentialing, assessment for competency and ongoing performance appraisal
- Patient perception surveys and complaint monitoring
- Risk management, including unusual occurrence tracking, safety and infection control monitoring
- Active problem identification
- Compliance to applicable laws and regulations
- Analysis of OASIS data – Potentially Avoidable Event Reports; Outcome Based Quality Management (OBQM) Reports; CMS Home Health Compare Reports and HHCAHPs Reports.
- Contract oversight
Medicare STAR Rating for Quality and Service

Section 3  Credentialing and Peer Review

The SCAL Regional Home Care/Continuing Care Quality and Patient Safety Program includes the methods for assessing and continuously improving the care delivered to hospital patients through the review of practitioner performance. Credentialing, privileging, and peer review are considered integral to the development and implementation of quality improvement, patient safety, resource utilization and risk management strategies.

The Medical Executive Committee of the Professional Staff reviews and recommends practitioners seeking privileges, and acts on results of focused practitioner performance evaluation (FPPE) and ongoing practitioners performance evaluation (OPPE), and trends identified by peer review.

Credentialing and Privileges

Credentialing and privileging activities are conducted in accordance with written policies and procedures for credentialing, re-credentialing, privileging, appointment, reappointment, proctoring, and ongoing practitioner performance evaluation (OPPE). Recommendations for Professional Staff membership and/or clinical privileges are made by the Medical Executive Committee whose recommendations are further submitted to the Kaiser Foundation Hospitals Board of Directors' QHIC for final approval consistent with the process delineated in the Professional Staff Bylaws.

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

Peer Review

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

The objective of the Peer Review Program is to:

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

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

The Continuing Care Medical Director, based on peer review findings may recommend activities to improve performance that include but are not limited to:

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

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

### Contract Evaluation and Oversight

At least annually (more often as necessary), the SCAL Regional Home Care/Continuing Care assesses the quality monitoring of the agencies, organizations and individuals with which it contracts for the provision of care, treatment, and services provided to the home care patients. The home care clinical contract list will be approved by the Medical Executive Committee annually based on review of quality and performance data.

The KFH - SCAL Regional Home Care/Continuing Care leaders will select the best methods to oversee the quality and safety of services provided through contractual agreement. Examples of sources of information that may be used for evaluating contracted services include the following:

- Review of information about the contractor’s Joint Commission accreditation or certification status
- Direct observation of the provision of care
- Audit of documentation, including medical records
- Review of incident reports
- Review of periodic reports submitted by the individual or hospital providing services under Contractual agreement
- Collection of data that address the efficacy of the contracted service
- Review of performance reports based on indicators required in the contractual agreement
- Input from staff and patients
- Review of patient satisfaction studies
- Review of results of risk management activities

The individual assigned responsibility for each contract is accountable to review the contract expectations and establish appropriate quality and operational indicators and monitoring frequencies, and to report performance through the established quality structure. In the event that contracted services do not meet expectations, leaders take steps to improve care, treatment, and services.

### Contract Oversight

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

**Health Plan Contract Oversight Procedure Utilization Management of Shift Care Cases**

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

**Procedure**

**Kaiser Permanente Responsibility**

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

**Contract Vendor Responsibility**

1. Diligently seek coverage for open shifts and documents such attempts. Provides documentation to Kaiser when requested. Notifies Kaiser when shifts are canceled by patient/caregiver or when shifts are cancelled by contract vendor due to inability to staff and the number of shifts/hours/range fall below the shifts/hours/range specified on the POC. This notification must occur as soon as possible once known on the next business day.
2. When unable to meet the hours ordered in the POC, assesses and documents the patient/family’s need for an alternate level of care. Contacts and works with Kaiser when an alternate level of care is requested by the patient/family.
3. Notify attending physician when unable to meet the POC orders.
5. Develops and implements actions plans to correct identified problems. Keeps Kaiser informed on resolution of the action plans.
6. Contract Agency notifies Kaiser of changes to the POC regarding the provider type and the number of hours per day, week, or month.
8. Submit copies of the visit notes with each billing cycle when requested.
9. Submit copy of POC for each new patient and each recertification.

Section 4 Confidentiality

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

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

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

Identification of Member/Stakeholders Needs, Expectations and Satisfaction

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

Member Rights

A. Accessibility - Home Health agencies provide clinical care/services 7 days/week, 365 days/year. The agency office hours are generally from 8:30 A.M. to 5:00 P.M. Individual Home Health agency office hours may vary.

B. Phone Accessibility - A triage nurse is available 7 days/week, 24 hours/day to respond to all calls from Home Health Agency patients. After-hours advice care is available for patients when unexpected situations arise. Individual patient needs are met by processes specific to each agency.

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

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

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

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

**Continuum of Care**
It is the objective of Home Health to provide all patients with continuity of care across the continuum from hospital to home to the ambulatory setting.

### Regional Indicators

<table>
<thead>
<tr>
<th>Domains of Quality</th>
<th>Home Health and Palliative Care Quality Management Indicators</th>
<th>Frequency of Data Collection</th>
<th>Frequency of Reporting</th>
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<tr>
<td><strong>Satisfaction</strong></td>
<td>• CMS STAR Rating- Service Report</td>
<td>Monthly</td>
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<td></td>
<td>• HHCAHPS for Home Health and Palliative Care</td>
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<td>• Rate of Agency</td>
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<td>• Informed about Arrival</td>
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<td><strong>Clinical Quality</strong></td>
<td>• Potentially Avoidable Events –Monitoring occurs based on Tier 1 and Tier 2 as directed CMS</td>
<td>Quarterly</td>
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<td>1. Emergent Care for Injury Causes by Fall/Accident @ Home</td>
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<td>2. Emergent Care for wound infection, deteriorating wound status</td>
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<td>3. Unexpected Death</td>
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<td>4. Increase in # of Pressure Ulcers</td>
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<td>• HHCAHPS- Patients/Caregivers instructed on medication side effects for safe medication management (#14)</td>
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<td>• CMS Home Health Compare Report</td>
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<td>• CMS STAR Rating-Quality</td>
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<td>• Re-hospitalization Rate within 30 days from discharge from the hospital (SHP data)</td>
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<td><strong>Infection Control</strong></td>
<td>Rate of Home Care acquired UTI w/Foley catheter</td>
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<td><strong>Access</strong></td>
<td>• 48 hour admission timeliness (HH and PC)</td>
<td>Monthly</td>
<td>Quarterly</td>
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<td></td>
<td>• Number of In-patient Admissions/1000 Palliative Care Days</td>
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<td><strong>Regulatory Compliance</strong></td>
<td>• Accuracy of NOMNC for Home Health and Palliative Care</td>
<td>Monthly</td>
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<td>• Timeliness – Provided to patient at least 48 hours prior to discharge</td>
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<td>• Accurate Content- Per CMS requirements</td>
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<td>• Contract agency NOMNC compliance</td>
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<td>• MD Face to Face visit</td>
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<td>• HH Certification/POC signed appropriately and</td>
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<td><strong>timely by Physician</strong></td>
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<td>HH documentation supports medical necessity</td>
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<td>Oasis error report compliance</td>
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<td>SB853 Compliance (HH and Palliative Care)</td>
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2017 Home Care/Continuing Care Quality Program Description
Annual Work Plan and Evaluation

Kaiser Foundation SCAL Region Home Care / Continuing Care

Approved by the Kaiser Foundation Regional Home Care SCQC Committee on
______________________ (Date)
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Section 1 – Quality Program Overview

Purpose

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

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

The foundational elements of all quality and patient safety initiatives and activities provide a framework that also supports quality improvement processes at KFH SCAL Regional Home Care/Continuing Care. They are:
1. An understanding of systems thinking, High Reliability Organizations (HRO), human error and human factors.
2. The creation and maintenance of a culture in which reporting takes place in a "Just Culture"
3. Proactive and prioritized performance improvements to prevent failure, mitigate hazards, and improve systems and process reliability.
4. Seeking input from and collaborating with patients and families.
5. Assuring compliance with all state and national regulatory, accreditation, and certification standards supporting quality and patient safety.
6. Ongoing identification, sharing, and appropriate implementation of successful practices from other parts of the organization, other healthcare organizations, and organizations outside of healthcare.

Mission, Vision, Values

Mission:
Our mission is to provide quality health care and service to our patients at an affordable cost.

Vision:
Our vision is to help patients optimize their health by providing access to outstanding, compassionate primary and specialty services. We will promote our communities through outreach and educational programs.

Values:

Guiding Principles:
- Principle#1: Quality Assurance and Performance improvement will play a role as we monitor the accuracy of reported billing via our Sarbanes-Oxley (SOX) review program.
- Principle#2: Regional quality team will use the Quality Assurance and Performance Improvement program as a means to improve clinical operations and sustained quality of care to our members.
HOME CARE/CONTINUING CARE QUALITY HOSPICE PROGRAM DESCRIPTION

- Principle#3: QAPI means providing the member and the family unit the best clinical and non-clinical care, services and satisfaction throughout the Continuum of Care; including across Southern California, Medical Centers, Departments, Disciplines, every time without fail. Our members are why we exist.

- Principle#4: Our QAPI program will focus on systems and processes, rather than individuals. The emphasis is on identifying system gaps rather than on blaming individuals.

- Principle#5: Kaiser Permanente bases decisions on data, which includes input from all stakeholders including the voice of the members.

- Principle#6: KP set goals for performance and measures progress toward those goals. The methodology for measurement is through Evidence Based Practice (EBP) and Plan-Do-Study-Act (PDSA).

- Principle#7: KP supports quality assurance and performance improvement by encouraging staff to support each other and to be accountable for their own professional performance and practice.

- Principle#8: KP has a culture that encourages, rather than punishes, employees who speak up to identify errors or system breakdowns.
The objective of KFH- SCAL Regional Home Care/Continuing Care Quality and Patient Safety Program is to provide a leadership driven framework and organizational structure to achieve the mission and strategic goals of the organization. The Quality and Patient Safety Program structure and oversight ensures that consistent and systematic efforts are maintained to continually measure, assess, and improve processes and outcomes related to services provided.

**AUTHORITY AND STRUCTURE**

**Kaiser Foundation Hospitals Board of Directors**
Kaiser Foundation Hospitals Board of Directors is a California non-profit, public benefit corporation that owns and operates general acute care hospitals in California, Hawaii, and Oregon. Each hospital is licensed by the state in which it is located, certified by CMS and accredited by The Joint Commission. The Board of Directors of Kaiser Foundation Hospitals, the governing body, through its Quality and Health Improvement Committee ("QHIC"), oversees each home care agency’s Quality and Patient Safety Program ("Program"). The QHIC assures each home care agency’s executive and Professional Staff leadership develops the Home care Agency’s program consistent with the Home Care’s mission, vision and values. The Agency’s executive leadership is accountable to the QHIC to assure the planning and implementation, including establishing priorities for KFH - SCAL Regional Home Care/Continuing Care Quality.
and Patient Safety Program with respect to the delivery of existing services and the implementation of new home care services.

**Governing Structure:**
The Governance of the Hospice Agency is vested in the Governing Body and the Medical Center Administrative Team. This governance is made up of four bodies, The Kaiser Foundation Governing Board, Regional Home Care Governance Committee, Regional Operational Partners and Medical Centers Partners.

**Purpose of the Governing Body:**
The Governing Body provides National leadership oversight. The President of the Region for Operations and the Executive Director of Home Health and Hospice provides Regional leadership. The Medical Center SVP/Area Manager oversees the Kaiser Foundation Hospitals (KFH) and Kaiser Foundation Health Plan (KPHP) function. The Medical Center SVP/Area Manager communicates directives and inquires with the Home Health and Hospice Area Administrator also collaborating with the Executive Director of Home Health and Hospice and the Regional Home Care Operations Director. Agency level requests of the Medical Center Administrative Team, Regional Leadership and the Governing Body are made through this established chain of command.

**Purpose of the Home Care Governance Committee:**
Kaiser Permanente Southern California (KPSC) Regional Governance Committee will oversee the state of agency administration as outlined in local Professional Advisory Committees (PAC).

Medicare Conditions of Participation outline the requirement for a governing body to assume full legal authority and responsibility for the operation of home health and hospice agency. Further, a hospice’s governing body is responsible for ensuring an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually.

The federal *Conditions of Participation* (COP) mandate a group of multi-disciplinary professional personnel establish and annually review the agency’s policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation.

KPSC Home Care agencies fulfill this by conducting meetings at least three times per year with the Professional Advisory Committee (PAC) or the Agency fulfills this by conducting an annual review meeting. PAC minutes and supporting documentation will reflect evidence of compliance with regulations.

**Role & Activities of the Committee:**
Oversee accountability for the quality of care and financial performance
Guide/consult strategic plans, including the development of new programs and services
Provide direction to the business, property, affairs, and funds of the entity
Ensure that the entity functions in the most effective and efficient manner consistent with KP’s mission and values
Ensure alignment & integration of Home Care Services across the continuum of care & overall KP goals & strategies.

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

**Medical Center**
The Kaiser Foundation Hospital Board of Directors has designated each Medical Center’s
SVP/Area Manager as the Governing Body of the local Home Health Agency and as such has delegated decision-making authority for Agency operations to the Executive Director. Such authority includes:

Accountability – Approves policies, oversees management of fiscal affairs, including budgets, and appoints Administrators for home health agencies and hospice services within the Medical Center’s service area. Monitors Home Health operations and quality performance. Orientation may include orientation to his/her role as the Area Administrator of Home Health and Hospice. Orientation includes written materials and information regarding Home Health services and the role and responsibilities of the Governing Body members to the agencies.

The Area Administrator of Home Health and Hospice annually approves the list of indicators that measure the quality of care and service delivered, appropriateness of the service, and regulatory readiness. Indicators are selected based on regulatory requirements, high risk or problem prone areas or significant trends identified in data collection results. These indicators will provide the basis for the quality program at each Home Health agency and reflect the means to report on the aggregate status of all agencies throughout the Region.

**Home Care Leadership:**
The Home Care/Continuing Care leadership team focuses its efforts on home care operations and strategic priorities. KFH - SCAL Regional Home Care/Continuing Care is managed by the Regional Executive Director for Home Care who serves as the home care administrator. In collaboration with the Regional Quality Continuing Care Director, and the Regional Continuing Care Medical Director, Leadership is responsible for providing a framework for the delivery of quality care and services provided by the agencies based on the home care’s mission, Board of Directors’ QHIC initiatives, and home care identified opportunities for improvement. Leadership is also responsible for developing and implementing an effective planning process that allows for defining timely and clear goals.

The Regional Executive Director for Home Care, the Regional Quality Continuing Care Director, and the Regional Continuing Care Medical Director, collaborate with other members of the leadership team including the Regional Director of Operations for Home Care, the Regional Director of Clinical Service for Home Care, and the local Home Care Agency leadership and the quality leaders on implementing the Quality and Patient Safety Program.

The Regional Executive Director for Home Care is responsible for the operations of Home Care Services and is accountable to the governing body for the management of the Home Care Agency.

Kaiser Foundation SCAL Regional Home Care/Continuing Care Leadership is responsible for:

- Ensuring collaboration with community leaders and organizations to design services to be provided by the hospital that are appropriate to the scope and level of care required by the population served;
- Ensuring communication of the organization’s mission, vision, values, goals, objectives and strategies across the facility;
- Utilizing situational leadership behaviors to provide appropriate direction and management for all services and/or departments;
- Ensuring uniform delivery of patient care services provided throughout the hospital;
- Ensuring that systems are in place to promote the integration of services, and to support the patient beyond the hospital walls;
- Appointing committees, work groups, performance improvement teams and other forums to ensure multidisciplinary and interdepartmental collaboration on issues of mutual concern;
- Establishing structures and processes that focus on safety and quality, improving the health care safety of patients, and reducing preventable adverse patient events;
- Implementing changes in existing processes to improve the quality of the care provided;
- Establishing quality of care and patient safety metrics, which can be monitored through the hospital’s plan;
HOME CARE/CONTINUING CARE QUALITY
HOSPICE PROGRAM DESCRIPTION

- Establishing a learning environment where employee development and continuing education opportunities serve to promote retention of staff and to foster excellence in the delivery of care and support services;
- Providing ongoing patient safety training for physicians, nurses and hospital staff;
- Promoting a “Just Culture” that recognizes human beings make mistakes, supports reporting, advocates fair treatment, and has intolerance for reckless behavior;
- Ensuring that staffing resources are available, trained and competent to appropriately meet the needs of the patients served;
- Ensuring the Medical Executive Committee submits reports to the Board of Directors’ QHIC regularly and as requested; and
- Providing routine reporting and special reports as requested to the Board of Directors’ QHIC.

Agency Management
Hospice Management Team Role/Responsibilities - The daily operation of the Hospice agency is vested in the Management Team who collectively and individually assume daily responsibility for Agency operations, staff performance and patient care outcomes. The Agency Management Team includes the Area Administrator of Home Health and Hospice and middle managers and may also include individuals who perform operational coordination roles. Each member of the Management Team is carefully selected and qualified through credentialing, education and experience for their level of supervision and managerial leadership.

The following describes the Management Team:

1. **Area Administrator of Home Health and Hospice** - the Area Administrator of Home Health and Hospice is the person who is appointed in writing by the Medical Center SVP/Area Manager as delegated by the governing body of the HH Agency to organize and direct the services and ongoing functions of the Agency. (See Home Health Policy 4-006.1)

2. **Regional Quality Manager** - The Regional Quality Manager designated for each agency for quality program oversight assumes responsibility for the quality management program through participation in the development of the quality plan, designing tools for problem identification/resolution, compliance monitoring, standards development, inter-rater reliability (IRR) and recommendation and collaboration with corrective action plans. The Regional Quality Manager works with the Leadership teams and Quality staff in each agency on all aspects of the Quality Program including performance improvement, quality outcomes, regulatory compliance, and service.

3. **Director of Patient Care Services** - The Director of Patient Care Services (DPCS) collaborates with other departments within KFH and KFHP, other KP Home Health agencies, external community resources and Home Care Agencies within this broad range of activities. The management team coordinates and integrates Home Care into the functions of the organization.

4. **Clinical Supervisors, Agency Supervisors-Managers and Team Leaders** - These positions exist for the management/supervision of the direct patient care functions and agency operations.

5. **Professional Advisory Committee (PAC)** - See below - III Quality Oversight

6. **Medical Staff** - The Southern California Permanente Medical Group is directed and administered as a separate entity from KFH and the Kaiser Foundation Health Plan.

   **Regional Level** - The Medical Directors of SCPMG are responsible for the executive level decisions made regarding SCPMG issues.

   **Facility Based Medical Staff Positions:**

   **Hospice Medical Director** - The HO Medical Director provides consultation and acts as a liaison to the area Medical Director and Regional Departments. The responsibilities of the Medical Director shall include but are not limited to:
a) Availability to the HH management/staff members by direct access; Participation in standards approval, quality management, utilization review, PAC Meetings and assistance in dealing with conflict resolution; Provision of direct medical home care; Designation of alternative MD in his/her absence.  
b) Attending Physician - Patients admitted to HH are attended by their primary physician. The following are the responsibilities of the attending physician: authorize and sign the plan of care in a timely manner; review and modify the plan of care as required; participant with the Home Health interdisciplinary team; and provide necessary medical examination and care.

Medical Executive Committee (MEC): The Medical Executive Committee is responsible to ensure the proper functioning of all departments, committees and other activities of the Professional Staff and to monitor the effectiveness of Professional Staff activities. The MEC has oversight of the quality of care and patient safety provided to patients and their families. The MEC is responsible for the organization of the performance improvement and patient safety activities of the Professional Staff as well as the mechanisms used to conduct, evaluate and revise such activities.

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

The committee facilitates the preparation of reports related to the hospital’s quality assurance, performance improvement, and patient safety activities to be submitted to the Board of Directors’ QHIC through the Medical Executive Committee on an ongoing basis and as requested.

Other committees: Coordination and integration of the QM activities occurs through formal relationships at the medical center, regional and program levels. This includes other Professional Staff Committees, departmental committees, and specifically focused committees and work groups have been given, by leadership, the responsibility to develop, implement, and monitor performance effectiveness for the services and processes within their scope. These committees and work groups report up through the quality structure.

Section 2 – Performance Improvement

Performance Measure Overview

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

The Board of Directors’ QHIC has set an expectation that the home care administrator in partnership with the Continuing Care Medical Director will identify, prioritize and remedy quality and safe patient care issues as they occur, consistent with the parameters of the quality plan. This is accomplished in part through the collaboration of the home care administrator and the hospital Medical Executive Committee. Home Care leadership shall report these issues and their remediation on an annual basis in the Agency’s annual quality and patient safety evaluation.

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

Quality Oversight & Scope:
Hospice Agencies use the concepts of Quality Management (QM) in the development of a systematic Quality Management practice model. Organizational and clinical functions are designed, measured, assessed and improved on an ongoing basis to meet professional, regulatory and accreditation standards.

Medical Center Quality Committee - The Medical Center quality committee has oversight responsibility for the quality activity in the Hospice Agency. The Medical Center quality committee will review and approve the HO Program Descriptions as well as the agency’s Annual HO Work Plan and HO Program Evaluation. The Area Administrator of Home Health and Hospice or designee reports to the Medical Center Quality Committee. Frequency of reporting is determined by the Medical Center Quality Committee. The Medical Center Quality Committee reviews all key quality monitors.

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

*IDG and/or IDT Function:* The IDG and/or IDT is a committee of professional personnel who are available to meet weekly or on an as needed basis to advise the Hospice Agency on professional issues.

*IDG and/or IDT Membership:* The membership shall include the following individuals who are employees of the hospice: at least one physician, one registered nurse, a social worker, and a pastoral or other counselor.

*IDG Duties:*
- Participates in the establishment of the plan of care
- Provision or supervision of hospice care and services
- Periodic review and updating of the plan of care for each individual receiving hospice care

These committees will address quality issues, monitor agency performance for improvement activities, and track progress on action plans. This committee, under the leadership of the Quality Manager or designee analyzes data, evaluates results of analysis and institutes QI activities as needed and ensures follow-up as appropriate.

Home Care Area Administrators Committee - The Area Administrators of Home Health and Hospice meet at least 9 times per year and are responsible for overseeing the following QM activities:

- structure, process and outcome standards development;
- compliance monitoring of structure, processes, outcome standards and aggregate collation of area statistics;
- overseeing the development of data sources for problem identification, as well as resolution and monitoring the effectiveness of problem identification methods;
- identifying opportunities for improving systems, programs and patient care; and
- identifying teams to pursue corrective action and improvement activities.

Hospice Quality Committee — Each Hospice Agency has a Quality Committee, or Professional Interdisciplinary Group (IDG), or Professional Advisory Committee (PAC) who participate in the evaluation of the Agency’s program. The IDG and/or IDT committee participates in the evaluation of the Agency’s program and assists the Agency in maintaining liaison with other Health Care providers in the community and with the Agency’s community information program.

*Membership:* The membership shall include the following individuals who are employees of the hospice: at least one physician, one registered nurse, a social worker, and a pastoral or other counselor.

*Duties:*
- Establishment of policies governing the day to day provision of hospice care and services
- Annual review of the Agency policies regarding scope of services offered, admission discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications and
program evaluations.

- Review quality outcome measures and quality improvement activities and make recommendations.
- Analyze data, evaluate results of analysis and institute QI activities as needed and ensure follow up as appropriate.
- Meet frequently to advise the Agency on professional issues.
- Maintain dated meeting minutes of the proceedings.
- Meeting minutes reflect all committee decisions & actions and recommendations and are dated and signed. These are reported to the Executive Director at least three times a year.
- Other duties, as deemed appropriate.

The Hospice designated Quality Manager from each Agency meet at least 9 times per year. The QM Committee directs the quality assessment and quality improvement efforts for Home Care and coordinates QM activities for each agency. This committee exists to identify opportunities for improvement and consistency, and to conduct benchmark among the agencies. The committee coordinates and implements improvement initiatives, best practice opportunities and consistent education and training with the agency leaders and quality management staff.

Hospice Quality Assurance and Performance Improvement Program

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

QAPI Goals:

- The regional QAPI program will address compliance measures outlined by regulatory metrics from Center for Medicare & Medicaid Services (CMS).
- The regional QAPI program will collect, monitor, review, compare, and interpret data from various sources-CASPER, Hospice CAHPS, vendors, and chart audits, etc.
- The overall goal is to always ensure safe, effective, appropriate and affordable care as we manage through efficacy, availability, timeliness, continuity, safety, respect and caring.
- Incorporate quality improvement methodologies within QA&I activities to address clinical and psychosocial issues.
- Demonstrate quality of care and service provided.
- Assess, measure, analyze and evaluate systematically quality of care and service provided to members.
- Ensure continuity and coordination of care and service to members.
- Assure credentialing policies and procedures meet expectations and are implemented and maintained effectively.
- Promote communication and feedback on quality findings and targeted improvement efforts to appropriate audiences.
- Identify areas to improve processes, patterns and outcomes of care.
- Assure compliance with internal and external accrediting and regulatory standards.
- Each Area Medical Center establishes goals as described in each QI Plan.

Program Activities and Scope:

- QAPI Program will gather input from focus groups, process mapping to identify areas of improvements. It will consolidate, and prioritize, considering if the area is a high risk problem versus an opportunity for
improvement. The program will look for alignment to other current quality indicators that measure outcomes and key indicator to determine if standards have been met.

- The focus will be on high-risk, high volume, or problem prone areas of service, considering the incidence, prevalence, and severity of problems in those areas. The goal is to correct any immediate problem that directly or potentially threatens the health and safety of our members.

- The program will track and analyze unusual occurrences and complaints utilizing Midas so that the agency can implement preventative actions and sustainable measures.

- The program will use Root Cause Analysis (RCA) or Inter rater Reliability (IRR) to identify contributing causal factors that leads to variations in performance.

- The program will reference any regulatory and clinical performance standards to identify deviations; implement changes or corrective actions that will result in improvement, testing small pilots before rolling out to entire region; review QAPI plan every year (continuing to show improvement)

- The program will access online QAPI courses in HHQI University to stay versed in HH QAPI, topic specific courses related to Acute Care Hospitalization, Medication Management, and Cardiovascular Health.

- The program will support Standards and policy development

- The program will support patient and family surveys and complaint monitoring

- The program will support monitoring of contracted services

- The program will support monitoring of publicly reported data and performance improvement

- The program will report and communicate collected information results to region, designated agency and Medical Center committees, thus enabling ability to make practice changes and improve quality of care and service.

- The program will demonstrate value to purchasers through data performance collection and information reporting as required.

- The program will comply with regulatory and accreditation review requirements, including California DPH, Medi-Cal, California DMHC and The Joint Commission.

- The program will support Patient Safety and Behavioral Health Care Programs.

- The program will foster sharing state-of-the-art QA&I practices and strategies that widely support Medical Center improvement efforts.

- The program will set QA&I activity priorities to support Strategic Goal achievement.

- The program will incorporate member expectations into standards of care and service.

- The program will support medical center care management activities development.

Methodology for Improving Performance:

A. Plan – Do – Study/Check - Act

The research method followed to assess, monitor and continuously improve Home Health and Hospice processes and performance is the Plan – Do – Study/Check – Act (PDS/CA) cycle for performance improvement. Each performance improvement initiative and indicator managed by the Agency QI Team has improvement activities that follow or align with the PDS/CA Cycle. Local Agency performance improvement activities may follow methods similar to PDS/CA as approved by their local Medical Center Quality Committee.
B. **Statistical Processes and Tools**
Statistical Process Control (SPC) tools i.e. Pareto analyses, trending data, use of control charts, and other performance improvement tools are used to analyze and display data, and applied to determine whether an indicator or a process is stable and sustainable within acceptable variation or meeting customer and stakeholder needs.

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

D. **Regional Quality Team Committee**
The regional quality team will be a standing committee with ad hoc members that meets monthly to review trends, regulatory compliance issues, set regional policy and procedures. This group will meet the second Tuesday of each month in a designated agency each month. This group will include the Regional Director of Continuing Care, Regional Clinical Director for HH & HO, Regional Quality Managers and an Agency Quality Coordinator. Ad Hoc or Subject Matter Experts (SME) will be invited as needed.

### Patient Safety

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

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

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

### Annual Quality and Patient Safety Program Evaluation

Annually, responsible home care and Professional Staff leaders evaluate each component of the Quality and Patient Safety Program, evaluate performance against targets and develop work plans for the ensuing year. The evaluation specifically:

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

The Hospice Agency has a system of assessing and improving the quality of services. Components of the HH Quality Plan include:

- Continuing education
- Professional credentialing, assessment for competency and ongoing performance appraisal
- Patient perception surveys and complaint monitoring
- Risk management, including unusual occurrence tracking, safety and infection control monitoring
- Active problem identification
- Compliance to applicable laws and regulations
- Quality Assessment and Performance Improvement (QAPI) CMS
- Contract oversight
- CMS STAR Rating for Quality and Service

### Section 3  Credentialing and Peer Review

The SCAL Regional Home Care/Continuing Care Quality and Patient Safety Program includes the methods for assessing and continuously improving the care delivered to hospital patients through the review of practitioner performance. Credentialing, privileging, and peer review are considered integral to the development and implementation of quality improvement, patient safety, resource utilization and risk management strategies.

The Medical Executive Committee of the Professional Staff reviews and recommends practitioners seeking privileges, and acts on results of focused practitioner performance evaluation (FPPE) and ongoing practitioners performance evaluation (OPPE), and trends identified by peer review.

### Credentialing and Privileges

Credentialing and privileging activities are conducted in accordance with written policies and procedures for credentialing, re-credentialing, privileging, appointment, reappointment, proctoring, and ongoing practitioner performance evaluation (OPPE). Recommendations for Professional Staff membership and/or clinical privileges...
are made by the Medical Executive Committee whose recommendations are further submitted to the Kaiser Foundation Hospitals Board of Directors’ QHIC for final approval consistent with the process delineated in the Professional Staff Bylaws.

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

### Peer Review

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

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

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

The Continuing Care Medical Director, based on peer review findings may recommend activities to improve performance that include but are not limited to:
- Education programs
- Proctoring or Focused Professional Practice Evaluation (FPPE)
- Patient safety education or strategies
- Interdepartmental collaboration
- New protocols/guidelines or modification of existing protocols
- Modification of measures for review
- Acquisition and use of new equipment/technology
- Individual counseling of a practitioner
- Additional data collection and trending
- Performance improvement plans for individual providers

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

At least annually (more often as necessary), the SCAL Regional Home Care/Continuing Care assesses the quality monitoring of the agencies, organizations and individuals with which it contracts for the provision of care, treatment, and services provided to the home care patients. The home care clinical contract list will be approved by the Medical Executive Committee annually based on review of quality and performance data.

The KFH - SCAL Regional Home Care/Continuing Care leaders will select the best methods to oversee the quality and safety of services provided through contractual agreement. Examples of sources of information that may be used for evaluating contracted services include the following:

- Review of information about the contractor’s Joint Commission accreditation or certification status
- Direct observation of the provision of care
- Audit of documentation, including medical records
- Review of incident reports
- Review of periodic reports submitted by the individual or hospital providing services under Contractual agreement
- Collection of data that address the efficacy of the contracted service
- Review of performance reports based on indicators required in the contractual agreement
- Input from staff and patients
- Review of patient satisfaction studies
- Review of results of risk management activities

The individual assigned responsibility for each contract is accountable to review the contract expectations and establish appropriate quality and operational indicators and monitoring frequencies, and to report performance through the established quality structure. In the event that contracted services do not meet expectations, leaders take steps to improve care, treatment, and services.

Contract Oversight

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

Section 4 Confidentiality

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

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

Contract Services - KP requires its business associates to safeguard protected health information (PHI) that KP discloses to them, or that is created or received by them or behalf of KP. (HIPPA Policy for Business Associates)
Identification of Member/Stakeholders Needs, Expectations and Satisfaction

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

Member Rights

A. Accessibility - Hospice agencies provide clinical care/services 7 days/week, 365 days/year. The agency office hours are generally from 8:30 A.M. to 5:00 P.M. Individual Hospice agency office hours may vary. Nursing services, physician services and drugs and biologicals are routinely available on a 24 hour-basis. Hospice meets the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illnesses and related conditions. Hospice provides 4 levels of care: (1) routine home care; (2) continuous home care; (3) inpatient respite care; and (4) general inpatient care.

B. Phone Accessibility - A triage nurse is available 7 days/week, 24 hours/day to respond to all calls from Hospice Agency patients and families. All other covered services are available on a 24 hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions. Provisions of these services are in a manner consistent with accepted standards. After-hours advice care is available for patients when unexpected situations arise. Individual patient needs are met by processes specific to each agency.

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

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

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

Medical Record

The Agency HO medical record is the legal record used in documenting and communicating patient information and care. The content, availability, retention and protection of the HO medical record meet all regulatory guidelines, e.g. Title 22, Medicare Conditions of Participation, etc. See Member Rights above regarding confidentiality of medical record.
Continuum of Care
It is the objective of Hospice to provide all patients with continuity of care across the continuum from hospital to home to the ambulatory setting.

Regional Hospice Indicators

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<tr>
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<th>Hospice Quality Management Indicators</th>
<th>Frequency of Data Collection</th>
<th>Frequency of Reporting</th>
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<tr>
<td>Satisfaction</td>
<td>• Patient Satisfaction</td>
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<td></td>
<td>• Overall Satisfaction Rate (Percent Always)</td>
<td>Monthly</td>
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<td></td>
<td>• Satisfaction with Weekend, Nights and Holiday Services</td>
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<td>• After hours rounding for patients/caregivers that called after hours triage</td>
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<td></td>
<td>• Overall Satisfaction with Got as Much Help with Pain as Needed (Always)</td>
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<td>• Complaint monitoring and service recovery</td>
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<td></td>
<td>• Satisfaction survey data monitoring HO CAHPS data through third party vendor (DEYTA)</td>
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<tr>
<td>Clinical Quality</td>
<td>• 24 hour admission timeliness</td>
<td>Monthly</td>
<td>Quarterly</td>
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<td></td>
<td>• Record review of hospice care and terminality with Terminal Illness Criteria audits</td>
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<tr>
<td>Infection Control</td>
<td>• Rate of Home Care acquired UTI w/foley</td>
<td>Quarterly</td>
<td>Quarterly</td>
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<tr>
<td>Regulatory Compliance</td>
<td>• CHHA supervision</td>
<td>Monthly</td>
<td>Quarterly</td>
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<td></td>
<td>• MD Face to Face visit</td>
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<td></td>
<td>• Hospice benefit election form completed accurately</td>
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<td>• Hospice CTI accurate and timely</td>
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<td>• Hospice medical record documentation supports terminal illness criteria</td>
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<td>• Hospice SB853 compliance</td>
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<td>• HIS Completion and Transmission</td>
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<td>• SOX billing compliance</td>
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KAISER FOUNDATION HEALTH PLAN
SOUTHERN CALIFORNIA

REGIONAL DIVERSITY & INCLUSION DEPARTMENT

PROGRAM DESCRIPTION
Kaiser Permanente Southern California – Organizational Commitment to Diversity & Inclusion

Kaiser Permanente is committed to diversity and inclusion 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.

Overview – Kaiser Permanente Southern California

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

The KPSC Diversity & Inclusion (D&I) Program includes various components outlined in the D&I Department Program Description to which an overarching quality assurance program is augmented by the Labor Management Partnership (LMP) for comprehensive inclusion. KPSC 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 the KPSC D&I Department Program Description is to inform both internal and external audiences how KPSC is organized to support the Program’s commitment to Diversity & Inclusion and Culturally & Linguistically Appropriate Services (CLAS).

Diversity and Inclusion Structure and Scope

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

The Program’s expansive diversity infrastructure is key to its successful efforts to fully integrate Diversity into the fabric of the organization, and is led by the National Diversity & Inclusion Department, KPSC Regional Diversity & Inclusion (D&I) Department, Human Resources Department, National Diversity & Inclusion Council, the KPSC Regional Culturally Responsive Care/Diversity & Inclusion (CRC/D&I) Council, local Medical Center Culturally Responsive Care/Diversity & Inclusion Councils, along with the Multicultural Business Resource Groups (MBRG), Centers of Excellence, Culturally Competent Care leaders, and numerous Regional stakeholders.

The organization’s view of diversity is all-inclusive, to include race, ethnicity, gender, sexual orientation, gender identity, gender expression, age, literacy, education, language, 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.

National Diversity & Inclusion (D&I) Department

Both the National D&I Department and the National D&I Council are charged with promoting, supporting and assisting the Regions in implementing the National D&I Strategy by providing guidance, support and structure for all KP regions, including Southern California.

The National D&I strategy includes primary objectives related to the organization’s mission, business goals and the diversity & inclusion strategy, which includes:
1. **Care**: Provide the best care and service for all populations to eliminate disparities and create care equity.
2. **Workforce**: Optimize diversity representation at every level of staff and create inclusive workplace environments to optimize all talent potential.
3. **Marketplace**: Provide the most compelling value in the healthcare industry for our diverse populations and communities.
4. **Community Partnership/Supplier Diversity**: Build equity through businesses development and job creation in our communities.
5. **Diversity and Inclusion Compliance**: Ensure diversity and inclusion policy and regulatory compliance through effective collaboration and learning with accountable entities.

Research and Development is one of National Diversity & Inclusion’s Linguistic and Cultural Programs strategic pathways toward achieving the mission/goal of ensuring meaningful linguistic access, care and service delivery with respect through continuous quality improvement processes in research and development. A comprehensive set of research projects aimed at the systematic exploration, definition, and development of methods and models of linguistically and culturally appropriate care tools for industry use. These studies are Kaiser Permanente’s most important advancement in language-focused evidence-based research. The range of studies covers interpretation and translation services, provider linguistic proficiency, and language access systems. The projects also examine the impact of provider-patient language concordance on visit patterns/frequencies, patient/provider satisfaction, treatment adherence/understanding, patient health and effect on health disparities/inequities. The Equitable Care Health Outcomes (ECHO) strategies align with KP National Quality Transforming Care Delivery to provide the best care and service for all populations to eliminate disparities and create equity in our communities.

In addition, National Diversity & Inclusion has developed tools intended to assess the Program’s current Culturally and Linguistically Appropriate Services (CLAS) compliance- to identify areas of progress, opportunities for improvements, and best practices across the Regions.

**KPSC Regional Diversity & Inclusion Department**

The KPSC Regional D&I Department Program resides within the governing entity of Kaiser Foundation Health Plan, with strategies and services that are aligned with the National Diversity & Inclusion strategy, the KPSC Culturally Responsive Care/Diversity & Inclusion Council (SCCRC/D&I) strategic goals, the KP Promise, Mission, and Values. Regional D&I also support 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. Furthermore, the strategy supports the retention, development and utilization of the highest caliber diverse workforce (employees, leaders and physicians) in the industry.

The purpose of KPSC Regional D&I Department Program is to:
- provide leadership for culture and linguistic services in support of CLAS Standards of the 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 the support staff, clinical staff and practitioners through education, training, 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 D&I 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;
- build capacity to offer culturally and linguistically appropriate services and communicate information of such services to members/patients;
- provide oversight of interpreter services which includes, the Qualified Bilingual Staff Program (assessment and training) for KP staff interpreters, and quality monitoring process for contracted interpreter services;
- provide cultural & linguistic training to staff and providers during New Employee Orientation and beyond. The training objectives include enhanced awareness of cultural competency imperatives and beliefs and practices.
- in partnership with Compliance and local leadership, ensure compliance with ongoing culturally and linguistic required training;
- develop, monitor and communicate diversity metrics;
- maintain the Diversity & Inclusion website updates;
- facilitate membership growth through effective market segmentation that targets specific populations;
- facilitate the development of partnerships to engage community/membership i.e. Patient Advisory Council to obtain input in a variety of C&L services;
- monitor ongoing compliance with Language Assistance requirements, evaluate and make modifications as necessary to address needed improvements in C&L performance and support activities required to ensure that Federal, State laws, regulations and contractual C&L requirements are adhered to, and support the Program in responding to audits and surveys from our regulators and/or accrediting agencies of such compliance.

The Regional D&I Department supports the infrastructure responsible for driving the region's strategic diversity and inclusion initiatives. This infrastructure includes the KPSC CRC/D&I Council, local Diversity Councils, Patient Advisory Councils, Multicultural Business Resource Groups (MBRGs), and peer groups involved with culture and linguistic services, quality oversight, training/education, member services, and member/community engagement. The Regional D&I Department works with Health Plan Regulatory Services (HPRS), Accreditation, Regulatory & Licensing (AR&L), and KP HealthConnect (KPHC) to facilitate Program compliance in the areas of cultural and linguistic (C&L) services and the appropriate collection of patient demographic and language preference data. Furthermore, the Regional D&I Department reports the results of the Program C&L activities to the Southern California Quality Committee (SCQC) annually.

The Regional D&I Department supports KP’s commitment to providing language assistance services to enhance the quality of care for our Limited English Proficient (LEP) members by conducting ongoing compliance monitoring of the Language Assistance Program (LAP), which includes the Department of Managed Health Care (DMHC) LAP regulations. Regional D&I is responsible for updating the policies on Qualified Interpreter Services and Quality Translation Process for Member Informing Materials to ensure overall compliance with all Federal and State laws. The Regional D&I Department consults with Health Plan Regulatory Services (HPRS) and Northern 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 Work stream
- Compliance Monitoring
- Language Assistance Program Implementation and Monitoring Guide - Play Book

The Regional D&I Department works closely with Quality, Compliance, HPRS, AR&L, and Functional Departments in the areas of C&L / D&I compliance monitoring, driving the region's quality oversight initiatives to ensure language assistance services are adhered to, including the methodology for compliance oversight of outside contracted providers.

In addition, an annual culture and language assistance program CLAS assessment is conducted to assess the Region’s current activities, strategies and status/outcomes for each National CLAS Standard as issued by the Department of Health and Human Services Office of Minority Health. The CLAS Assessment is reported annually to KPSC Southern California Quality Committee (SCQC) and to the National D&I Department. The report assists in assessing accomplishments, progress, and areas of improvement, which enables the organization to provide program direction, additional tools and resources, as well as assist in identifying overall program needs and best practices.

Medical Center Service Areas
Each medical center service area leadership team is responsible for delivering culturally responsive care, language assistance services and adhering to regulatory standards and meeting contractual obligations. There is a physician and an administrative lead on each team. Both advocate for their respective medical center. Each medical center has
a local CRC/D&I Council that is led by these representatives. This forum allows for alignment of the CRC/D&I initiatives and goals among the region and medical center.

The leadership teams are responsible for:
- establishing a committee structure that provides quality oversight and review;
- holding medical center, KFHP, KFH and SCPMG 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 & inclusion goals based on regional goals; and
- directing action as necessary to improve care, service and access, such as providing education and training.

The medical centers establish their own programs, priorities, resources, systems and are most responsive to the particular health care issues of the communities served by their medical center. Each medical center reports its results of the program activities quarterly to the Regional Diversity & Inclusion Department and to the SCCRC/D&I Council, which is reported to the Southern California Quality Committee (SCQC).

**Regional Diversity & Inclusion Department Program Goals and Objectives**

**Goals**
- Provide a comprehensive linguistics program;
- Maintain and improve quality of care and service provided to members;
- Support achievement of KPSC CRC/D&I Council Strategic Goals;
- Support and implement language assistance programs;
- Minimize risk and liability;
- Assess, measure, analyze and evaluate systematically the quality of interpreters and service 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 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 Culturally Responsive Care (CRC) 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 diversity and inclusion activities in the region.
- Comply with regulatory and accreditation requirements.
- Support medical center improvement efforts. Set activity priorities to support strategic goal achievement.

**Southern California Culturally Responsive Care/Diversity & Inclusion Council (CRC/D&I)**

The Southern California Culturally Responsive Care/Diversity & Inclusion Council (CRC/D&I) provides oversight for culturally responsive care and cultural and linguistic services provided within the region. This group is composed of representatives from each medical center (Physician and Administrative Champion) and regional stakeholders that meet on a quarterly basis. Each medical center has a local council that is led by a physician and an administrative lead who advocates diversity and inclusion at their respective medical center. This forum allows for alignment of the CRC/D&I initiatives and goals among the region and medical centers.
KPSC CRC/D&I Council’s functions include:

- Review and recommend policy decisions;
- Institute needed action (based on quality improvement and patient safety priorities and initiates studies, as appropriate);
- Ensure follow-up for all committees and subcommittees;
- Report to executive sponsors, Joint Operations Group (JOG), and the Southern California Quality Committee (SCQC);
- Establish or make recommendations to establish C&L priorities and activities;
- Monitor performance to ensure the region meets or exceeds legal, accreditation, licensing and external reporting requirements;
- Provides oversight of the medical center diversity & inclusion activities and performance through medical center reports;
- Develop and facilitate linkage to internal/external resources to further enhance C&L program initiatives for delivery of services in meeting the needs of our membership/patients and communities, e.g., CRC/D&I Council at the local facilities, Member/Patient Advisory Councils, Public Affairs, Community Benefits, Multicultural Member Marketing;
- Advise/recommend to the sponsor annual goals, strategy development and tactics on the CRC initiative;
- Identify gaps/challenges and monitor progress of CRC initiatives as well as overall organization performance;
- Communicate progress of CRC initiatives to the SCPMG Board and Executive Leadership annually;
- Align the work of the CRC/D&I councils at the Medical Centers to the CRC Initiative goals;
- Interface with Medical Center’s leadership to communicate the work of the CRC/D&I Council and provide consultation, advice and education;
- Identify tools to measure and monitor the effectiveness of the CRC/D&I initiatives;
- Share and disseminate information to local and regional groups.

Performance Goals – Priority Setting and Accountabilities

CRC/D&I performance goals, objectives and priorities are determined by the KPSC CRC/D&I Council through the development of a three year strategic plan and are approved by the Joint Operations Group (JOG). Annually an update/status of the goals and objectives, as defined in the KPSC CRC/D&I Council strategic work plan, are reviewed by the JOG. This governing body designates oversight of the Diversity & Inclusion program to the Southern California Quality Committee (SCQC). The Regional D&I Department, CRC Leads or Medical Center areas may incorporate unique goals specific to the medical center/department goals developed at the Medical Center/Departmental level. In addition, the strategic plan is incorporated in the D&I annual report out to SCQC of all the CRC and D&I work, initiatives, opportunities for improvement, strategies and next steps for review and approval from SCQC.

Training and Education

Regional D&I develops, coordinates, communicates and implements ongoing training and educational courses, tools and resources through KP Learn web based training, in-person training, facilitated “train-the-trainer” specialized trainings, along with monthly QuickTips, email blasts, flyers, and through the diversity 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. Diversity training and education is also incorporated into efforts to rectify member issues, concerns, complaints and grievances. To ensure that diversity education and training is being appropriately provided on cultural competency, sensitivity, or diversity training at key points of contact to all levels of staff, medical center assessments are conducted through surveys, direct observation, mock-audits and monitoring of member/patient satisfaction.

KP staff and providers are trained on C&L standards and on interacting with seniors and persons with disabilities, in order to ensure that all staff and providers are aware of how to access and assist Limited English Proficient (LEP) members needing language interpretation, including Sign Language interpretation services and to ensure that culturally appropriate services are rendered. This occurs through New Employee Orientation, in-service staff meetings, and ongoing through regular lunch and learns and through KP Learn website., Diversity Health Video Series presentations, diversity webinars and through the annual Kaiser Permanente Diversity & Inclusion Conference. The Regional D&I
Department collects, reviews and provides feedback on diversity trainings that are provided at the medical center and regional levels through various tools and communication venues, i.e. training evaluations.

Partnerships are developed with, but not limited to, KPSC Learning and Development, Local Education and Training, Front Line Leaders (Receptionist/Service Reps), Department Administrators, Managers, Long Term Support, Workflow Consultants, KP HealthConnect, Human Resources, Employee Assistance Program, Labor Management Partnership and the medical center Diversity Champions to ensure the appropriate training, job aids, scripting, understanding, and 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.

In person and web-based training completion reports are monitored and tracked by Regional D&I Department and disseminated to the medical center service areas and reported to the KPSC Regional CRC/D&I Council.

### Language Assistance Program

#### Language Assistance Services

The Regional D&I Department provides a Comprehensive Linguistics Program (CLP) for the Southern California Region to ensure meaningful access to language assistance at every point of contact for Kaiser Permanente’s diverse consumers. The CLP uses various linguistic resources to meet the needs of KPSC limited English proficient patients and members. Each local area has the ability to use the various components of the CLP to meet the needs of their local market. The three main components to the CLP are:

- **Qualified Bilingual Staff (QBS)** - The QBS program 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.

- **Certified Healthcare Interpreters (CHCI)** – The sole function of a CHCI is to provide interpretation skills at both a conversational and clinical level. In addition to meeting the requirements of a QBS employee, a CHCI must have a health care interpreter certification. The CHCI position exists in certain medical center areas.

- **Contracted Language Vendors** - KPSC contracts with language assistance vendors to provide interpretation services over-the-phone, in-person and through video.

The implementation of video interpretation services, will enhance timely access and availability to interpreters’ services for patients who require American Sign Language.

#### Reporting

The Regional D&I Department monitors the overall language assistance program for KPSC 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
- Quality Performance Indicators
- Complaints & Grievances
- Satisfaction Surveys

#### Monitoring

The Regional D&I Department employs a comprehensive monitoring approach to ensure the language assistance 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, KPSC randomly surveys members that have self-identified as requiring language assistance services. In addition to the member satisfaction surveys, Regional D&I regularly reviews Member Services complaints regarding language assistance. Performance assessments are also conducted to measure and identify gaps in performance with reporting and follow-up with medical center leadership as applicable.

**Translation Services**

KPSC follows the Quality Translation Process for Member Informing Materials Policy which addresses our standards for provisions of accurate, consistent, quality written translations of member/patient informing materials. The Regional D&I Department collaborates with the Translation Services Program to ensure that processes are implemented and staff are trained to utilize the resources to provide members the same level of translation services. 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 (does not contain member/patient specific information) and non-standard vital documents (does contain member/patient specific information) to include providing the Notice of Language Assistance (NOLA) in threshold languages.

- **Qualified Translation Professionals** – contract with external preferred translation vendors through a formal RFP process. The vendor contracts include quality control processes and their assessment of the use of competent translators.

- **Member Requests** – honor 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 Alternative Formats 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 individuals 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, Style Guide for Spanish and Chinese, 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 D&I 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 documents in their preferred language and are provided of such within 21 calendar day maximum as stated in the Policy. Translated documents are accessible to staff via the Clinical Library for member educational material, and medical consent translated forms can be obtained through Document Services.

**Member Demographic Data Collection/Needs Assessments (Race, Ethnicity and Language Needs)**

To thoroughly understand the needs of KPSC members, a wide variety of data sources are used. In order to effectively deliver quality health care that is sensitive to the unique attributes of each patient’s culture and linguistic needs, address
risk factors, determine appropriate preventive care and treatment options for each patient, address health-related disparities and provide quality linguistic services, KPSC leverages the efficiency and advantages offered by KP HealthConnect (KPHC), our electronic medical record system, to centralize the collection of demographic data. KPSC collect self-reported race, ethnicity, language preferences (spoken, written and interpreter need) information from all of our members/patients in all business lines (i.e. Commercial, Medicare) at various points of contact. Furthermore, a Language Assistance Questionnaire and Interpreter Need Flag was developed in KPHC. The Interpreter flag serves as an alert to staff to offer language assistance for each visit, and the questionnaire is utilized to document the encounter (use and refusal of interpreter services) and the type of services provided. KP employees and physicians are required to maintain the confidentiality and accuracy of member/patient information. KP may collect, use, and share protected health information (including race, ethnicity, language preference, and religion) for treatment, health operations, and for other routine purposes as permitted by law, such as for use in research and reducing health care disparities.

Analysis of race and ethnicity data is completed by comparing staff, provider, community (Nielsen Claritas data) and membership data. To assist in this effort, KP collaborates with researchers at the RAND Corporation to estimate racial and ethnic composition of groups of people using both a member’s geocoded address and surname to estimate the likelihood that the member belongs to one of the six Office of Management and Budget’s race and ethnicity categories.

KPSC 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. In KP’s GEMS Datamart, if a reported race and ethnicity value exists for a person, the BISG distribution can be updated to give 100% certainty to the reported race and ethnicity category, while preserving the uncertainty of other individuals. This resulting combination of reported and imputed probability vectors can be summed across groups of people to give the best estimate of the racial composition of the group. Every three years KPSC 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.

In support of the membership forecasting process, KPSC compiles population demographics using Nielsen Claritas’s data, with projections, to determine the cultural responsive programming and hiring needs. The American Community Survey is used in conjunction with the Census data.

KP as a whole utilizes this data to identify needs and areas of opportunity, balance resources, enhance training, develop health education materials and assess effectiveness of the cultural and linguistic program for our diverse membership, patients and communities we serve. The data is not utilized to discriminate in the delivery of health care services, acceptance of any member in in need of health care services for treatment, underwriting, nor denial of coverage and benefits. Demographic data is posted and available through the Regional D&I Department website.

**Member Satisfaction, Rights and Engagement**

KPSC systematically assesses and monitors members’ understanding and satisfaction of its operations and procedures. This is accomplished in a variety of ways such as surveying members to assess satisfaction with language assistance services, review of member complaints and grievances, engagement with member/patient advisory councils, review of member informing materials and signage.

Member Complaint Analysis is performed through ongoing monitoring and evaluation of member complaints and grievances to assess member satisfaction, identify trends, and opportunities for improvement. Summarized findings are provided to SCQC and KPSC CRC/D&I Council.

Member benefits and services are described in detail within the Member Handbook, Evidence of Coverage and Disclosure Form (EOC) which is provided to all new members and includes language assistance services.

Medical Center Area Patient Advisory Councils provides our members and the community a voice and allows KP to collaborate in providing Patient- and Family-Centered Care. The Patient Advisory Council places the members at the center of our Value Compass to improve quality, safety, and service. Leaderships commitment to and involvement in a Council, from both KFH/HP and PMG, is crucial to its success. It’s recommend at least one KFH and one PMG leader serve as regular members of the Council. Leadership must also demonstrate that it supports and values the Council’s recommendations.
KPSC Guidebook provides information to new members on where and how to seek care and service along with member rights and responsibilities. This Guidebook is provided to all new members upon enrollment and annually, and incorporates various C&L regulatory requirements of informing members of C&L services, their rights and responsibilities, to include: 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, gender identity, health status, or disability. All covered services are provided in a culturally and linguistically appropriate manner.

The Guidebook and Evidence of Coverage are translated in threshold languages according to State Requirements for commercial members and County Requirements for Medi-Cal members.

**Regulatory Compliance and Quality**

**Southern California Quality Committee (SCQC)**
The SCQC is co-chaired by the VP for Quality and Risk Management and the Assistant Medical Director for Quality and Risk Management appointed by the President and Executive Medical Director as the key senior leaders administratively responsible for the leadership and direction of the quality program. The co-chairs of the SCQC are accountable to the President and the Executive Medical Director to oversee the quality oversight processes and initiatives. In 2009, the Regional Diversity & Inclusion Department reports annually to SCQC to ensure the quality process and compliance of the program. In addition, the Southern California Quality Committee (SCQC) reports the Southern California Diversity & Inclusion Program activities to the Governing Board on an annual basis.

**Accreditation, Regulation and Licensing (AR&L)**
The AR&L Practice 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. The AR&L leader is a member of the Diversity & Inclusion Council. In 2010, the Regional Diversity & Inclusion Department staff joined the Regional AR&L team which conducts continuous readiness surveys of each facility to evaluate compliance with the Conditions of Participation, Joint Commission Standards and Department of Health Services regulations among other regulations. 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 reports to the Senior VP and National Health Plan manager and is a member of SCQC 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.

**Regional Compliance & Privacy Officer**
The Regional Compliance & Privacy Officer reports to the Regional President and Senior VP and Chief Compliance Officer and is responsible for the design and implementation of the Regional Compliance Program in collaboration with the Program Office Corporate Compliance Program. Compliance issues are addressed at the Regional Compliance Committee. The Compliance Department supports regulatory compliance with Cultural and Linguistics requirements.

**Internal Compliance & Audit Teams**
KP utilizes internal compliance audit teams (i.e., the Regional Compliance Audit Team) to conduct independent audits, reviews, and assessments of high-risk areas. The purpose of the independent audits is to objectively evaluate the effectiveness of applicable compliance programs or activities that mitigate compliance risks. Regulatory audits help to improve KP operations through its continual evaluation of internal controls, management of compliance risks, and identification of potential areas of compliance performance improvement. The Regulatory Audit Teams collaborate with The National Compliance Office, Internal Audit Services, Survey Readiness team within the Health Plan Regulatory Services department. Auditors work directly with operational partners to define compliance risks, audit scope, and
In 2009, the Regional D&I Department began collaborating and providing consultation to the Regional Compliance Audit Team (RCAT) which conducts continuous readiness surveys of each facility to evaluate compliance with the Department of Managed Health Care (DMHC) regulations among others. Audit team responsibilities include but not limited to such items as collaborating with the Care Delivery Team to perform various hospital related audits and assessments; performing independent audits, reviews, and assessments of operational units that perform Health Plan functions and collaborate with impacted departments to develop corrective action plans (CAPs).

### Site Assessment Process

The Regional D&I Department employs a multifaceted approach to monitoring performance to ensure that the Language Assistance requirements of regulators, including the Language Assistance Program (LAP) requirements, are consistently met and that culturally appropriate care is provided in the member’s language to enhance the quality of the health care Kaiser Permanente members receive. Regional D&I partners with several compliance/regulatory functions such as: Accreditation, Regulation and Licensing (AR&L), Health Plan Regulatory Services (HPRS), and Internal Regulatory Compliant Audit Team(s).

Each Medical Center is provided with the detailed regulatory assessment process to ensure compliance with all government and legal requirements. The Regional Site Visit Assessment tool was developed by the Regional D&I Department to ensure compliance with all Culturally and Linguistic Federal, State and local regulatory requirements as well as contractual requirements. The tool is also provided to assist the facility in providing optimal culturally appropriate care to our limited English proficient patient/members.

The internal site visits include but are not limited to local area policy and document review, key stakeholder input, interview process, tracers and facility walk-through of the Hospitals and Medical Office Buildings. Each of the standards monitored are assessed against risk areas that have been identified, and areas that met all monitored criteria are reviewed to identify best practices.

Medical Center Leadership as well as SCQC is provided detailed information regarding overall compliance of the medical center area and readiness for a survey by regulatory and accrediting bodies.

### Group Needs Assessment (GNA)

Diversity & Inclusion in partnership with Health Education and Medi-Cal and State Programs conduct a Health Education and Cultural & Linguistic Group Needs Assessment (GNA) to identify the health education, cultural & linguistic needs of KPSC 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 GNA. The GNA is conducted every 5 years and updated annually to assess the needs of the community we serve. The GNA Summary Report is reported to the DHCS at the completion of each GNA. The Summary Report shall include: objectives; methodology; data sources; survey instruments; findings and conclusions; program and policy implications; and references. Findings and conclusions must include the following information for Members: demographic profile; related health risks, problems and conditions; related knowledge, attitudes and practices including cultural beliefs and practices; perceived health education needs including learning needs; preferred methods of learning and literacy level; and culturally competent community resources.

### Community Engagement - Multicultural Business Resource Group (MBRG) / Retiree Association

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 MBRGs. The national policy and KPSC operation guidelines establish requirements to assist MBRGs in aligning their goals, objectives, and activities consistent with KP’s mission, diversity and inclusion 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 MBRGs operating in KPSC is the MBRG Regional Governing Council (RGC). The RGC includes members from such areas as...
as: Regional D&I Department, Human Resources, Compliance, Finance, Community Benefits, Public Affairs, SCPMG HR (non-voting members for MBRG funding), with the aim to serve as an advisory forum providing guidance and oversight to assist the MBRGs in meeting the overall mission, goals, objectives and compliance requirements.

Regional D&I Department provides day-to-day operational guidance and direction to the MBRG 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 MBRG Lead meetings/networking, education and training along with consulting in issue-resolutions.

KPSC recognizes the value of KP retirees (employees and physicians) as an extension organization into the communities we serve, along with their past contributions to the organization success. KP is committed to KP Retiree offering opportunities for retirees to stay connected to the organization, while providing/organizing opportunities to participate in voluntary activities in the communities we serve.

### Supplier Diversity

KP is committed to building a solid foundation for supporting Total Health. Through KP Supplier Diversity initiative we are 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.

### Youth Outreach/Pipeline Programs

KPSC Youth Workforce Programs (i.e., Summer Youth Employment, INROADS, Health Career Connections, KP Internship & Apothecary Circle (Pharmacists program) focus on providing under-served diverse High School and College students with meaningful employment experiences in the health care field, educational sessions and motivational workshops to introduce them to the possibility of pursuing a career in health care while enhancing job skills and work performance. These programs are designed to encourage and mentor students to become skilled and experienced health care workers who reflect the diverse makeup of our communities, serving as a pipeline for the organization and community-at-large to enhance the future of the health care workforce.

KPSC commitment to diversity and inclusion provides opportunities to developmental and physically disabled youth through Project SEARCH an on-site training program for individuals with developmental and physical disabilities. The program provides students with disabilities the training needed to become productive member of the labor work force. The program is in collaboration with Project SEARCH, local School Districts, Rehabilitation Centers and job coaches.
Who We Are / Mission: *Inspire people. Inform choices. Improve Health.*
We partner with our members to make healthier choices easier by utilizing a variety of tools that respect members' needs, readiness, and learning preferences. We encourage small steps to change by helping members choose their own *goals* and experience success, and supporting healthy living at every stage along the wellness to illness continuum.

Organizational Commitment to Diversity & Inclusion:
Kaiser Permanente is committed to diversity and inclusion 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, improve total health, and is designed to ensure that all medically necessary covered services are available and accessible to all members in a culturally competent manner, including those with limited English proficiency, diverse cultural and ethnic backgrounds, 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.

Areas of Expertise:
The Center for Healthy Living (CHL), with 13 local area CHL departments, leads and collaborates in the consultation, communication, and coordination of high-quality, consistent, cost-effective healthy living programs, products, and services that advocate and integrate the total health brand position at Kaiser Permanente to motivate health behavior change and self-care. Our expertise lies in the following areas:

- **Healthy Living Programs and Resources**
  Develop action-oriented communications about key health topics and resources for members, leaders, physicians, employees, and purchasers.

- **Member Education Materials**
  Develop, produce, translate, promote, and distribute quality, branded, accurate, and understandable educational materials in print and for the Web that meet with regulatory and health literacy standards. Materials are delivered in classes, emailed for telephonic wellness coaching sessions, online, and in medical encounters.
• **Health Information and Education Programs**
  Manage and promote Kaiser Permanente Wellness Coaching by Phone, and promote the Health Encyclopedia and education resources on kp.org.

• **Consulting**
  Provide needs assessment, planning, and identification of interactive learning tools and programs to support lifestyle behavior change, self-management, and achievement of our clinical strategic goals and strategic organizational initiatives, including our community partners.

**Southern California Regional Products:**
- Program-wide resources and programs: online Health Encyclopedia and Health Education pages
- Standardized regional manuals for core class curricula
- Standardized health education and promotional material
- Wellness Coaching by Phone
- Worksite wellness consultation and health education program delivery

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**Program Description Approved by:**

James C. Wannares  
Director, Regional Center for Healthy Living  
1/24/17  

Ray R. Nanda, MD  
Physician Director, Regional Center for Healthy Living  
1/24/17
This Quality Assurance Program Agreement (the “Agreement”), dated as of September 9, 2013, is by and among Kaiser Foundation Health Plan, Inc. (“Health Plan”), Kaiser Foundation Hospitals (“KFH”), The Permanente Medical Group, Inc. (“TPMG”), and Southern California Permanente Medical Group (“SCPMG”). All parties are collectively referred to herein as the “Contracting Parties.”

WHEREAS, the mission of the Health Plan, KFH, TPMG and SCPMG is to provide and/or arrange for the provision of high quality, affordable health care services, and to improve the health of the communities they serve; and

WHEREAS, the Health Plan, KFH, TPMG and SCPMG are each committed to assuring, assessing, and continuously improving the care and service delivered to or arranged for Kaiser Permanente members and patients; and

WHEREAS, Health Plan acknowledges that both TPMG and SCPMG engage in comprehensive quality activities designed to evaluate and ensure the quality of care provided to Kaiser Permanente members and patients and that Health Plan’s quality program uses and builds upon the significant and integral contributions of TPMG’s and SCPMG’s quality activities and functions related to the assessment and improvement of the quality of care provided to members and patients; and

WHEREAS, KFH maintains quality assurance activities pursuant to separate legal and regulatory obligations under California Health & Safety Code, Section 1250 et seq. and Title 42 of the Code of Federal Regulations, Section 482.21. The provisions of this Agreement are not intended to interfere with KFH’s separate quality assurance obligations, but to encourage Health Plan to use and build upon the significant contributions of the KFH quality activities; and

WHEREAS, Health Plan maintains accreditation by meeting standards set forth by the National Committee for Quality Assurance (“NCQA”) and meets federal requirements set forth by the Centers for Medicare and Medicaid Services (CMS) and Medicare Advantage. KFH, TPMG and SCPMG agree to cooperate and support the Health Plan in order to meet all NCQA accreditation and federal program requirements; and

WHEREAS, pursuant to Section 1349 of the Knox-Keene Act, Health Plan has secured a license from the Department of Managed Health Care and must comply with California laws governing licensed health care service plans; and

WHEREAS, KFH, TPMG and SCPMG acknowledge and agree to support the Health Plan in meeting its legal obligation to demonstrate to the California Department of Managed Health Care its compliance with statutes and regulations governing quality of care review, that includes monitoring the quality of care, performance of medical personnel, utilization of services and facilities, and costs in accordance with California Health & Safety Code, Section 1370 and Title 28 of the California Code of Regulations, Section 1300.70; and
WHEREAS, Health Plan, KFH, TPMG and SCPMG agree that Health Plan is responsible for demonstrating to the California Department of Managed Health Care the adequacy of quality review and the efficacy of the ensuring quality improvement activities, including improvement of the quality review process itself in accordance with California Health & Safety Code Section 1370 and Title 28 of the California Code of Regulations, Section 1300.70; and

WHEREAS, Health Plan, TPMG, SCPMG, and KFH desire to memorialize the authority, accountabilities, roles and responsibilities of each party related to quality assurance functions performed in connection with Health Plan’s quality assurance program (“QAP”).

NOW THEREFORE, the Contracting Parties support the Health Plan’s QAP as follows:

A. General Roles and Responsibilities

The Contracting Parties agree to perform the quality activities (“Quality Activities”) as described in this Agreement and Program Documents (see definition of Program Documents in Part D., below). The Agreement is hereby incorporated by reference into the Program Documents.

B. Guiding Principles Related to Identification, Review and Disposition of Quality Issues and Delineation of Utilization Management Activities

Health Plan is required by California Health & Safety Code, Section 1370 and Title 28 of the California Code of Regulations, Section 1300.70 to establish a quality assurance program. The scope of the Health Plan’s QAP includes the continuous review of the quality of care and utilization of services and shall be maintained by Health Plan, with assistance and input from KFH and TPMG in Northern California and KFH and SCPMG in Southern California.

The QAP shall be designed to identify, thoroughly review, and resolve quality issues (“Quality Issues”) in a timely manner. In support of the QAP, the Contracting Parties agree to the following goals and principles:

1. Effectively identify, evaluate and respond to each potential quality issue in a timely manner, regardless of the information source, (e.g., member grievances, clinical department referral, Regulator).

2. Consistently apply a standard set of review criteria to each case evaluation and document findings conclusions and actions, as appropriate, in common QAP systems.

3. The QAP will generate an effective system of reports that will enable Health Plan 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).
4. Feedback from the QAP to clinical operations, KFH 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.

5. The Utilization Management Program (“UM”) is an integral part of the Health Plan’s QAP. Quality, risk and safety processes and program initiatives are incorporated into the Plan’s UM Program.

6. Quality and risk issues, patterns and trends identified through UM clinical review processes are escalated to the appropriate 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.

C. Responsibilities of the Contracting Parties

Cooperation with QAP Oversight Activities and Audits
The Contracting Parties agree to cooperate with each other to help ensure that each Contracting Party complies with all applicable laws and regulations governing QAPs (e.g., California Health & Safety Code, Section 1370; Title 28 of the California Code of Regulations, Section 1300.70; standards and guidelines promulgated by NCQA).

Each Contracting Party agrees to cooperate fully with all audit and Health Plan oversight activities conducted in accordance with the Program Documents, as well as those oversight activities conducted by their respective regulatory and/or accreditation agencies, including, without limitation, providing access to all requested files and documents during regular business hours.

The Contracting Parties agree to cause their respective employees and/or partners to participate in meetings, projects or other tasks or activities related to the QAPs, or services reasonably related and necessary or ancillary thereto.

Associated Contractual Obligations
TPMG, SCPMG and Health Plan all acknowledge that they must perform all of their associated obligations as set forth in the Medical Service Agreement (“MSA”), and KFH acknowledges that it must perform its associated obligations as set forth in the Hospital Services Agreement (“HSA”) with Health Plan, in order to enable each of the Contracting Parties to provide high quality medical services at an affordable price (this includes, for example, Health Plan’s provision of facilities and administrative services incident thereto, as well as general administrative services in connection with membership enrollment, membership records, collection of Program Revenue, Reimbursement and Service Claims and other membership relations functions). Nothing in this Agreement is meant to modify any of the obligations set forth in the respective MSAs and HSA.

Delineation and Performance of Quality Activities
KFH, TPMG and SCPMG agree to perform the applicable Quality Activities set forth in the Program Documents. Quality Activities include, without limitation, quality and peer review, adverse action determinations and fair hearing procedures, identification of systems issues, review of arbitration decisions, credentialing and
privileging activities, notification of physician conduct, submission of reports, and participation in quality initiatives.

Delineation and Performance of Utilization and Resource Management Activities
The Contracting Parties participate in a variety of utilization management and resource management activities and processes to continuously evaluate the efficiency, efficacy, medical necessity and quality of care provided to Kaiser Permanente Members. In most instances, KFH, TPMG and SCPMG providers are not required to obtain prior authorization from the Health Plan or authorization from KFH, TPMG or SCPMG, to provide or obtain services for members.

Utilization Management Activities/Functions
For purposes of this Agreement, utilization management activities and functions means those activities described in Health and Safety Code §1367.01(a), which states, “A health care service plan and 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 prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section [§1367.01].”

While the various requirements of §1367.01 are in the first instance the responsibility of Health Plan, §1367.01 recognizes that a health plan may delegate utilization management decisions to others, including contracted medical groups. If such delegation does occur, a health plan retains the responsibility to oversee the delegated activity to ensure that it is in compliance with all requirements of §1367.01. Accordingly, whenever any utilization management decision-making function is performed within Kaiser Permanente the Contracting parties agree to work collaboratively to ensure compliance with §1367.01 and related provisions in the Knox-Keene Act and regulations, including §1363.5.

Resource Management
Resource Management 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 Contracting Parties work collaboratively in performing effective resource management. The activities that comprise resource management do not involve prior authorization of services and resource management activity is not subject to direct regulation under the Knox-Keene Act as is the utilization management activity described above. Resource management is the activity concerned with the prudent and clinically appropriate allocation of resources in the provision of health care services.

<table>
<thead>
<tr>
<th>UTILIZATION MANAGEMENT FUNCTIONS DESCRIPTION</th>
<th>AUTHORITY</th>
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<tbody>
<tr>
<td>Decisions to create, modify, or discontinue the requirement for prior authorization for certain health care services and the selection and/or development and adoption of utilization management criteria used in determining medical necessity.</td>
<td>TPMG, SCPMG, KFHP, KFH</td>
</tr>
<tr>
<td>Approvals and denials of services requiring prior-authorization, concurrent care authorization and post service care authorization.</td>
<td>TPMG, SCPMG, KFH</td>
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</table>
Develop, review and approve the policies and procedures used to perform the selected UM activities

<table>
<thead>
<tr>
<th>UTILIZATION REVIEW AT LOCAL LEVEL</th>
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<tbody>
<tr>
<td>Hospital admission and concurrent review for non-contracted, non-KFH facilities and Contracted Facilities.</td>
<td>TPMG, SCPMG, KFH</td>
</tr>
<tr>
<td>Referrals management (i.e., Out of Plan Specialty Care)</td>
<td>TPMG, SCPMG, KFH</td>
</tr>
<tr>
<td>Out of plan and subcontracted - Skilled nursing facility and acute rehab admission and concurrent review.</td>
<td>TPMG, SCPMG, KFH</td>
</tr>
<tr>
<td>Issuance of Notices of Non-Coverage (NONCs) for both KFH and non-KFH Inpatient Utilization.</td>
<td>TPMG, SCPMG, KFH</td>
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</tbody>
</table>
Delegation and Oversight of Sub-Contractors
Health Plan may delegate Utilization Management functions to sub-contracted entities delivering health care services to Kaiser Permanente members such as Chiropractic and Acupuncture Care. These entities such as American Specialty Health Plan (ASHP) are typically Knox-Keene licensed health plans with qualified, licensed health care professionals such as chiropractors who make medical necessity determinations for Chiropractic and Acupuncture Care. Health Plan maintains accountability for all UM functions delegated to and performed by the sub-contractor and have mechanisms in place to oversee all Utilization Management Program activities at least annually to ensure compliance with all Federal, State and accrediting body standards and regulations.

Health Plan Oversight
Health Plan retains authority to administer Health Plan’s QAP and will oversee and monitor Quality Activities performed by each Contracting Party to ensure the provision of quality care and timely and appropriate utilization of services in accordance with professionally recognized standards of practice and legal requirements.

Health Plan may delineate certain of its administrative functions to KFH, TPMG and SPCM. These functions may include, but are not limited to, quality improvement and utilization management. The Health Plan remains ultimately accountable for all services provided to its membership through KFH, TPMG and SPCM and affiliated provider contracts. Health Plan continuously oversees and evaluates the performance of delineated functions and administrative contractors by:

- Formal evaluation of capacity to perform the assigned activities in accordance with state and federal regulatory and accreditation standards
- Oversight performed locally by Health Plan Area Managers/ Executive Directors assigned to specific services areas
- Oversight performed through appropriate Health Plan Quality and Utilization Management Committees
- Oversight activities performed by the Health Plan’s Physician Advisor in conjunction with the appropriate Health Plan Utilization Management and Quality Committees as appropriate.
- Reviewing routine periodic Quality and Utilization Management reports submitted by TPMG, SPCM and KFH.
- Tracking and analyzing provider and member complaints, grievances and other performance indices.
- Conducting periodic reviews of systems, staff, and policies and procedures.

Evaluation of Performance/Audits
Health Plan continually evaluates the Contracting Parties’ performance of the Quality Activities. Evaluation of a Contracting Party’s performance includes: (a) evaluation of the performance of the Contracting Parties to ensure that the quality program is operating in accordance with standards and processes set forth in the Program Documents, (b) evaluation of the efficacy of the Quality Activities, including without limitation, physician and system improvement plans, hospital operations improvement plans and other corrective actions imposed as part of the review process and identification and referral of systems issues, and (c) audits of compliance with the Program Documents in accordance with the audit procedures contained in the Program Documents.

Corrective Action
Health Plan will notify a Contracting Party of any instance where, as a result of Health Plan’s oversight activities, Health Plan determines that the Contracting Party’s performance is not in compliance with the Program Documents, performance expectations, NCQA standards, or applicable laws and regulations. If
Health Plan has reason to believe that a Contracted Party has not carried out the Quality Activities in accordance with the terms of this Agreement, Program Documents, or in accordance with Health Plan’s reasonable performance expectations, Health Plan may take all steps it deems necessary to ensure effective operation of the quality assurance program, including but not limited to, the following:

- Meet and confer with the Contracting Party to attempt to come to an agreement about the steps the Contracting Party needs to take to comply with policies and procedures set forth in the Program Documents.
- Conduct additional audits of the Contracting Party’s performance of the Quality Activities upon reasonable advance notice.
- Require the Contracting Party to submit to Health Plan, within a reasonable time frame, a corrective action plan to address any non-compliance, or other problems identified by Health Plan.
- Require the Contracting Party to implement, by a specific time, a corrective action plan approved by Health Plan.

D. Program Documents

Program Documents include Quality and Utilization Management Program Descriptions, associated policies and procedures designed to comply with regulatory, legal and accreditation requirements, books and records maintained by Committees and Forums responsible for the QAP and the Quality and Utilization Management Delineation Agreement (the “Documents”).

Each Contracting Party will cooperate and provide support as needed to maintain the Program Documents. All Documents are subject to annual review and revisions as appropriate and ad hoc based on regulatory, legal and accreditation changes to quality improvement and utilization review/resource management programs and processes.

**Adoption of Program Documents**

Each Contracting Party will adopt and comply with the Program Documents, including, without limitation, the provision of required reports, minutes and exhibits in the form and format and with the frequency specified.

**Maintenance of Records**

The Contracting Parties will each prepare and maintain all information and records created in connection with performing the Quality Activities in accordance with the Program Documents, and will permit Health Plan, the California Department of Managed Health Care, the California Department of Health Services, and the United States Department of Health and Human Services to review the information and records in accordance with the requirements of law.

**Review of Reports/Committee Minutes**

The Contracting Parties have full access to regional reports and committee minutes to ensure compliance with Program Documents.

E. Reporting Adverse Events

**Sentinel Events and Practitioner Conduct**

The Contracting Parties shall provide prompt notification to each other of incidents that are likely to affect any license, certification, privileges or accreditation of the Contracting Party (or a provider or health practitioner employed by or contracted with the Contracting Party) or which materially affect the ability of the Contracting Party (or a provider or health practitioner employed by or contracted with the Contracting Party) to meet its obligations to Kaiser Permanente members and patients.

In the event another Contracted Party has reason to believe that a Quality Issue needs to be addressed.
Attachment B
by Health Plan, the Contracting Party and Health Plan agree to meet and confer to discuss the steps that might be taken by Health Plan to address the Quality Issue.

F. Notices
   Termination of Agreement
The Health Plan directs the scope of its authority delineated to KFH, TPMG and SCPMG and may revoke all or part of its authority at any time. In addition, KFH, TPMG and SCPMG may terminate this Agreement as to any other Contracting Party, without cause, upon the provision of ninety (90) days written notice to the Health Plan, with a copy of the notice to the other Contracting Parties.

Any notice required under this Agreement shall be provided to the following, as applicable:

<table>
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<tr>
<th>Health Plan/KFH NCAL: Regional President</th>
<th>TPMG: Executive Medical Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Plan/KFH SCAL: Regional President</td>
<td>SCPMG: Executive Medical Director</td>
</tr>
</tbody>
</table>

This Agreement was reviewed and approved by: KFH: Regional President

Kaiser Foundation Health Plan, Inc./Hospitals Northern California
By [Signature] 9/3/13

The Permanente Medical Group, Inc.
By [Signature] 9/3/13

Kaiser Foundation Health Plan, Inc./Hospitals Southern California
By [Signature] 9/3/13

Southern California Permanente Medical Group
By [Signature] 9/3/13
Attachments

- Complaint Related Referrals to Quality from Member Services/Patient Assistance Policy and Member Services Quality Complaint Screening Criteria
- Review of Department Quality Concerns Policy
- Peer Review and Evaluation of Licensed Independent Practitioner Performance Policy
- Regional Quality Management Reporting Policy
- Oversight Monitoring and Audits of Quality Process Policy
- Fair Hearing Plan – Northern California
- Fair Hearing Plan – Southern California
- Credentialing and Privileging Policy – Northern California
- Credentialing and Privileging Policy – Southern California
- Northern California Regional Program Description
- Southern California Regional Quality Program Description
Regional Quality Improvement Program Resources
Performance Excellence / Accreditation / Regulatory / Risk Management / Licensing / Safety

- Lawrence D. Lurvey, MD, JD
  Regional Assistance Medical Director
  Quality, Risk, Regulatory Services and Maternal Child Health

- Nirav R Shah, MD, MPH
  Senior VP & Chief Operations Officer
  Quality & Risk Management, Patient Care Services
  Clinical Operations Support

- Kati Traunweiser, MBA
  Vice President Quality and Regulatory Services

Organizational chart represents interdependent functions.
QUALITY AND HEALTH IMPROVEMENT COMMITTEE (QHIC) CHARTER

A. Composition

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

B. Authority and Duties

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

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

1. Quality Assurance
   a. Overseeing quality systems, including quality goals, objectives, and performance measures;
   b. Identifying and addressing deficiencies in quality;
   c. Reviewing, and as appropriate approving, standards for the global member experience including standards for quality assurance, quality of care, patient safety, service quality, utilization, and risk management; and
   d. Reviewing and addressing the results of internal and external system audits.
2. **Quality and Health Improvement**

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

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

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

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

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

3. **Organizational Accreditation & Credentialing**

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

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

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

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

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

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

The committee shall report its decisions, actions and recommendations to the Board of Directors.
QUALITY AND HEALTH IMPROVEMENT COMMITTEE (QHIC) CHARTER

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   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 on Accreditation of Healthcare Organizations, 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 professional staff, or clinical staff or medical staff, clinical privileges, and other actions related to professional staff or medical staff or clinical staff membership and clinical privileges that require governing body approval.

e. Approving professional staff or medical staff or provider staff Bylaws and Rules and Regulations and amendments thereto.
f. Approving policies and procedures, when governing body approval is required, of hospitals and other facilities operated by the corporation.

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

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

4. Governance of the Psychiatric Health Facility

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

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

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

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

e. Identifying the requirement for health and treatment records.

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

The committee shall report its decisions, actions and recommendations to the Board of Directors.
KAISER PERMANENTE
2017 Southern California Quality Committee (SCQC) Charter

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

The primary KFHP oversight / regional hospitals oversight group established by the President and Executive Medical Director is the Southern California Quality Oversight Committee (SCQC). The SCQC is co-chaired by the Health Plan Vice President of Quality and Regulatory Services and the SCPMG Assistant Medical Director for Quality and Risk Management appointed by the President and Executive Medical Director as the key senior leaders administratively responsible for the leadership and direction of the quality program. The co-chairs of the SCQC are accountable to the KFHP President and the SCPMG Executive Medical Director who in turn hold them accountable to oversee the quality oversight processes and initiatives.

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

The Purpose of the SCQC is to:
- Evaluate the safety and quality of care and services provided to Kaiser Permanente members and patients in Southern California in all settings
- Support continuous improvement in these areas
- Establish Quality Program direction by identifying and addressing strategic opportunities to establish and maintain the Southern California Region’s 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.

Reporting Structure:
The Southern California Quality Committee (SCQC) reports its activities and functions to the Kaiser Foundation Health Plan and Hospitals, Inc., Boards of Directors.

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

Sub-committees and functional reports are submitted on a quarterly and ad-hoc basis. In addition, the Kaiser Foundation Hospitals submit to the SCQC and to Quality and Health Improvement Committee (QHIC):
- Performance on standard program-wide quality/patient safety/utilization indicators
- Summaries of significant event reports and follow-up actions
- Summaries of accreditation, credentialing and licensing agencies’ reports and findings
- Summaries of other key quality/operational indicators including access metrics, member satisfaction, continuing care indicators
- Annual quality program descriptions, quality workplans, and program evaluations

Authority and Scope:
The SCQC has authority to speak and act on behalf of KFH, KFHP, and SCPMG senior leadership on quality improvement issues including, but not limited to, the following:
- Responsible for oversight of the region wide metrics, which include Clinical Effectiveness,

- 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, QHIC and the KP National Quality Committee (KPNQC).
- Approving data prepared for the QHIC and oversight of required follow-up.
- Functioning as the formal quality and service intermediary between the Regional Senior Leaders and the Medical Centers.
- Determining accountability and ensuring quality issues are investigated and resolved.
- Serving as the final decision-making body on impasse issues and policy decisions.
- Committing the organization to action and monitoring progress relative to the action plan.

Meeting Process:
SCQC will meet monthly, for no less than ten months of the year. Membership includes representatives from KFH, KFHP, and SCPMG. The quorum is a simple majority of the members. Co-chair leadership is shared with at least one co-chair from KFHP. SCQC actions and decisions are documented in contemporaneous minutes of the meetings proceedings.

The Quality Evaluation and Support Team (QuEST):
QuEST provides support to SCQC by serving as an expert body to provide consultation and recommendations to SCQC. QuEST reviews and makes recommendations, follow-up communications and activities prior to presentation to SCQC.

SCQC Membership:

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<thead>
<tr>
<th>VOTING MEMBERS / BACKUP</th>
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<tbody>
<tr>
<td>LAWRENCE LURVEY, MD, Co-Chair</td>
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<tr>
<td>Assistant Medical Director SCPMG Quality, Risk Management, Patient Safety.</td>
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<tr>
<td>KATI TRAUNWEISER, Co-Chair</td>
</tr>
<tr>
<td>Vice President, Quality and Regulatory Services</td>
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<tr>
<td>JULIE MILLER-PHIPPS</td>
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<tr>
<td>Group President - Southern California Region</td>
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<tr>
<td>MICHAEL KANTER, MD</td>
</tr>
<tr>
<td>Medical Director - Quality, Risk, Patient Safety</td>
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<tr>
<td>NIRAV SHAH, MD</td>
</tr>
<tr>
<td>Senior Vice President, Chief Operating Office, Clinical Operations</td>
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<tr>
<td>VACANT</td>
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<tr>
<td>Director – Pharmacy Quality &amp; Medication Safety</td>
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<tr>
<td>ANNET ARAKELIAN, PharmD</td>
</tr>
<tr>
<td>Executive Director, Medicare Strategy and Care Delivery</td>
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<tr>
<td>BENJAMIN BRODER, MD, PhD, CPPS</td>
</tr>
<tr>
<td>Assistant Medical Director of Quality and Clinical Analysis</td>
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<tr>
<td>CINDY CALVILLO, RN</td>
</tr>
<tr>
<td>Executive Director – Utilization Management Program</td>
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<tr>
<td>VOTING MEMBERS / BACKUP</td>
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<tr>
<td>CHRISTIAN RODGERS</td>
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<tr>
<td>Lead Practice Consultant – Clinical Operations Support</td>
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<tr>
<td>DARLA HOLLAND, MD</td>
</tr>
<tr>
<td>Chairperson – Regional Credentialing Committee</td>
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<tr>
<td>GERALD McCALL</td>
</tr>
<tr>
<td>Senior Vice President of Operations</td>
</tr>
<tr>
<td>JAMES DEFONTES, MD</td>
</tr>
<tr>
<td>Assistant Executive Medical Director. SCPMG Administration Perioperative Services and Patient Safety</td>
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<tr>
<td>JERRY SPICER, RN / LINDA FAHEY, RN</td>
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<tr>
<td>Vice President - Regional Patient Care Services / Regional Director – Patient Care Services</td>
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<tr>
<td>JOHN YAMAMOTO</td>
</tr>
<tr>
<td>Vice President - Legal and Government Relations. Assistant General Counsel</td>
</tr>
<tr>
<td>CINDI S. JOHNSON / KATHY KIGERL</td>
</tr>
<tr>
<td>Chief Quality Officer – Medical Group / Regional Medical Group Administrator</td>
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<tr>
<td>TRENITA WARD</td>
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<tr>
<td>Vice President - California Member Services</td>
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<tr>
<td>PAT TAYLOR / LISA KOLUN</td>
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<tr>
<td>Executive Director – Regulatory Response / Vice President Health Plan Regulatory Services</td>
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<tr>
<td>MICHAEL MORRIS, MD</td>
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<tr>
<td>Assistant Executive Medical Director - Care Experience, Service, and Access</td>
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<tr>
<td>PAULA GOODMAN-CREWS, LCSW</td>
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<td>SCAL Regional Bioethics Program Director</td>
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<td>VACANT</td>
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<td>Vice President, Clinical Operations Support, Outside Medical &amp; Continuing Care</td>
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<td>SIMA B. HARTOUNIAN</td>
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<tr>
<td>Vice President of Compliance - Regional Compliance Officer</td>
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<tr>
<td>STEPHANIE SHANER, MD</td>
</tr>
<tr>
<td>Assistant Area Medical Director Quality, Risk, Patient Safety, and Regulatory Services</td>
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<tr>
<td>Chief, Department of Addiction Medicine Los Angeles Medical Center</td>
</tr>
<tr>
<td>VICKIE ALEXANDER</td>
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<tr>
<td>Statewide Compliance Director - California Member Services</td>
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<tr>
<td>VITA WILLETI</td>
</tr>
<tr>
<td>Sr. Vice President, Area Manager - KFH / HP - Riverside</td>
</tr>
<tr>
<td>WILLIAM B. CASWELL</td>
</tr>
<tr>
<td>Senior Vice President of Operations</td>
</tr>
</tbody>
</table>

**Confidentiality**

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

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

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

Local Service Area Quality Structure

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

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

The Leadership Teams are responsible for:

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

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

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

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

- The physician directors of quality and the directors of quality from each medical center come together in regular forums with the regional Health Plan leaders and Assistant Medical Director for Quality and Risk Management to discuss issues, processes and share ideas. In addition, the directors of quality meet monthly to discuss issues and processes.
- The SCQC requests local medical center reports and corrective action plans as appropriate on all Board of Director required reporting elements as well as the Regional reporting elements (e.g. Clinical Strategic Goals).
- The local medical centers are represented on SCQC and its sub-committees.
- The KFHP leaders receive regular reports on their local performance of all quality and regulatory issues.
- Continuous Readiness Assessments at the local medical centers are conducted by a team of internal consultants reporting to the KFHP Vice President for Quality and Risk Management and the SCPMG Regional Assistant Medical Director for Quality and Risk Management. This team conducts biannual assessments.
site visits to each medical center, monitoring against identified standards and quality vulnerabilities as identified through previous surveys, trends on sentinel events or other regulatory agency vulnerabilities, and quality performance as reported through regional reports. The purpose of the monitoring is to assess on-going sustained improvement of corrective action plans, identification of new high-risk vulnerabilities and on-going accrediting and regulatory readiness.

**SCQC Subcommittees – Accountabilities**

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

- Access Committee
- Autism Spectrum Disorder Related (ARSOT)
- Bariatric Surgery Steering Team (BSSC)
- Behavioral Health Oversight Committee
- Clinical Information Systems Quality and Patient Safety Committee (CISQPS)
- Continuing Care Committee
- Hospital Clinical Improvement Team (HCIT)
- Medication Safety Oversight Committee (MSOC)
- Member Concerns Committee (MCC)
- Procedure Outcomes Strategy Team (POST)
- Regional Bioethics Committee
- Regional Credentialing Committee (RCC)
- Regional Diversity Committee
- Regional Member Advisory Committee (RMAC)
- Regional Peer Review Oversight Committee (RPROC)
- Regional Pharmacy Nursing Committee
- Regional Radiation Safety Committee (RRSC)
- Perinatal Steering Committee
- Regional Transplant Quality Committee (RTQC)
- National Transplant Services/Renal Program
- Utilization Management – SCAL Executive Resource Stewardship Committee (SCERSC) and SCERSC Planning Group (SPG)
**Access Committee 2016 CHARTER**

**REPORTING STRUCTURE**
- The Access Committee reports directly to the Southern California Committee (SCQC) and will report appropriate activities and issues to SCQC on a quarterly basis or more frequently as needed.

**ROLES & RESPONSIBILITIES**
1. Understand and execute the access requirements by regulatory and accrediting organizations.
2. Review access performance data for all areas to identify and understand trends, distributions and outliers in wait times at the regional, medical center and department levels.
3. Review access complaints, trends and patterns and recommend areas of focus based on those data.
4. Request and oversee implementation of corrective action plans to address gaps in access.
5. Escalate concerns and report resolution of CAPs to the SCQC.
6. Provide oversight for submission of area-specific and regional Rate of Compliance (ROC) data for annual Timely Access Report submitted to DMHC. (Attachment: SCAL Annual Rate of Compliance Metrics)

**MEETING PROCESS**
The committee will meet monthly. Membership includes representatives from Kaiser Foundation Health Plan/Hospital and SCPMG, with a quorum being a simple majority of the members. Actions and decisions of the Access Committee are documented in minutes of the meeting proceedings.

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

**CONFIDENTIALITY**
Participation may necessitate access to privileged or otherwise confidential information. The confidentiality of such information is vital to the free and candid communication necessary to fulfill the activities and functions of the committee. Members of the Access Committee explicitly agree, as a condition of membership to:
- Respect and maintain the confidentiality of all discussions and information
- Make no voluntary disclosure of discussions or information except to authorized persons
- Notify the Committee Chairs in the event any person or entity seeks to compel disclosure of privileged information
- Not create or retain any copies or reproductions of discussions or information except as required for participation

**MEMBERSHIP**

**Chairs:**
- Michael E. Morris, MD, Medical Group Assistant Executive Medical Director, Care Experience
- Kati Traunweiser, VP, Quality and Regulatory Services

**Members:**
- Ashley Williams, Senior Consultant, Regional Access
- Bruce Horn, Regional Director, Diagnostic Imaging Services
- Chris Donnelly, Assistant Area Medical Director, Orange County
- Cydnee Crawley, Regional Practice Leader Consultant, Service and Access
- Elizabeth Trueblood, Survey Readiness Manager, Health Plan Regulatory Services
- Farrell Jorgensen, Managing Director, Quality and Regulatory Oversight
- Glenda MaHall, Health Plan Executive Director, Quality/Risk/Regulatory/Safety
- John Yamamoto, Health Plan Legal Counsel

Attachment F
• Nolan Thompson, Regional Chief Psychiatry
• Patricia Taylor, Executive Director, Regulatory Response, Health Plan Regulatory Services
• Paul Castaldo, Regional Associate Medical Group Administrator for Behavioral Health Care Services
• Teri Gahre, Regional Autism Coordinator
• Tina Han, Assistant Medical Group Administrator, Regional Service and Access
• Waynetta Kingsford, HPRS Director of Provider Delivery Systems
The Rate of Compliance (ROC) is a component of the Timely Access Report submitted annually to California’s Department of Managed Health Care (the “Department”) as required by Section 1300.67.2.2 of Title 28 of the California Code of Regulations (the “Timely Access Regulation”). The ROC includes reporting on area-specific data, regional data, and program-wide data.

The Plan’s annual Rate of Compliance is derived from a weighted average of results in four measurement categories: the Provider Survey Average Rate, the Access Complaints Rate, the Average Days Wait Rate, and the Appointments within Standard Rate. The ROC for each geographic Plan Area (“Area”) is equal to a weighted average of the four rates described in detail below:

- Provider Survey Average Rate – 20%
- Access Complaints Rate – 20%
- Average Days Wait Rate – 10%
- Appointments within Standard Rate – 50%.

The ROC for each Area is calculated as follows:

\[
\text{Area ROC} = (0.2)(\text{Provider Survey Average Rate}) + (0.2)(\text{Access Complaints Rate}) + (0.1)(\text{Average Days Wait Rate}) + (0.5)(\text{Appointments within Standard Rate})
\]

The ROC for each Region is equal to the average ROC of all the Areas comprising that Region, calculated as follows:

\[
\text{Regional ROC} = \frac{(\text{ROC of Area 1} + \text{ROC of Area 2} + \text{ROC of Area 3})}{\text{Total Number of Areas}}
\]

If the Plan’s Area scores at least 90% in the aggregate using the weighted metrics, the Plan will report satisfactory rate of compliance in its annual ROC report to the Department. The 90% aggregate benchmark was approved by the Department on January 31, 2014. The Plan continues to include its actual aggregate ROC percentages for each Area in the annual Timely Access ROC report submitted to the Department.

**Provider Average Survey**

The Provider Survey Average Compliance Rate represents 20% of the overall ROC for each Area. The Provider Survey Average Compliance Rate utilizes data from the Plan’s annual provider survey. The survey is designed to solicit physicians’ and non-physician mental health providers’ perspectives and concerns regarding compliance with the Timely Access Regulation. The Plan utilizes the five provider survey questions previously approved by the Department.

The provider survey is administered online via Survey Monkey. Each question has 5 possible responses, which are scored as follows: 1 – Very Dissatisfied; 2 – Dissatisfied; 3 – Neither Dissatisfied nor Satisfied; 4 – Satisfied; 5 – Very Satisfied. The scores for each question are averaged in each Area (the “Observed Mean”). Next, the Observed Mean is divided by a “Target Mean” of 3.5 to obtain a compliance rate for each question in each Area.
Provider Survey Question
…how satisfied are you with:

1. The referral and/or prior authorization process necessary for your patients’ to obtain covered services?
   Calculation Methods: Observed Mean / Target Mean = Rate 1

2. Your patients’ access to urgent care?
   Calculation Methods: Observed Mean / Target Mean = Rate 2

3. Your patients’ access to non-urgent primary care?
   Calculation Methods: Observed Mean / Target Mean = Rate 3

4. Your patients’ access to non-urgent specialty services?
   Calculation Methods: Observed Mean / Target Mean = Rate 4

5. Your patients’ access to non-urgent ancillary diagnostic and treatment services?
   Calculation Methods: Observed Mean / Target Mean = Rate 5

The Provider Survey Average Compliance Rate is calculated for each Area by averaging the rate obtained for each question shown above.

Provider Survey Average Compliance Rate = (Rate 1 + Rate 2 + Rate 3 + Rate 4 + Rate 5) / 5

Each Plan Area is assigned a score of either 0% or 100%, depending on whether the Plan’s target mean of 3.5 was met. Scoring is demonstrated in the example below:

<table>
<thead>
<tr>
<th>Plan Area</th>
<th>Question 1 (observed mean)</th>
<th>Question 2 (observed mean)</th>
<th>Question 3 (observed mean)</th>
<th>Question 4 (observed mean)</th>
<th>Question 5 (observed mean)</th>
<th>Observed Mean</th>
<th>Provider Survey Compliance Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Los Angeles</td>
<td>3.2</td>
<td>4.1</td>
<td>2.9</td>
<td>3.2</td>
<td>4</td>
<td>3.48</td>
<td>0%</td>
</tr>
<tr>
<td>West Los Angeles</td>
<td>4.5</td>
<td>4.0</td>
<td>3.9</td>
<td>4.5</td>
<td>4.8</td>
<td>4.35</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Access Complaints Compliance Rate**

The Access Complaints Compliance Rate represents 20% of the overall ROC for each Area. The Access Complaints Compliance Rate utilizes data from the Plan’s Complaints Integrated Workflow and Reporting System (“CIWRS”) and its companion Data Warehouse, Enterprise Performance Management (“EPM”). The Plan requires all grievances to be tracked through CIWRS and EPM. The Access Complaints Compliance Rate also utilizes MIA membership data to determine the total commercial membership in each Area at the close of each quarter.

To arrive at the Access Complaints Compliance Rate, first the total number of grievances in each Area during each calendar quarter is divided by the total commercial membership in the Area at the close of the quarter:

- Total Count of Grievances in Q1 / Commercial Membership at Close of Q1 = Rate 1
- Total Count of Grievances in Q2 / Commercial Membership at Close of Q2 = Rate 2
- Total Count of Grievances in Q3 / Commercial Membership at Close of Q1 = Rate 3
- Total Count of Grievances in Q4 / Commercial Membership at Close of Q2 = Rate 4

Then, the quarterly compliance rates obtained in the step above are averaged to obtain each Area’s Access Complaints Compliance Rate:

Access Complaints Compliance Rate = (Quarterly Rate 1 + Quarterly Rate 2 + Quarterly Rate 3 + Quarterly Rate 4) / 4
**Average Days Wait Rate**
The Average Days Wait Rate represents 10% of the overall ROC for each Area. The Average Days Wait Rate is derived from calendar year “Appointment Access Data” for each Area. This Appointment Access Data consists of the quarterly average “Appointment Wait Times” for four categories of appointments: (1) urgent appointments with primary care physicians; (2) non-urgent appointments with primary care physicians; (3) urgent appointments with specialists; and (4) non-urgent appointments with specialists.

In the Plan’s Southern California Region, the “Cadence” scheduling system in KP HealthConnect is used for booking enrollee appointments. Cadence permits the user to input a “Target Date” for an appointment. For urgent appointments and non-urgent appointments that do not constitute follow up care, the Target Date is set to the date the enrollee first requested the appointment. In the case of a referral from another provider within the Southern California Permanente Medical Group, the Target Date is set to the date the referral was generated by the provider. The Days Wait for an enrollee is calculated by comparing the Target Date for an appointment to the date the enrollee is seen by a provider.

To calculate the average Appointment Wait Time for each Area for the four measured appointment categories, the Days Wait is calculated for all corresponding appointments in the Area within the relevant time period. The Days Wait for all appointments within each measured appointment category is then averaged to calculate the average Appointment Wait Time for each measured category.

To arrive at the Average Days Wait Rate, the average Appointment Wait Time for the year in each of the four categories of appointments measured is examined. Next, each category of appointment is assigned either 100% or 0% based upon whether the annual average Appointment Wait Time is less than or equal to the standard in the Timely Access Regulation applicable to the particular type of appointment at issue. The assigned rates for the four categories of appointments measured are then averaged to arrive at an Average Days Wait Rate for each Area:

\[
\text{Appointment Access Compliance Rate} = \frac{(\text{Rate for urgent appointments with primary care physicians} + \text{Rate for non-urgent appointments with primary care physicians} + \text{Rate for urgent appointments with specialists} + \text{Rate for non-urgent appointments with specialists})}{4}
\]

Overall, for the four categories of appointments for which average Appointment Wait Times are measured, an Area’s Average Days Wait Rate will either be 0%, 25%, 50%, 75% or 100%.

**Appointments within Standard Rate**
The Appointments within Standard Rate represents 50% of the overall ROC for each Area. Each department within each Kaiser Permanente facility measures its percentage of appointments scheduled within the standards set forth in the Timely Access Regulation. This methodology differs from Average Days Wait because it shows the percentage of appointments where members were actually booked appointments within the applicable standard in the Timely Access Regulation; in comparison, the Average Days Wait measurement is the average of all members’ wait times for particular types of appointments.

---

1 Non-urgent appointments, by regulation, do not include preventative care and periodic follow up care, which may be scheduled in advance “consistent with professionally recognized standards of practice as determined by the treating licensed health care provider”. See Timely Access Regulation Section (c)(5)(h). Therefore, such follow up care is not included in the calculation of the average Appointment Wait Time for non-urgent appointments in any category.
For the Appointments Within Standard measure, percentages are calculated quarterly, and consolidated by Plan Area into the same appointment types measured by the Average Days Wait Rate: (1) urgent appointments with primary care physicians, (2) non-urgent appointments with primary care physicians, (3) urgent appointments with specialists (including MD and non-MD mental health specialists), and (4) non-urgent appointments with specialists (including MD and non-MD mental health specialists). Each quarter, the percentage for each type of appointment measured is averaged, and then averaged for the year to derive the Appointments within Standard Rate. This is demonstrated in the examples below:

<table>
<thead>
<tr>
<th>Plan Area</th>
<th>Urgent PCP</th>
<th>Non-Urgent PCP</th>
<th>Urgent Specialty</th>
<th>Non-Urgent Specialty</th>
<th>Quarterly Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>Downey</td>
<td>98%</td>
<td>95%</td>
<td>95%</td>
<td>94.5%</td>
</tr>
<tr>
<td>Q2</td>
<td>Downey</td>
<td>95%</td>
<td>97%</td>
<td>93%</td>
<td>93.5%</td>
</tr>
<tr>
<td>Q3</td>
<td>Downey</td>
<td>99%</td>
<td>96%</td>
<td>93%</td>
<td>95.75%</td>
</tr>
<tr>
<td>Q4</td>
<td>Downey</td>
<td>98%</td>
<td>99%</td>
<td>96%</td>
<td>97.25%</td>
</tr>
</tbody>
</table>

Appointments Within Standard Rate

\[
\text{Appointments Within Standard Rate} = \frac{(Q1 \text{ Quarterly Average} + Q2 \text{ Quarterly Average} + Q3 \text{ Quarterly Average} + Q4 \text{ Quarterly Average})}{4}
\]

95.25%
SOUTHERN CALIFORNIA BARIATRIC SURGERY STEERING COMMITTEE (SCBSSC) CHARTER

The Kaiser Permanente Southern California Region (KPSC) provides a comprehensive bariatric surgical program for its membership. The Bariatric Surgery Steering Committee, a sub-committee of the Southern California Quality Committee (SCQC) provides coordination and oversight of bariatric surgery related services such as:

- Development of regional bariatric surgery services program description and workplan/goals.
- Assessment and evaluation of pre-surgical preparation program (Options)
- Analysis of quality data from all surgical centers, including contracted sites, with annual reporting to SCQC
- Monitoring of access to services
- Analysis of member complaints with routine reporting to the Member Concerns Committee
- Evaluation of new requests for expansion of network
- Evaluation of new technology and procedures
- Periodic review/revision of clinical practice and referral guidelines
- Development of educational programs for members and providers
- Development of enhancements to program, such as bariatric surgery registry and post-op management program.
- Monitoring of status of center of excellence accreditation status for surgical programs, including contracted sites.

Membership includes the following:

Quality
Health Plan Regulatory Services
Health Plan/Hospital Executive Director
Medical Group Administrator
Bariatric Champions
Contracts Administrator
Adult Weight Management Regional Lead
Options Coordinators
Regional Health Educator
Bariatric Surgeons
Complete Care

The BSSC meets bimonthly and reports to SCQC and Member Concerns Committee at least annually.
KAISER PERMANENTE SOUTHERN CALIFORNIA
BEHAVIORAL HEALTH QUALITY OVERSIGHT COMMITTEE CHARTER

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

AUTHORITY AND SCOPE
The functions of BHQOC will include, but may not be limited to:
- Identifying, reviewing, and evaluating relevant quality, patient safety and other performance improvement measures and report results to SCQC.
- Review data and facilitate compliance with quality and regulatory standards.
- Identify regulatory gaps in Behavioral Health and determine necessary actions to improve care delivery process.

AREAS of FOCUS
- Autism quality measures
- Regulatory standards
- Publicly reported quality measures (HEDIS)
  - Other quality measures
- Behavioral Healthcare related complaints and grievances
- Behavioral Healthcare related patient safety activities
- Behavioral Healthcare contracted quality oversight
- Measurable impact on quality of Behavioral Healthcare
- Quality of Behavioral Healthcare delivered to our members

REPORTING STRUCTURE
- The BHQOC is a subcommittee of the Southern California Quality Committee (SCQC) and reports to SCQC on at least a semi-annual basis.
- The SCPMG Regional Chief Administrator Officer and Vice President of Quality & Regulatory Services are committee sponsors.

MEETING PROCESS
The BHQOC meetings will occur on a monthly basis with a minimum of 10 meetings per calendar year.
**ANNUAL EVALUATION**
The Behavioral Health Quality Oversight Committee Charter is reviewed, updated and approved annually.

**CONFIDENTIALITY**
Participation in BHQOC may necessitate access to privileged or otherwise confidential information. The confidentiality of such information is vital to the free and candid communication necessary to fulfill the activities and function of BHQOC.

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

**MEMBERSHIP**
Membership includes representatives from KFH, KFHP, and SCPMG. The committee is chaired by SCPMG Regional Chief of Psychiatry, SCPMG Regional Chief of Addiction Medicine, and KFHP Regional Health Plan Executive Leader.

The following individuals constitute the BHQOC membership:

**Tri - Chairs:**
SCPMG Regional Chief of Psychiatry
SCPMG Regional Chief of Addiction Medicine
KFHP Regional Health Plan Executive Leader

**Member(s)**
SCPMG Behavioral Health Leader
SCPMG Director of Regulatory and Performance Assessment
SCPMG Health Plan Regulatory Services Representative
SCPMG Behavioral Health Outcomes Training Leader
KFHP Vice President Quality & Regulatory Services
KFHP Senior Consultant, Health Plan Behavioral Health

**Ad Hoc:**
SCPMG Director Behavioral Health Business Operations
SCPMG Regional Coordinator for Autism and Developmental Disabilities
SCPMG Physician Leader Regional Behavioral Healthcare and Psychiatric Utilization Management
KFHP Managing Director Membership Services
Kaiser Permanente Behavioral Health Member Advisory Representative

*Support Staff: Health Plan Quality Staff*
Southern California
Kaiser Permanente
Clinical Information Systems
Quality and Patient Safety Oversight
Committee Charter

Date Revised:  January 29, 2017

Questions/Corrections?
Please Contact:  Stella Kientz (626) 405-3699
**Charter**

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

<table>
<thead>
<tr>
<th>Organization</th>
<th>Clinical Information Systems Quality and Patient Safety Committee is a sub-committee of the Southern California Quality Committee (SCQC).</th>
</tr>
</thead>
</table>
| Participants | * Physician Leaders of Quality, KP HealthConnect, Laboratory and Pharmacy  
* SCPMG and KFH Medical Center and Hospital Operations Leadership  
* Quality, Patient Safety and Risk Management leadership  
* KP HealthConnect application owners  
* Application and subject-area expert  
* Data Accuracy Unit |
**Hospital Clinical Improvement Team**

**Executive Sponsor(s):** Joint Operations Group, SCQC  
**Regional Lead(s):** Nirav Shah MD, Michael Kanter MD

**Charter:** We believe there is an opportunity to improve safety, reliability, and efficiency for patients in and around the hospital setting. The Hospital Clinical Improvement Team will drive clinical care improvement through improved diagnosis and treatment strategy selection for patients within KPSC hospitals and in the peri-hospitalization period. The team will consist of a group of practicing clinicians and administrators with proven hospital leadership ability. The team will serve both governance and development functions, which include managing the regional portfolio of hospital related goals, measures, process improvement ideas, and clinical decision support tools.

In the figure below, the HCIT is responsible for aims, measures, and selecting regional change initiatives (an example is provided). Other existing groups serve the roles of sponsors, representatives providing input and feedback informed by process change execution (via PDSA cycles), and service (data/analytic/cognitive tool) providers.

http://www.ihi.org/knowedge/Pages/HowtoImprove/
In Scope:
- Patients in the hospital environment (including care delivered immediately prior to or after the hospital encounter)
- All clinical services pertaining to the delivery of patient care in the hospital environment
- Oversight of inpatient KPHC predictive analytics and clinical decision support tools (including selection, functional evaluation, and persistent quality evaluation)

Out of scope:
Issues not directly related to improving the quality of care for patients in the hospital setting.

Expected Deliverables:
- Governance and approval of goals, targets for specific measures, defined interventions, and metrics for hospital clinical improvement which are then submitted for JOG sponsorship
- Identifying hospital clinical quality improvement opportunities
- Participation in cross continuum (pre- and post-hospital transitions & care) improvement planning
- Sponsoring and contributing to clinical improvement efforts within the hospital
- Setting Predictive Analytics/Clinical Decision Support (PA/CDS) priorities with Regional leadership.
- Selecting/approving/improving algorithms for identification and recommendations.
- Testing the algorithms both through simulation and in their clinical practice.
- Spreading and incorporating feedback on PA/CDS functioning

Milestones:
- Deal with evolving capacity (ramping up) of HCIT, relationships with partners and various leadership and front-line groups.
- Membership finalized and initial meeting each year in Q1
- Defined set of potential annual goals each year in Q3
- Aligned goals for each year identified and agreed upon in Q3
- Confirmed outcome and process measures for each initiative in Q1

Organizational structure:

HCIT Structure
- 4-5 practicing hospital based clinicians (Emergency Department, Hospitalist, Critical Care)
- 1-2 nursing representatives
- 1 hospital pharmacy representative
- 1 administrative representative (hospital COO or Area Manager / Senior Vice President)
- 1 hospital quality representative
- 1-2 regional quality leaders

Connection to Related Groups
- Regional Leadership (Joint Operations Group and specifically Michael Kanter and Nirav Shah): Sponsors efforts, removes barriers.

The following groups are represented in the HCIT, execute upon and refine process improvements via coordinated PDSA cycles, and may set
aims and goals beyond those specified by the HCIT
• Medical Center Leadership team
• Chiefs Groups
• Nursing
• Pharmacy
• Assistant Hospital Administrators of Quality

Regional Performance Improvement, Consultancies, Data and Analytic Departments (i.e., Clinical Analysis, Decision Support, and Clinical Intelligence & Decision Support), and IT groups including KP HealthConnect are service providers. While they must support a large set of customers, priority needs to be provided to the HCIT directed activities.

**Metrics of success:**
• Goals agreement annually
• Metrics set quarterly
• Improvement activities implemented
• Improvement achieved
Southern California
Regional Medication Safety Oversight Committee

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

Mission Statement:
The Regional Medication Safety Oversight Committee exists to eliminate medication errors that cause harm or potential harm to our patients by overseeing, coordinating and supporting medication safety efforts, just culture, and improved outcomes.

Oversight and Collaboration:
The Committee oversight encompasses consideration of regulatory requirements, assessment of medication safety data and audits, review of sentinel events, and other causes of patient harm or potential harm pertaining to medications. Medication safety issues are forwarded from various internal and external sources. Oversight and collaboration includes the following; local medication safety committees, SCPMG care ambulatory practice leaders, medication management teams, KP HealthConnect leads, pharmacy nursing committee, pharmacy informatics and pharmacy operations leaders.

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

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

Meeting:
The Regional Medication Safety Oversight Committee meets monthly. A quorum consists of at least 1/3 of membership of mixed representation from the Committee roster. Committee members are asked to identify an alternate who is kept informed of MSOC issues and activities.

Confidentiality:
The Committee activities necessitate the access to privileged or otherwise confidential information. The confidentiality of such information is vital to the free and candid communications necessary to fulfill the oversight functions of the Committee. Committee members agree to adhere to all KPSC confidentiality policies and procedures.
MEMBER CONCERNS COMMITTEE
CHARTER

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

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

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

REPORTING STRUCTURE
- The MCC is a subcommittee of the Southern California Quality Committee (SCQC). MCC reports to SCQC on a quarterly basis.
- The MCC maintains ongoing reporting and communication with local KPSC medical center departments, committees, and/or leaders responsible for oversight of KPSC initiatives and priorities.
- KFH/P Senior Vice Presidents of Operations and SCPMG Assistant Medical Director, Quality & Risk Management are committee sponsors.

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

**MEETING PROCESS**
The MCC shall meet every other month no less than six months each year.

Membership includes representatives from KFH, KFHP, and SCPMG. A quorum is a simple majority of the members in attendance. The committee is chaired by a KFHP CA Member Services Executive Director. MCC actions and decisions are documented in contemporaneous minutes of the meeting proceedings.

**ANNUAL EVALUATION**
MCC activities are reported to SCQC quarterly. The MCC Charter is reviewed, updated and approved annually.

**CONFIDENTIALITY**
Participation in MCC may necessitate access to privileged or otherwise confidential information. The confidentiality of such information is vital to the free and candid communications necessary to fulfill the activities and functions of the MCC. Members of the MCC explicitly agree, as a condition of membership, to:
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 MCC activities.
3. Notify a MCC 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.

**MEMBERSHIP**
The following individuals constitute the MCC membership:

Sr. Vice President, Health Plan Operations
Vice President, Quality and Regulatory Services
Vice President, California Member Services
Health Plan Physician Advisor KFHP
Health Plan Physician Advisor KFHP
Managing Director, Quality and Regulatory Oversight
Managing Director, California Member Services, Grievance Operations
Director, Regulatory Relations & Performance Assessment
Director, Regulatory Investigation & Response
Compliance Consultant V, Medicare Compliance

**OTHER PARTICIPANTS**
Chief Operating Officer, SCAL Hospital Administration
Executive Director, Member Service & Performance Improvement (MS&PI) Quality & Risk
Managing Director, Medi-Cal Strategy and State Programs
Director, Regulatory Information Systems & Services - RIMSS
Assistant Medical Group Administrator, Regional Service and Access
Manager, Member Service Data Analytics and Technology

**AD HOC**
Executive Director, Regulatory Response; HPRS Regulatory Information Systems Services
Executive Director, Quality/Risk/Regulatory/Safety

Approved By MCC on: March 03, 2016
Attachment M

Procedure Outcomes Strategy Team (POST)
Charter

Purpose
Provide strategic oversight to the development, review, approval and implementation of initiatives to collect and report clinical measures and outcomes of therapeutic procedures and therapeutic procedure-related technologies. Review results, refer findings to appropriate leadership and stakeholder groups, and make strategy recommendations as appropriate.

Scope
The scope includes requests for collection and reporting of data on clinical outcomes of procedures and procedure-related technologies. This includes but is not limited to requests to monitor outcomes of newly deployed procedures or technologies and requests related to external reporting requirements. Primary customers include the CSG Planning and Measurement Committee, Regional Chiefs Groups and Regional Committees, the Medical Technology Assessment Team, and the Medical Technology Deployment Strategy Team. Requests for collection and reporting of data on clinical outcomes not related to therapeutic procedures are outside the scope of this team and will be referred to the CSG Planning and Measurement Subcommittee.

Objectives
- Develop a vision for the collection and reporting of clinical outcomes/volumes within the scope of this charter.
- Develop a strategic approach for achieving the vision.
- Make recommendations to Senior Leadership for the resources and support needed to achieve the vision; this may include recommendations for enhancements to data systems to ensure high quality data.
- Ensure that initiatives are consistent with the strategic plan, provide value to the organization, and will produce benefit for our members.
- Ensure that initiatives are designed and implemented appropriately to achieve desired goals.
- Prioritize initiatives when resources are limited.
- Provide a single point of review for initiatives to avoid redundancy and conflicting goals.
- Review monitoring results and ensure findings are shared with and acted on by appropriate stakeholder groups.
- Ensure that learnings are shared and applied.

Accountability
- Reports semi-annually to SCQC
- Collaborates with NTDST to prioritize technologies for monitoring
- Includes appropriate content experts on an as-needed basis
Purpose and Goal:
The Southern California Bioethics Program:
1) encourages pursuit of health for Kaiser Foundation Health Plan members and Southern California Permanente Medical Group patients in a manner that honors biomedical, personal, social, and spiritual values;
2) provides leadership to promote and sustain the incorporation of Bioethics principles, policies, education, advice, and case consultation into a vertically integrated environment of ethical care;
3) provides an advisory, multidisciplinary forum for the open-minded discussion of ethical concerns that arise in the context of legal, regulatory, patient, and professional demands on the practice of medicine and the delivery of health care.

Composition and Reporting of the Bioethics Program:
The Program will be composed of two lead administrators of equal administrative authority called Directors of the Southern California Bioethics Program; the Regional Committee on Bioethics; the Clinical Ethicists or Directors of Medical Bioethics; and the Medical Center Committees on Bioethics. The Bioethics Program reports to the Southern California Quality Committee and to both the President of the Southern California Divisional Offices of Kaiser Foundation Hospitals and Health Plan (SCKFHHP) and to the Executive Medical Director of the Southern California Permanente Medical Group (SCPMG) or their designees. In addition the Bioethics Program reports to the Southern California Quality Committee (SCQC).

One Director of the Bioethics Program will be appointed by the President of SCKFHHP and the other by the Executive Medical Director of SCPMG or their designees. The Directors will report to the SCQC, and to the President of SCKFHHP, the Executive Medical Director of SCPMG or their designees.

The Southern California Region will support a Regional Committee on Bioethics as outlined below.

Directors of Medical Bioethics or Clinical Ethicists will be hired at medical centers to work with but also independently of the Committees on Bioethics and will report to the Medical Center’s Hospital Executive Director and Medical Director or designees.

Qualifications for the Directors of the Southern California Bioethics Program:

Physician Director

1) will have a degree of MD or DO, will be Certified by a Specialty Board, in good standing within the Southern California Permanente Medical Group, and exhibit meritorious behavior and practice

2) will have been educated in Bioethics as evidenced by a certificate or degree in Ethics, organized educational activities over several years, or comparable experience

3) will have experience with ethics case reviews and the ethics consultation process and be able to produce
consultations of quality that have been performed

4) will have experience in the creation of policies with ethical importance and be able to demonstrate a collaborative working process to achieve that goal

5) will have demonstrated ability to chair a meeting

6) will have demonstrated ability to deliver a lecture

Non-Physician Director

1) will have a professional degree from a Bioethics “feeder” field, including but not limited to social work, nursing, ethics, theology, law, or philosophy.

2) will have been educated in Bioethics as evidenced by a certificate or degree in Ethics, organized educational activities over several years, or comparable experience

3) will have experience with ethics case reviews and the ethics consultation process and be able to produce consultations of quality that have been performed

4) will have experience in the creation of policies with ethical importance and be able to demonstrate a collaborative working process to achieve that goal

5) will have demonstrated ability to chair a meeting

6) will have demonstrated ability to deliver a lecture

Strategy for Implementation:

The Directors of Regional Ethics will strengthen Ethical quality of care delivered by the Medical Center Committees on Bioethics, the Clinical Ethicists/Directors of Medical Bioethics, the individual Medical Centers, and the Regional Committee on Bioethics. The Directors will:

1) design and update metrics for the performance of Clinical Ethicists/Directors of Biomedical Ethics within the Kaiser Permanente Medical Care Program. This may include a measure of the individual case consultations, the closing of Ethics Quality Gaps, a measure of satisfaction of performance, and the ability to assist with the adoption of policies at a Medical Center.

2) review Medical Centers with regard to ability to provide for case consultations, adoption of policies of a bioethical nature, and educational programs through standardized metrics

3) assess the performance of the Regional Committee on Bioethics with regard to how well it serves as a resource for medical centers, policy recommendations, case consultation review, and an advisory function to the Medical Care Program.

4) attend meetings of the Regional Committee on Bioethics

5) provide for continuity and management of projects initiated through the Regional Committee on Bioethics that require ongoing participation between meetings of the Regional Committee on Bioethics. This may include assistance with managing the Subcommittee on Policy Suggestion.
6) represent the Regional Committee on Bioethics when this is needed. This will include representation at the Inter-regional Medical Ethics Committee
7) provide recommendations to the SCQC for opportunities to strengthen the program with regard to the metrics. This may include both the location for these changes and method for improvement
8) participate in the hiring of Directors of Medical Bioethics within the Southern California Region
9) provide a resource to the Directors of Medical Bioethics with regard to consultations, assistance with advice on projects, and techniques for the closing of ethics quality gaps
10) determine the charter and operation of the Regional Committee on Bioethics in consultation with members of the Regional Committee on Bioethics, the Vice President of Quality and Risk Management and the Medical Director of Quality and Clinical Analysis or as designated by the President of SCKFHHP and to the Executive Medical Director of the SCPMG or their designees

Support:

Secretarial support for the Bioethics Program will come from the office of the Assistant Medical Director of Quality and Clinical Analysis and from the SCPMG legal department.

Support for the Bioethics Program will come from funds allotted through Quality and Risk Management. Additional support for time will come from the Medical Centers supporting activities of the individuals who comprise the Bioethics Program.

Procedures for the Regional Committee on Bioethics

Section I: The Regional Committee on Bioethics

A. will provide consultation for entities within the Kaiser Permanente Southern California Region Medical Care Program. In this capacity, the committee may review regional guidelines, policies, or issues of an ethical nature.

B. will support the education of staff and health plan members in Bioethics from a regional level.

C. will facilitate communication among the area medical center Committees on Bioethics.

D. will provide counsel to the medical center Committees on Bioethics.

E. will facilitate communication between various Kaiser domains and stakeholder groups to achieve consensus on issues with an ethical dimension

F. Will contribute to the review of the Quality of the Activities performed by Clinical Ethicists at each Medical Center that has a Clinical Ethicist and will review the Quality of the Ethics program at each of the Medical Centers

Section II: Reporting and Group Process.

A. Reporting: The Regional Committee on Bioethics will report to both the President of the Southern California Divisional Offices of Kaiser Foundation Hospitals and Health Plan (SCKFHHP) and to the
Executive Medical Director of the Southern California Permanente Medical Group (SCPMG) or their designees and to the Southern California Quality Committee (SCQC) through the Directors of the Southern California Bioethics Program.

B. Committee Co-Chairs: The Regional Committee on Bioethics will have two Co-Chairs of equal accountability and administrative power. One must be a SCPMG physician. These Co-Chairs will be recommended by the Regional Committee on Bioethics and appointed by either the Medical Director of the Southern California Permanente Medical Group or the President SCAL Divisional Offices. Recommendations for these two positions will be made through an election process. The Regional Committee on Bioethics will be asked every three (3) years if another member of the committee is interested in the cochair position that would justify an election.

C. Meeting agenda: The Co-Chairs of the Regional Committee on Bioethics shall develop the agenda for each scheduled meeting, with input from committee members and the Directors of the Bioethics Program. The preliminary agenda will be distributed to committee members, sufficiently in advance to allow adequate time for preparation for the issues to be discussed. Action items will be indicated clearly; as well as the time planned for each item on the agenda.

D. Meeting process: Decisions by the Regional Committee on Bioethics shall be made by simple majority vote. The Co-Chairs must ensure that issues of importance are discussed to an evolving consensus before polling the committee. Only Regional Bioethics Committee members designated as Voting Members (see III.A below) can vote. The Co-Chairs should encourage the participation of all members in consensus assessment.

E. A minimum of four meetings will be scheduled each year. The use of standing sub-committees and ad hoc working committees meeting separately are recommended. Minutes shall record the committee meetings and shall include as attachments any materials distributed.

Section III: Composition of the Regional Committee on Bioethics.

A. The two Co-Chairs of each area medical center Committee on Bioethics or their designees, specific patient representatives, and the Directors of the Bioethics Program comprise the Voting Members of the Regional Committee on Bioethics. A list of current members of the Regional Committee, administrative staff of the Committee, and consultants to the Committee will be kept up-to-date, and available to all members.

B. Members of the Regional Committee who do not vote are considered to be Consultants. The Consultants are expected to attend and contribute in meetings. They will not vote. These consultants include: The SCPMG Legal Department, the Regional Legal Department, Regional Accreditation/Regulatory/Licensing, Compliance, Regional Clinical Services, KFH Administration, invited consultants in Bioethics, and the Chair of the Northern California Region Bioethics Committee. Other consultants or guests may be invited at the discretion of the Regional Committee on Bioethics.
Section IV: Strategy for Implementation:

The Regional Committee on Bioethics will produce a concrete and measurable product in each of the areas listed above as goals for the Committee.

The Committee on Bioethics will provide consultation for groups within the Kaiser Permanente Southern California Region Medical Care Program organized in an administrative or direct medical care capacity. In this regard, the committee may review regional guidelines, policies, ethics quality gaps, or an approach to issues of an ethical nature.

Members of the Regional Committee on Bioethics will provide a forum capable of bringing together disparate groups and delivering knowledgeable advice on issues of an ethical nature. The Regional Committee on Bioethics must provide education and training for its members in Bioethics and in group process. Each new member will be educated through an orientation program. The Regional Committee will consider the need and appropriateness of any request for assistance before examining the ethical issues. Subjects for review include administrative guidelines or policies developed within Kaiser Permanente as well as bioethical aspects of political, legal, or economic issues that affect health care delivery in the community. The Regional Committee on Bioethics may assist in the development of consistency in policies related to bioethics throughout medical centers in the region.

The Regional Committee on Bioethics will support the education of hospital staff and health plan members in Bioethics from a regional level.

Region-wide educational projects in Bioethics will be organized or funded through the Regional Committee. These efforts may be for the direct benefit of health plan members, medical professionals, the Committees on Bioethics at individual medical centers, or members of the Regional Committee. The members of the Regional Committee retain an individual obligation to maintain their own knowledge base in the field of Bioethics. Educational programs for members of the Regional Committee designed by the Regional Committee may serve to supplement that education. This latter program must include the sharing of expertise and experience in both the process and general content of case review.

The Regional Committee will provide a forum for the dissemination and discussion of information related to bioethics. These topics may include governmental, judicial, legislative, or administrative matters of bioethical significance. In general, members of the Regional Committee will communicate selected topics discussed at regional meetings to the individual area Committees on Bioethics.

The Regional Committee will create an easily accessible resource center or library for:

1) Procedures for case review
2) Administrative policies developed or reviewed by any Committee on Bioethics within Kaiser Permanente Medical Care Program, Southern California Region

3) Written standards of operation created by the Regional or individual medical center Committees on Bioethics

4) Resource materials that support bioethics for regional and medical center use. These may include policies, pamphlets, or other materials that have been created by any of the medical center Bioethics Committees

The Co-Chairs of each medical center will be charged with contributing to this library. Each medical center will provide a copy of any relevant material. No information of a confidential nature or protected health information will be included in this library.

The Regional Bioethics Committee will provide administrative support for education in bioethics to any part of the regional Kaiser Permanente organization. This role may be expanded to include inter-regional education programs.

The responsibility for education in bioethics at each medical center rests with each medical center’s Committee on Bioethics.

The Regional Committee on Bioethics will facilitate communication among the area medical center Committees on Bioethics.

The Regional Committee will provide a method to share resources among the individual medical center Bioethics Committees. These resources include:

1) Payment for consultative services provided by consultants in bioethics contracted by Kaiser Permanente

2) A regional library of bioethics materials collected from the individual medical centers, the Regional Committees on Bioethics, inter-regional documents within Kaiser Permanente, and items from outside the Kaiser Permanente program

3) Staff support to manage the library

4) Secretarial support to manage the business of the Regional Committee on Bioethics and the needs of the Bioethics Program

5) The Regional Committee on Bioethics will assist in the development of a network for communication among the individual Medical Center Committees on Bioethics.

The Regional Committee on Bioethics will provide counsel to the medical center Committees on Bioethics.
Assistance with individual case reviews—either the process or content of case review—will be provided in the forum of the Regional Committee on Bioethics as requested by an individual medical center Committee on Bioethics.

The Regional Committee on Bioethics will be available to discuss policies under evaluation by individual medical center Committees on Bioethics.

The Regional Committee on Bioethics will seek to improve the role of Committees on Bioethics within the Kaiser Permanente Medical Care Program through research and consensus building.

The Regional Committee on Bioethics will create and maintain a log of types of cases reviewed at the individual medical centers and support the implementation of policies concerning issues of bioethical importance as this is considered important by the individual medical center Committees on Bioethics.

**Section V. Review Procedures for the Subcommittee on Policy Suggestion**

1. Conditions under which a Review is generated:

Any member of the Regional Committee on Bioethics (or any person designated as Co-Chair of an Area Medical Center's Committee on Bioethics) may request a review of a policy, or consideration for the creation of a policy. Any official entity within Kaiser Permanente with certification by the person charged with overseeing the function of that entity may request policy review or creation by the Regional Committee on Bioethics. Requests for review or creation of policy will be considered by the Co-Chairs of the Regional Committee on Bioethics. At the discretion of either Co-Chair, a request for review or creation will be presented to a Subcommittee on Policy Suggestion (SOPS).

2. When organizations outside Kaiser Permanente or individuals inside or outside KP request a policy review or policy creation:

The request must be presented to the Regional Committee by a member of the Regional Committee on Bioethics who believes the policy review is needed. If a member of the Regional Committee on Bioethics receives such a request and does not want to advocate review of that policy, that member has two options. The member may refer either the issue or the requesting person/party to a Co-Chair of the Regional Committee on Bioethics. In either case, the Co-Chairs may decide not to review the policy.

3. Review by the Subcommittee On Policy Suggestion:

A. Subcommittee composition

The Subcommittee will be made up of three members of the Regional Committee on Bioethics and a chair of the Subcommittee. It is desirable that all members of the Regional Committee rotate through this subcommittee except the Co-Chairs of the Regional Committee on Bioethics. A rotating schedule will be maintained by the Co-Chairs or the secretary of the Regional Committee. Members may rotate in as they are able. A record will be kept of those participating in the policy review process. Members fulfilling their obligation to participate will be less likely to be chosen for the next review. The person
who will serve as chair of these subcommittees on policy suggestion will be appointed by the Co-Chairs of the Regional Committee on Bioethics.

B. Ad hoc members of the Subcommittee

At the discretion of the subcommittee, other persons may participate in the work, or the meetings of the subcommittee.

C. The First Product of the SOPS

A policy reviewed or created by the subcommittee will be organized to include background information relevant to the need for policy-making. This first product should include an exposition of relevant legal or ethical precedents and possible constraints on the ability of the Regional Committee on Bioethics to offer suggestions for policy-making. Following this will be options of possible suggestions for policy. Finally, the subcommittee will draft an initial suggestion for policy consideration if this is possible. This product will be in written form and presented to the Regional Committee on Bioethics.

The SOPS will consider how to present the policy to the Regional Committee on Bioethics. The SOPS will anticipate the type and amount of contribution needed from the stakeholders whose behavior will be affected by a given policy.

4. Review of Policy by the Regional Committee on Bioethics

A. Adequate representation of the views of stakeholders will be important. The expression of this priority will be determined by recommendations of the SOPS. The views of groups such as patients, special interest groups, and health-care providers will be needed but the amount, quality, and nature of their input must be suggested by the SOPS. We assume that the forum for presentation will be at a general meeting of the Regional Committee on Bioethics or over several meetings but not limited to this convention.

B. Open Discussion: Following presentation by the SOPS, a Co-Chair of the Committee on Bioethics or designee will lead an open discussion of the issues of policy suggestion. After time for viewpoints to be shared, and as needed, a preliminary vote (non-determining) may be held to decide the amount of consensus on the issue. Following the preliminary vote, or when the Co-Chair or designee decides this is needed, a second, consensus-building discussion will follow. At a suitable time, as consensus develops, a final determining vote will be taken. Final determination will be by simple majority vote. We recognize that for some policy issues, it is conceivable that a simple majority vote may be inadequate to allow implementation of a specific policy measure. We expect this point to be anticipated by the SOPS and discussed in advance with the Regional Committee on Bioethics. The SOPS should advise the general committee if a change from this procedure will be expected.

C. The SOPS, working with the Co-Chairs of the Regional Committee on Bioethics will determine a strategy to implement a policy that has been approved. This strategy may include sending this policy to the local medical center committee on bioethics for approval and review. Following approval, the policy would be forwarded to the local Medical Executive Committee for adoption. Variation in procedures may include that the medical center committee on bioethics may elect first to send the policy to departments or groups of stakeholders relevant to the policy acceptance before sending the policy to
the medical executive committee. Alternatively, the medical center committee on bioethics may see the latter function as the responsibility of the Medical Executive Committee. The best process may depend on the nature of the policy.

In addition, after a policy is approved by the Regional Committee on Bioethics, relevant stakeholders who have requested notification should be advised of the policy approval. For example, a revised, approved policy on resuscitative services should be sent to the Regional Critical Care Committee for improved implementation and adoption.

D. Policy revision: revisions to policies created at the Regional Committee on Bioethics should be revised by the Regional Committee on Bioethics. The ethical approaches approved in these policies should not be revised by a medical center’s Committee on Bioethics. When a policy is due for revision at a medical center, the chair of the medical center committee on bioethics or the clinical ethicist at that location should bring the need for review to a Co-Chair of the Regional Committee on Bioethics. Medical center ethics committees may make revisions to policy related to local workflow, logistics, and nomenclature or may provide further clarification of process in the local setting.
Regional Credentialing Committee
Revised May 03, 2017

The Regional Credentials Committee (RCC) is a subcommittee of the Southern California Quality Committee (SCQC). Its function is to improve patient care and safety through optimization of the credentialing and privileging processes while meeting all regulatory requirements. The RCC collaborates with the Regional Peer Review Oversight Committee (RPROC) and with members of each local Kaiser Foundation Hospital/Medical Center Credentials Committee and an as needed basis. The committee serves both as a decision making body and in an advisory role to the SCQC as defined below:

Decision making responsibilities for credentialing and privileging regionally, as follows:

a. Granting of Approval to Participate and Re-approval to Participate of affiliated, per diem, locum tenens, telemedicine, Allied Health Practitioners and all Providers to participate in the Kaiser Foundation Health Plan of the Southern California Region
b. Approval of privileging and proctoring processes
c. Review and Approval of delegated credentialing processes
d. Oversight and management of the credentialing and privileging data base
e. Oversight of local implementation of the credentialing and privileging policies and procedures.
f. Ongoing review and monitoring of sanctioned activities.
g. Oversight of the linkage with Regional Contracting and Clams Departments for the purpose of ensuring that Practitioners and Providers are credentialed, when appropriate, to see Health Plan members.
h. Oversight of Bylaws revision processes in conjunction with Accreditation, Regulation and Licensing
i. Analysis of reports from monthly oversight reviews.
j. Review of reports from RPROC and oversight of credentialing actions taken to ensure consistent standards across the Southern California program.

Advisory responsibility for credentialing and privileging regionally, as follows:

a. Review and revision of Credentialing and Privileging policies and procedures.
b. Development of educational programs to promote consistent implementation of consistent credentialing practices.
c. Promote consistency of credentialing practices and uniformity of privileging criteria across departments, hospitals and medical centers in the southern California program.
d. Escalate significant issues, trends, and variations to SCQC.
e. Promote sharing of learning across the southern California program
f. Support compliance with Kaiser Permanente Policies and Procedures
g. Support compliance with standards and regulations referable to credentialing and privileging, including the Department of Managed Health Care, The Joint Commission, NCQA, The Center for Medicare and Medicaid Services, MDQR, and the California Department of Public Health.
**Reporting Structure:** The Regional Credentials Committee is a subcommittee of the Southern California Quality Committee and reports to SCQC at least quarterly. The committee maintains ongoing communication with the local medical center Credentials Committees and Medical Staff Departments, providing feedback on an ongoing basis.

**Meeting Process:** The RCC will meet monthly, no fewer than ten times per year. A quorum is a simple majority of members when at least 50% of the members’ present are physicians. RCC minutes will be maintained.

**Annual Evaluation:** The RCC will review its charter annually and review as needed.

**Confidentiality:** The RCC members, consultants, staff and participants shall maintain confidentiality of information.

**Membership:** Membership shall consist of physicians and non-physicians representing Kaiser Foundation Hospitals, Kaiser Foundation Health Plan, Inc., and Southern California Permanente Medical Group. The committee members will have expertise in, but not limited to, credentialing, privileging, quality, risk management, accreditation, and licensing. The Committee will be chaired by an SCPMG physician who is a member of SCQC and reports to that committee.

Members:
- 1. Medical Center Physician members who either chair the Medical Center Credentials Committee or serve as a member of the local committee.
- 2. Director of Regional Credentialing.
- 3. Regional Practice Specialist, Quality and Peer Review, RPROC Co-Chair*
- 4. Manager, SCAL Survey Readiness Unit, Health Plan Regulatory Services*
- 5. Representative SCPMG Contracting
- 6. KFH Executive Director or equivalent*
- 7. KFH Medical Staff Office Manager*
- 8. Chief Integration Officer, Quality Department
- 9. Assistant Medical Director, Permanente Human Resources
- 10. Assistant Medical Director, Quality, Risk Management & Patient Safety SCAL (ad hoc)
- 11. Representative from SCPMG Legal Department (ad hoc)
- 12. Representative from KFH Legal Department (ad hoc)

* Health Plan Representation
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<tr>
<th><strong>Team Name:</strong></th>
<th><strong>Southern California CRC/Diversity &amp; Inclusion Council (SCDC)</strong></th>
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</table>
| **Executive Sponsors:** | Julie K Miller-Phipps, President, Southern California Region and Ed Ellison, MD  
Role: Actively support the work of the Diversity Council by assuming ultimate accountability for their work, sanctioning work outcomes, setting direction in consultation with the Joint Operations Group (JOG), communicating regularly, removing barriers, monitoring work outcomes and openly supporting the Council’s success. |
| **JOG Sponsors:** | John Yamamoto (KFHP/H) and Marilyn Owsley (SCPMG)  
Role: Accountable for successful implementation of the Diversity Council initiatives, seek the executive sponsors’ assistance to remove barriers and monitor the progress of the team’s work. |
| **Executive Team** | Tracy Fietz, Marc Klau, MD, Michael Morris, MD, Michael Kanter, MD  
Role: Collaborate with Co-Chairs in developing the strategic plan, initiatives and implementation strategies. |
| **Co-Chairpersons:** | Shari Chevez, MD and Madalynne Wilkes-Grundy, MD, (CRC Physician Leads), Georgina Garcia, Chief Operating Officer  
Role: Set and maintain the direction of the Council by planning the agenda, facilitating the meetings and maintain communication with the executive and JOG sponsors and Executive Team. In addition, the co-chairs will provide guidance to the Diversity Program Manager and Culturally Responsive Care Sr. Consultant through the work of this Council, respectively. |
| **Administrative Leads:** | Rachel Sandoval, Diversity & Inclusion (D&I), Director  
Role: In collaboration with Co-Chairs, provide leadership to Kaiser Permanente Southern California Region on the Diversity& Inclusion program with joint accountability to Kaiser Foundation Health Plan/Hospital and Southern California Permanente Medical Group. Work in partnership with the Council Co-Chairs to ensure the vision and the work of the Council is carried out by responsible parties in the organization. CRC/Diversity & Inclusion program planning, development, and management. Provide staff support to the Council to ensure well planned, timely Council meetings and follow-up (agenda, agreements, etc.).  
Lakiesha Tidwell, Culturally Responsive Care (CRC), Managerial Consultant  
Role: In collaboration with Co-Chairs, provide leadership to Kaiser Permanente Southern California Region on the Culturally Responsive Care program. Work in partnership with the CRC Physician Leaders of each medical center to ensure the vision and the work of the team is carried out by responsible parties in the organization. CRC program planning, development, and management. Provide staff support to the Council to ensure well planned, timely Council meetings and follow-up (agenda, agreements, etc.). |
<table>
<thead>
<tr>
<th><strong>Leads</strong></th>
<th><strong>Location</strong></th>
<th><strong>Name</strong></th>
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<tr>
<td>Riverside</td>
<td>Shari Chevez, MD</td>
<td>Co-Chair, Physician Lead CRC</td>
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<td>Madalyne Wilkes-Grundy, MD</td>
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<td>Fontana</td>
<td>Georgina Garcia, RN</td>
<td>SCDC Co-Chair, Executive Director, RN, West Los Angeles Medical Center</td>
<td>Chief Operating Officer</td>
<td>323-648-1273 main 8-390-1273 tie line</td>
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<tr>
<td>Regional Offices</td>
<td>Rachel Sandoval</td>
<td>Director, Diversity &amp; Inclusion</td>
<td>SCAL D&amp;I Program</td>
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<tr>
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<td>Tracy Fietz</td>
<td>Medical Group Administrator</td>
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<tr>
<td>Woodland Hills</td>
<td>Shirley Suda, MD</td>
<td>Area Medical Director, MD</td>
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<td>Regional Offices</td>
<td>Michael Morris, MD</td>
<td>Regional Medical Director, Services &amp; Access, MD</td>
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<td>Regional Offices</td>
<td>Michael Kanter, MD</td>
<td>Medical Director of Quality and Clinical Analysis, MD</td>
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<td>Regional Offices</td>
<td>Marc Klau, MD</td>
<td>Head &amp; Neck, MD</td>
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<th><strong>Medical Center Members:</strong></th>
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<td>Antelope Valley</td>
<td>David Bronstein, MD</td>
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<td>Sandy Peterson, AMGA</td>
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<tr>
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<td>Kimberly Funk</td>
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<tr>
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<td>Courtney Hines</td>
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<td>Baldwin Park</td>
<td>Maria Carrasco, MD</td>
<td>Family Medicine, MD</td>
<td>Leslie Tittle, MD, AAMD</td>
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<td>Yolanda Padilla</td>
<td>Manager of Cultural &amp; Linguistic Services, ADA Coordinator</td>
<td>Michele Robinson, AMGA</td>
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<td>Downey</td>
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<td>Vanessa Sanchez</td>
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<td>Kern</td>
<td>Michelle Quiogue, MD</td>
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<td>Brian Floisand</td>
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<td>Afif El-Hasan, MD</td>
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<td>Panorama City</td>
<td>Sharon Okonkwo-Holmes, MD</td>
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<td>Christina Fam</td>
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<td>Shari Chevez, MD</td>
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<td>Joanne Witkowski, AAMD</td>
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<td>Callisha Bell</td>
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<td>Frank Martinez</td>
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<td>Connie Zaragoza</td>
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<tr>
<td>South Bay</td>
<td>Uyi Brown, MD</td>
<td>Family Medicine, MD</td>
<td>Ozzie Martinez, AMGA</td>
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<td></td>
<td>Juanita Murphy</td>
<td>Department Administrator, Reception Services, Director of Diversity Programs / Multicultural Business Resource Group</td>
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<td>Barbara Kennedy</td>
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<td>Mesia Polar</td>
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<td>Cristina M Aguilar</td>
<td>Project Manager</td>
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### Regional Members:

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<tr>
<td>Walnut Center</td>
<td>Kimberly Cyrus</td>
<td>Regional Diversity Consultant</td>
<td>SCAL Diversity &amp; Inclusion Department</td>
<td>626-405-4131 main 8-335-4131 tie line</td>
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<tr>
<td>Walnut Center</td>
<td>Melany G delRosario</td>
<td>Regional Diversity Consultant</td>
<td>SCAL Diversity &amp; Inclusion Department</td>
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<tr>
<td>Walnut Center</td>
<td>Christina Buendia</td>
<td>Regional Diversity Consultant / Multicultural Business Resource Group</td>
<td>SCAL Diversity &amp; Inclusion Department</td>
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<tr>
<td>Walnut Center</td>
<td>Anna Khachikyan</td>
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<td>Wil Villa</td>
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<td>Burbank</td>
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<td>Kathy Dower, RN</td>
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<td>Walnut Center</td>
<td>Gwendolyn Leake-Isaacs</td>
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<td>Walnut Center</td>
<td>Ruth Counts</td>
<td>Director, AR&amp;L</td>
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<td>Walnut Center</td>
<td>Vicki A Enriquez</td>
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<td>Walnut Center</td>
<td>Karen Coleman</td>
<td>Research Scientist, Research and Development</td>
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<td>Walnut Center</td>
<td>Janet Torres-Wun</td>
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<td>Walnut Center</td>
<td>Maryanne Malzone-Miller</td>
<td>Senior Director, Human Resources</td>
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<td>Walnut Center</td>
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<td>Carolyn Tornero</td>
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<td>Robert Hamilton</td>
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<td>Lucia Soh</td>
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<td>VP Regional Patient Care Services</td>
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<td>Angela Coron</td>
<td>Managing Director, Community Benefit</td>
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**Context:**
Kaiser Permanente recognizes the importance of diversity and cultural responsiveness in the quality and effectiveness of healthcare delivery. In its position as a leader in Southern California in delivery of responsive and culturally competent care, Kaiser Permanente seeks to appeal to the diverse workforce population, current & potential membership pool and the communities that we serve. The Southern California Diversity Advisory Council provides expertise and guidance to leadership on strategies that are culturally responsive to the needs of the population it serves as an employer, provider of quality care and community leader.

**Vision:**
Inspire the people of Kaiser Permanente in the Southern California region to embrace the rich diversity of our membership, employees, and physicians by promoting, supporting and recognizing excellence in cultural competence to maximize the health of our members and the local communities we serve.

**Mission:**
To advise the Joint Operations Group (JOG) and Executive Team and advocate for the achievement of strategic objectives related to:
- The reduction of health care disparities and cultural inequities for KP patients, members, and the communities served.
- The education and development of a work force that is prepared to provide culturally responsive care and is knowledgeable of diverse issues
- Strengthening community linkages to reduce cultural inequities in care.
- The creation and maintenance of a diverse, knowledgeable and responsive workforce (physicians and staff).
- The promotion of an open and inclusive work environment where the unique differences of each physician and staff are understood, valued, respected and utilized.
- Improving access to healthcare and KP systems.
- Providing direction on how to embed culturally responsive care/diversity into our existing organizational structure (i.e., our quality of care, service, marketing, recruitment, membership and education, etc.)
- Promote greater diversity and ensure cultural responsiveness at all levels of leadership.

**Role:**
- Make recommendations to the JOG, Executive Sponsors and the Executive Team on vision, strategy development, tactics, and required resources needed to implement appropriate CRC and Diversity programs
- Advise and educate relevant regional/local departments and medical center councils with the goal of developing and deploying regional programs that support the strategic objectives of the CRC and Diversity mission
- Ensure the organization is regulatory compliant with Cultural and Linguistically Appropriate Services (CLAS) standards
- Ensure recruitment and hiring practices support the development of a diverse and/or linguistically proficient staff and practice
- Align the diversity work with the National Diversity Council, the Regional Labor Management Council, the Human Resources Executive Committee, the Regional CRC/Diversity Council and other regional committees and initiatives/projects as needed.
- Identify care and program delivery gaps and challenges, collect and disseminate best practices, and monitor progress of identified diversity and culturally responsive care initiatives as well as overall organizational performance relative to culturally responsive care delivery.
- Collaborate with the Medical Centers to communicate the work of the SCDC and provide expertise, advice and education.
- Communicate progress of initiatives, programs, and goals to the Executive Leadership and JOG Sponsors annually.
- Communicate progress of initiatives, programs, and goals, to staff and physicians
- Promote integration of CRC/Diversity into regional/local quality and service standards.
- Increase the visibility and celebrate the success of diversity and cultural responsiveness throughout the Region.
- Promote the visibility of Kaiser Permanente as a diverse and culturally responsive organization in the community.
- Annual review and monitoring of all CRC/Diversity programs
| **Deliverables:** | • Develop goals consistent with the regional focus on service, access, quality and the Diversity Value, and a work plan for achieving them.  
• Maintain current knowledge of diversity initiatives within the Southern California Region and other Regions through an ongoing relationship with the Medical Center Diversity Councils and the National Diversity Council for the purpose of promoting and recommending successful practices.  
• Endorse guidelines and provide consultation to meet regulatory standards, as they relate to the Culturally and Linguistically Appropriate Services (CLAS) standards and other Cultural and Linguistics (C&L) Regulatory/Compliance related items.  
• Identify tools to measure the effectiveness of Regional diversity and culturally responsive care initiatives and monitor them.  
• Annually review and revise the initiatives and tactics of the Southern California CRC/Diversity Council Strategy.  
• Develop and implement communication plan to staff and physicians.  
• Identify and communicate with appropriate leadership when there are resources required for the successful achievement of objectives; escalate as appropriate.  
• Regularly examine the diversity structure and membership to ensure and improve integration of efforts between Southern California Permanente Medical Group and Health Plan.  
• Track and Monitor, program metrics and advocate and/or implement change based on data. |
| **Metrics:** | *Please refer to SC CRCDC Strategic Plan* |
| **Team Principles:** | • This work is a priority.  
• Use a member-focused approach.  
• Maintain stakeholder involvement.  
• Member role is senatorial in nature representing a particular stakeholder group. |
| **Meeting Frequency:** | Once each quarter, to be re-examined periodically.  
Regional Chairs and D&I Director and Program Manager will meet monthly to ensure appropriate KFHP/H and SCPMG integration of efforts. |
1. **Mission**
Create a forum where patient members serve as advisors to improve quality of service and safety, enhance systems of care, and educate health care professionals and staff on the patients’ perception of their health care experience at KPSC facilities.

2. **Purpose**
The KPSC Regional Member Advisory Council (RMAC) will bring together a diverse group of the KPSC Member Community to discuss appropriate healthcare issues, to provide input, and to recommend ways to improve our processes of care.
The Council will:
- Identify and advise KP on regional issues.
- Share effective practices from local Patient Advisory Councils (PACs) and other sources that impact members.
- Partner with KP regional groups addressing the same or similar issues.
- Encourage KP leaders to invite and respond to requests for patient advisors to participate in meetings, conferences, workgroups and performance improvement projects.

3. **Responsibilities and Group Norms**

**Responsibilities**
- Represent the perspective of Kaiser Permanente Southern California patients and families.
- Share appropriate RMAC information with local PAC.
- Adhere to Group Norms. Repeated failure to adhere to group norms may result in removal from the Council

**Group Norms**
- Arrive on time at meetings.
- Place cell phones on mute.
- Treat each other with dignity and respect.
- Be willing to listen to differing points of view; value these differences.
- Give freely of ideas and experiences without dominating the conversation.
- One person speaks at a time; no cross talk.
- Wait to be acknowledged by one of the co-chairs before speaking.
- Personal information shared at the RMAC meeting stays in the RMAC meeting.
- Allow all members to share issues without fear of ridicule or criticism in order to create a safe environment.
4. Sponsors
Group Sponsors:
Kaiser Permanente Southern California Quality Committee (SCQC)
• RMAC is a subcommittee of Southern California Quality Committee

Individual Sponsors:
• KPSC Regional President, Ex Officio
• Southern California Permanente Medical Group Medical Director, Ex Officio
• Southern California Permanente Medical Group Assistant Medical Director for Quality and Patient Safety
• Southern California Kaiser Foundation Health Plan/Hospital Senior Vice President and Chief Operating Officer for Quality, Risk Management, Patient Care Services, Clinical Operations and Support

5. Confidentiality
Council members will:
• Maintain appropriate and confidential handling of personal information; first names will be used when referring to family and friends in meetings.
• Refrain from speaking for KP or the RMAC in outside organizations without appropriate leadership approval.
• Maintain current confidentiality agreement. (Agreement to participate should be on file for every advisor.)

6. Annual Accomplishments/Goals
The council will:
• Develop an annual report that summarizes accomplishments and future directions / opportunities for improvement to be drafted by RMAC Co-Chairs.
• Provide an annual report to SCQC.

7. Amendment to Charter
This charter is a living document that will be changed, modified or otherwise amended as required to guide the Council, per the established decision making process of the council as stated in Policies and Procedures.
Regional Patient Advisory Council (RPAC)
Kaiser Permanente Regional Office
Charter

Mission
To improve quality of service and safety, enhance systems of care, and educate health care professionals and staff on the patients’ perception of their health care experience at KPSC facilities.

Purpose
The KPSC Regional Patient Advisory Council (RPAC) will bring together a diverse group of the KPSC Member Community to discuss appropriate healthcare issues, to provide input, and to recommend ways to improve our processes of care.

The Council will:
- Identify and advise KP on regional issues.
- Share effective practices from local Patient Advisory Councils (PACs) and other sources that impact members.
- Partner with KP regional groups addressing the same or similar issues.
- Encourage KP leaders to invite and respond to requests for patient advisors to participate in meetings, conferences, workgroups and performance improvement projects.

I. Sponsors
   Group Sponsors:
   - Kaiser Permanente Southern California Quality Committee (SCQC)
   - RPAC is a subcommittee of Southern California Quality Committee

II. Individual Sponsors:
KPSC Regional President, Ex Officio
   - Southern California Permanente Medical Group Medical Director, Ex Officio
   - Southern California Permanente Medical Group Assistant Medical Director for Quality and Patient Safety
   - Southern California Kaiser Foundation Health Plan/Hospital Senior Vice President and Chief Operating Officer for Quality, Risk Management, Patient Care Services, Clinical Operations and Support

III. Confidentiality
Council members will:
   - Maintain appropriate and confidential handling of personal information; first names will be used when referring to family and friends in meetings.
Regional Patient Advisory Council (RPAC)
Kaiser Permanente Regional Office
Charter

- Refrain from speaking for KP or the RPAC in outside organizations without appropriate leadership approval.
- Maintain current confidentiality agreement. (Agreement to participate should be on file for every advisor.)

IV. Annual Accomplishments/Goals
The council will:
- Develop an annual report that summarizes accomplishments and future directions / opportunities for improvement to be drafted by RPAC Co-Chairs.
- Provide an annual report to SCQC.

V. Amendment to Charter
This charter is a living document that will be changed, modified or otherwise amended as required to guide the Council, per the established decision making process of the council as stated in Policies and Procedures.

VI. Responsibilities and Group Norms
Responsibilities
- Represent the perspective of Kaiser Permanente Southern California patients and families.
- Share appropriate RPAC information with local PAC.
- Adhere to Group Norms. Repeated failure to adhere to group norms may result in removal from the Council.

Group Norms
1. Arrive on time at meetings.
2. Place cell phones on mute.
3. Treat each other with dignity and respect.
4. Be willing to listen to differing points of view; value these differences.
5. Give freely of ideas and experiences without dominating the conversation.
6. One person speaks at a time; no cross talk.
7. Wait to be acknowledged by one of the co-chairs before speaking.
8. Personal information shared at the RPAC meeting stays in the RPAC meeting.
9. Allow all members to share issues without fear of ridicule or criticism in order to create a safe environment.
The Regional Peer Review Oversight Committee (RPROC) is a subcommittee of the Southern California Quality Committee (SCQC). Its function is to improve patient care and safety through optimization of the peer and department quality review processes while meeting all regulatory requirements. The committee serves both as a decision making body and in an advisory role to the SCQC as defined below. The RPROC collaborates with the Regional Credentials Committee (RCC), Regional Quality Improvement (RQI) members and the Medical Center Quality Leaders to optimize and enhance the SCAL peer and department review programs.

General Responsibilities for peer and department review regionally, as follows:

a. Communicate issues and provide feedback regarding facility performance to medical centers and leadership.
b. Report routine status and recommendations to SCQC.
c. Escalate significant issues, trends, and variation to SCQC, including regular and ad hoc reporting.
d. Collaborate with the Medical Centers & the RCC regarding Focused Practitioner Review (FPR), P2 Scores, and Practice Improvement Plans (PIPs) for practitioners with activity at multiple medical centers.
e. Identify, prioritize, and facilitate resolution of quality of care trends identified through the Peer and Department Review Initiative.
f. Promote best practices within a just culture environment while ensuring competent care.
g. Oversight of practitioners where performance is below acceptable standards of care and/or conduct that is likely to be detrimental to patient safety, or the provision of quality patient care is identified through the ‘Member Concern Focused Practitioner Review’ reporting process, or significant departure from accepted practice (Focused Professional Practice Evaluation).

Decision making responsibilities for peer and department review regionally, as follows:

a. Oversight of selected quality improvement processes including Peer Review and Focused Practitioner Review.
b. Monitoring of peer and department review activities, to include aggregate reports of Peer Review, Department Review, and Systems Review.
c. Based on performance of above, request and track Corrective Action Plans (CAPs)
d. Monitor and evaluate effectiveness of CAPs, escalate and report to SCQC.
e. Review medical center committee minutes (FPR or Credentials & Privileges) to provide oversight of FPR process.

Advisory responsibility for peer review regionally, as follows:

a. Promote sharing of learnings concerning system improvements resulting from the peer review process throughout the Southern California Region.
b. Identify and promote uniformity and efficiencies of processes for Peer and Department Review.
c. Review and revise all Peer/Department Review and Focused Practitioner Review policies and procedures.
d. Develop annual goals for Peer and Department Review and the corresponding processes.
KAIser PErMANENtE SOUtHERN CALIFoRNIA
Regional Peer review Oversight Committee (RPROC)
CHARTER
2016

e. Escalate practices not consistent with KP Policies & Procedures and regulatory standards related to physician performance review, to include such regulatory bodies as DMHC, The Joint Commission, and NCQA.
f. Promote alignment of peer and system review findings to improve the care provided to all KFHP Members.

Reporting Structure: The Regional Peer Review Oversight Committee is a subcommittee of the Southern California Quality Committee and reports to SCQC at least semi-annually. The committee maintains a collaborative relationship and ongoing communication with the local medical center quality departments/leaders responsible for peer and department review processes.

Meeting Process
The RPROC will meet monthly, no fewer than ten times a year. A quorum is a simple majority of the members. When a quorum is present, a majority vote, that is a majority of the votes cast, is sufficient for the adoption of the motion at hand. RPROC minutes will be maintained (how).

Annual Evaluation:
The RPROC will review its Committee Charter annually and revise as needed.

Confidentiality:
The RPROC members, consultants, staff and participants shall maintain confidentiality of information.

Membership:
Membership shall consist of physicians and non-physicians representing Kaiser Foundation Hospitals, Kaiser Foundation Health Plan, Inc., and Southern California Permanente Medical Group. The committee members will have expertise in, but not limited to, quality, risk management, credentials, privileges, accreditation, and licensing. The Medical Center Physician Quality Leaders and Quality Directors will be ex officio members of the RPROC. The Committee will be co-chaired by a KFHP representative and an SCPMG physician.

Co-Chairs:
- Physician Quality Leader
- Regional Practice Leader, SCAL Quality & Regulatory Services

Members:
1. Executive Director, Quality/Risk/Regulatory/Safety
2. Managing Director Health Plan Quality/Regulatory
3. Regional Group Leader: MIDAS + Statit
4. Senior Consultant, Quality Operations
5. Quality Coordinator
6. Physician Quality Leaders (minimum of 2)
7. Medical Center Manager, Medical/Professional Staff Services
8. Quality Director (current chair of the Quality Directors Workgroup)
9. Quality Director (future chair of the Quality Directors Workgroup)
10. Medical Center Assistant Administrator for Quality & Risk Management
KAISER PERMANENTE SOUTHERN CALIFORNIA
Regional Peer Review Oversight Committee (RPROC)
CHARTER
2016

Ad Hoc Members (Sponsors):
SCAL Assistant Medical Director, Quality and Risk Management
SCAL Medical Director Quality and Risk Management
Vice President, Quality and Regulatory Services

Ex Officio Members:
SCAL Physician Quality Leaders
SCAL Quality Directors
# Charter

<table>
<thead>
<tr>
<th>Vision</th>
<th>The vision of the SCAL Pharmacy Nursing Committee is to improve medication processes and systems that are influenced by pharmacy and nursing through collaboration.</th>
</tr>
</thead>
</table>
| Goals | 1. Utilize a collaborative strategy for the development, implementation, monitoring, maintenance and evaluation of safe medication use systems and processes to support pharmacy and nursing operations  
2. Develop and implement regional medication use policies, procedures and reports to support operations between pharmacy and nursing.  
3. Assess, evaluate and reassess and/or initiate agreed upon medication use systems and processes (e.g. automated dispensing devices, barcode medication administration, etc.)  
4. Provide oversight of the use of “smart” infusion pumps  
5. Design standardized drug delivery systems and processes.  
6. Oversight for development and implementation of appropriate education plans related to medication use systems/processes.  
7. Communicate committee decisions, policies and procedures, reports, and recommendations to all key stakeholders, and assess the effectiveness of these elements.  
8. Align efforts in Southern California with other KP regions and Program Offices. |
| Guidelines | • Follow legal, regulatory, and compliance standards and requirements.  
• Optimize functional groups and processes where possible.  
• Embrace the ideology of the Labor Management Partnership.  
• Adopt a systems perspective to recognize and address all necessary linkages between pharmacy and nursing operations in the inpatient and ambulatory care settings  
• Focus on quality of care and patient safety |
| Benefits | • Design safe, effective medication use systems by leveraging the expertise of subject matter experts within regional/medical center pharmacy and nursing operations, and the coalition of Kaiser Permanente Unions. Improve the safe use of smart infusion devices.  
• Improve the effectiveness of drug administration systems.  
• Improve the safe use of High Alert Medications. |
**Structure**

<table>
<thead>
<tr>
<th>Organization</th>
<th>The Pharmacy Nursing Committee is a sub-committee of the Southern California Quality Committee (SCQC).</th>
</tr>
</thead>
</table>
| Participants | • Regional Patient Care Services leadership  
• Regional Pharmacy Operations leadership  
• Regional Pharmacy Quality and Medication Safety  
• UNAC/UHCP Leadership  
• Quality, Patient Safety and Risk Management leadership  
• Medical Center Nurse Executive or Designee  
• Medical Center Director of Nursing Education  
• Medical Center Area Pharmacy Director, Inpatient Pharmacy Director, Inpatient Pharmacy Supervisor  
• Medical Center SCPMG Ambulatory Care Practice Coordinator  
• Regional SCPMG Ambulatory Practice leadership  
• ad hoc: Assistant Regional Medical Director, Quality and Patient Safety  
• ad hoc: Clinical Technology leadership |
SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP
Regional Radiation Safety Committee

CHARTER

Purpose

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

AUTHORITY AND SCOPE

The RRSC provides quality oversight of the safe and compliant use of all sources of ionizing radiation, ensures verification that only qualified personnel use those sources, oversees the radiation dosimetry program and oversees/supports the Regional Radiation Safety Officer (RSO) in the role of assuring compliance with pertinent laws, regulations and conditions of applicable radioactive materials licenses.

REPORTING STRUCTURE

RRSC is a sub-committee of the Southern California Quality Committee (SCQC) and committee activity is provided to SCQC by the Regional Radiation Safety Officer (RSO).

ROLES & RESPONSIBILITIES

1. Review and approve all new and renewal applications for non-human use of radioactivity.
2. Monitor all uses and users of ionizing radiation by:
   a. Identifying uses that require modification/correction/additional oversight;
   b. Direct corrective action as necessary;
   c. Follow up to ensure that corrective measures associated with radiation-related incidents have been implemented; and
   d. Verify implementation and monitor results for compliance.
3. Establish regional policies necessary to ensure compliance with applicable laws, regulations, conditions of radioactive materials licenses and accepted principles of good radiation safety practice.
4. Review the radiation dosimetry program on a regular basis.
5. Assigns/oversees the duties/responsibilities of the Regional RSO.
MEETING PROCESS

The committee meets four times a year, as required by conditions of our various Radioactive Materials Licenses, issued by the Radiologic Health Branch, California Department of Public Health. Ad hoc meetings may be called by the Regional RSO as needed to address serious radiation safety/regulatory issues that must be resolved before the next quarterly meeting.

MEMBERSHIP

Membership represents stakeholders who will have valuable input on the oversight of the radiation safety program throughout Southern California:

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

Permanent membership:
- A physician representing radiology and nuclear medicine;
- Regional Director, Diagnostic Imaging Services and Medical Imaging Technology and Informatics (MITI);
- Regional Director, Accreditation, Regulation and Licensing (AR&L); and
- Regional RSO

Ad-hoc membership:
- Regional Director, Risk Management

Reviewed: March 3, 2014 by RRSC
KAISER PERMANENTE SOUTHERN CALIFORNIA (KPSC)
REGIONAL TRANSPLANT QUALITY COMMITTEE (RTQC) CHARTER

PURPOSE:
The KPSC Regional Transplant Quality Committee (RTQC) supports the KFHP Board of Directors Quality and Health Improvement Committee (QHIC) in fulfilling its responsibilities for quality oversight of KPSC transplant care and services. The RTQC facilitates communication and collaboration among the various transplant quality entities of the organization at the local, regional and national levels and partners with the Kaiser Permanente National Transplant Services (NTS) Quality Improvement and the SCAL Regional Renal Quality Committee in quality improvement activities.

STRUCTURE/ORGANIZATION:
The RTQC formally reports to the KFHP Board of Directors Quality and Health Improvement Committee (QHIC) through the Southern California Quality Committee (SCQC). Representatives of NTS Quality Improvement and SCQC are members of the RTQC. Periodic written and verbal reports are provided to the SCQC and NTS Advisory Council. Similarly, reports are provided to the Los Angeles Medical Center (LAMC) Quality Committee for issues that relate to LAMC as the regional tertiary center for most transplant services and to the renal business group (RBG) for issues that relate to adult kidney transplantation.

The RTQC meets at least three times per year. A quorum will be satisfied by the attendance of 50% or greater of physician members. Decisions will be made by a simple majority of voting members. The RTQC meetings will be held consistent with processes that assure the confidentiality of data and information in accordance with organizational compliance guidelines.

COMPOSITION:
The KPSC Regional Transplant Quality Committee is composed of SCPMG physicians, Regional Health Plan Quality, Regional Medical Group Quality, NTS, and LAMC Medical Group and Hospital representatives. The sponsors are the Regional Health Plan Executive Director for Quality and the Assistant Regional Medical Director for Quality.

Majority of membership shall be comprised of SCPMG physicians and include:
- Chair – Regional Transplant Medical Director
- NTS Quality Improvement Medical Director
- LAMC Assistant Area Medical Director for Quality, Risk, Patient Safety and Regulatory Services
- Physician representatives from each organ transplant committee
  - Adult and Pediatric Bone Marrow
  - Adult and Pediatric Heart
  - Adult and Pediatric Kidney
Adult Liver and Pediatric Liver/Intestine
Adult Lung

- NTS Executive Director
- NTS Director California Hubs
- Director of the Renal Business Group (RBG) or designee
- Renal Business Group Quality Consultant
- Assistant Medical Group Administrator, LAMC or designee
- LAMC Hospital Representative or designee
- KPSC Regional Quality Representatives

The NTS Quality Improvement Senior Manager will serve in a consultative capacity.

**ROLES AND RESPONSIBILITIES:**

1. The primary responsibility of the RTQC is to provide quality oversight of the KPSC transplant programs. RTQC will:
   - monitor and trend the results of quality cases at local medical centers
   - advocate for and direct needed system improvements
   - review and evaluate the results of quality improvement activities
   - facilitate communication and collaboration across entities involved in transplant care
   - encourage sharing of best practices across transplant services.
   - annual review of patient and graft survival and comparison with national benchmarks to identify areas for improvement.

2. RTQC will partner with the NTS and the RBG to validate and investigate quality issues either within KPSC or at the external transplant centers of excellence and promote appropriate performance improvement measures.

3. Each member of the RTQC is expected to contribute his/her expertise and perspective according to his/her area of clinical and or administrative practice.

4. As an RTQC member, he/she reviews quality reports, supports the achievement of transplant specific goals and initiatives and makes recommendations for the overall improvement in the clinical care and management of the transplant population.

**QUALITY PROGRAM OBJECTIVES:**

The RTQC oversees the quality of care and service with the following objectives:

1. *Right Patient, Right time*
   - Timely identification and referral of appropriate candidates
   - Appropriate patient selection utilizing KP NTS selection criteria and evidence based pre-transplant guidelines

2. *Optimizing access to transplantation*
   - Track referral processes including timeliness of initial evaluation, pre-transplant work-up, referral to transplant COE and time to transplant
   - Coordination of efforts across specialty groups and internal and external transplant teams to streamline pre-transplant work-up process
3. **Keeping patients alive till the transplant**
   - Review all deaths pre BMT and death on the waitlist for solid organ transplantation
   - Track and monitor KP’s O/E waitlist mortality

4. **Surviving transplantation**
   - Track and monitor untoward events (sentinel/PCE/near miss/complications) within KPSC and at the COEs
   - Track and monitor re-transplant rate

5. **Optimizing health post-transplant**
   - Monitor post-transplant patient and graft survival (KP specific and COE)
   - Monitor and track long term post-transplant health outcomes

6. **Coordination and case management**
   - Facilitate communication between KPSC medical centers, KPSC transplant services, NTS’s Southern California hub, and COEs
   - Monitoring of care delivery in various venues (ED, urgent care, primary care, inpatient)
   - Monitoring member complaints
   - Conducting satisfaction surveys

**ANNUAL GOALS AND CHARTER:**

Annual goals will be established in January of each year after review by members of the committee. The RTQC charter will be reviewed annually and revised as necessary.
Kaiser Permanente
Southern California Executive Resource Committee (SCERSC) Charter

Scope:
This Charter sets out the functions, authorities, duties and responsibilities of the Southern California Executive Resource Committee for Kaiser Permanente – SCAL.

Mission:
Provide a forum for senior executives to work on and oversee programs/projects that span across SCPMG and KFH and require the presence of more than 1 executive from each KP entity.

Purpose of the SCERSC is to:

- Review operational practices and provide recommendations
- Oversee the alignment of all committees reporting to SCERSC and monitor implementation and performance within the strategy and assist in the evaluation of performances.
- Support continuous efforts, Monitor and Identify performance and take appropriate actions to improve quality/affordability activities.
- Establish financial and risk controls, as well as a financial plan and principles necessary for management.
- Establish oversight by identifying and addressing strategic opportunities to establish and maintain the Southern California Region’s healthcare leadership
- Ensure that priorities are aligned and integrated with other key organizational strategic priority areas of work
- Prioritize and create accountability deadlines: Define and review strategy for SCERSC on an on-going basis, setting strategic priorities.

Reporting Structure:
SCERSC is a subcommittee of Kaiser Permanente’s Southern California Quality Council (SCQC). The Southern California Quality Council reports its activities and functions to the Kaiser Foundation Health Plan and Hospitals, Inc., Boards of Directors.

Meeting Process:
SCERSC will meet monthly, for no less than ten months of the year with the assistance of the Senior Vice President of Operations at a time and place determined by the Project Manager. Additional meetings will be planned as required on approval of the committee. Membership includes representatives from KFH, KFHP, and SCPMG. The quorum is a simple majority of the members.
SCERSC action items and decisions are documented in minutes of the meetings proceedings by the Project Manager.

KFH and SCPMG Members approves the agenda of each meeting. Members may submit to the Chairman items to be discussed in the meeting.

Liaison delegates are invited to all SCERSC meetings if SCERSC members are not present.
SCERSC SCAL Key Strategic Initiatives

<table>
<thead>
<tr>
<th>Topic</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>IQM – Inpatient Quality Management</td>
<td>Monthly</td>
</tr>
<tr>
<td>OMEC – Outside Medical</td>
<td>Bi-Annually</td>
</tr>
<tr>
<td>Winter Planning</td>
<td>April and September</td>
</tr>
<tr>
<td>KP Reconnect (Readmissions)</td>
<td>Summer</td>
</tr>
<tr>
<td>SNF Strategy</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Home Health</td>
<td>Quarterly</td>
</tr>
<tr>
<td>PUAT – Product Utilization</td>
<td>Bi-Annually</td>
</tr>
<tr>
<td>CCQM – Continuing Care Quality Management</td>
<td>Quarterly</td>
</tr>
<tr>
<td>BHQM – Behavioral Health Quality Management</td>
<td>Bi-Annually</td>
</tr>
</tbody>
</table>

SCERSC Membership: The committee will be compromised of up to eleven (11) members.

<table>
<thead>
<tr>
<th>MEMBERS</th>
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<tbody>
<tr>
<td>WILLIAM CASWELL</td>
</tr>
<tr>
<td>Senior Vice President of Operations, KFH, Region</td>
</tr>
<tr>
<td>TODD SACHS, MD</td>
</tr>
<tr>
<td>Medical Director of Operations, SCPMG, Region</td>
</tr>
<tr>
<td>ANNIE RUSSELL, RN</td>
</tr>
<tr>
<td>Chief Operating Officer, SCPMG, Region</td>
</tr>
<tr>
<td>GERALD McCALL</td>
</tr>
<tr>
<td>Senior Vice President of Operations, KFH, Region</td>
</tr>
<tr>
<td>MICHAEL KANTER, MD</td>
</tr>
<tr>
<td>Medical Director of Quality and Clinical Analysis, SCPMG, Region</td>
</tr>
<tr>
<td>NIRAV SHAH, MD</td>
</tr>
<tr>
<td>Senior Vice President, Chief Operating Office, Clinical Operations, KFH, Region</td>
</tr>
<tr>
<td>GEORGE DISALVO</td>
</tr>
<tr>
<td>Chief Financial Officer, KFH, Region</td>
</tr>
<tr>
<td>CINDI JOHNSON</td>
</tr>
<tr>
<td>Chief Officer, Quality and Systems of Care, SCPMG, Region</td>
</tr>
<tr>
<td>JOHN BROOKEY, MD</td>
</tr>
<tr>
<td>Assistant Medical Director SCPMG Quality, Risk Management, Patient Safety</td>
</tr>
<tr>
<td>Health Plan Physician Advisor</td>
</tr>
<tr>
<td>KATI TRAUNWEISER</td>
</tr>
<tr>
<td>Vice President, - Quality and Regulatory Services, Region</td>
</tr>
<tr>
<td>JANN DORMAN</td>
</tr>
<tr>
<td>Vice President, Clinical Operations Support, Outside Medical &amp; Continuing Care, Region</td>
</tr>
</tbody>
</table>

Responsibilities:
The committee shall conduct an annual performance evaluation of the committee and annually evaluate the adequacy of its Charter

Confidentiality:
All SCERSC minutes, reports, recommendations, memoranda, and documented actions are considered working documents and are kept confidential. They are maintained in accordance with KFHP/SCPMG policies and procedures, and are privileged and protected.
All records are maintained in a manner that preserves their integrity in order to assure confidentiality is protected.

**Governance:**

- Establish and maintain governance and risk management (including charter and membership conditions)
- Oversight of management of risks and internal controls
- Safeguarding the integrity of the decision making process
# KAISER PERMANENTE HEALTH PLAN – SCAL REGION

## Utilization Management Steering Committee (UMSC)

### A Sub Committee of Southern California Quality Committee

#### 2017 Charter

| Authority | The President of Kaiser Foundation Health Plan (KFHP), Southern California Region, and the Executive Medical Director, Southern California Permanente Medical Group (SCPMG), are responsible for the implementation of the Kaiser Foundation Health Plan Utilization Management (UM) and Resource Management (RM) Program. The UM/RM Program scope extends across the continuum of care to ensure the provision of efficient and appropriate patient care services based on medical necessity and using healthcare resources efficiently and appropriately.  
Oversight responsibility for the KFHP UM/RM Program is assigned to the Southern California Quality Committee (SCQC). As a Sub-Committee of SCQC, the Utilization Management Steering Committee (UMSC), monitors and supports the KFHP UM Program.  
The Senior Vice President and Chief Operating Officer, Clinical Operations, KFHP and the Medical Director, Quality and Clinical Analysis, SCPMG, are members of SCQC and executive sponsors for the Utilization Management Steering Committee (UMSC). |
| Purpose | The UMSC oversees and supports the implementation, monitoring and evaluation, and continuous quality improvement of the KFHP UM Program to maintain an effective, organized UM program in compliance with applicable Federal and State laws/regulations and standards set forth by accrediting bodies. |
| Responsibilities and Scope of Activities | **UMSC has authority and responsibility for ensuring compliance with the following:**  
UM decision-making related to medically necessary treatment decisions is consistent with accepted standards of practice, to include severe mental illness, terminal illness, and benefit mandates such as Reconstructive and Transgender Surgery;  
Ensuring Mental Health parity in the development and application of UM policies and procedures;  
Oversight, monitoring, evaluation and implementation of processes by which the Plan conducts utilization review;  
Oversight and monitoring of the timely and accurate communication of UM decisions in accordance with state and federal requirements;  
Oversight and monitoring of the entities with delegated UM functions;  
Development and annual review of UM criteria with participation by actively practicing physicians in compliance with applicable state and federal requirements;  
Telephonic access for requests for authorization of health care services; |

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1 Section 1367.01(a), defines utilization review or utilization management functions as those processes “that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers.”
Appropriately licensed and credentialed physicians/healthcare professionals make UM decisions, based on medical necessity, to deny or modify services requested by providers of healthcare services for plan enrollees;

Oversight and monitoring of UM education and training to all relevant stakeholders;

No financial incentives exist that encourage UM decisions that result in denials or create barriers to care and services.

**UMSC conducts ongoing monitoring to identify potential UM practices within the KP delivery system to oversee the structure of the UM Program and to identify potential quality issues, including:**

Integration of UM into the KFHP Quality Improvement Program to ensure the effectiveness of the Utilization Management Program and to monitor compliance with established UM processes to include:

- evaluation of complaints and assessment for trends
- review of provider referral and specialist care patterns of practice
- review for potential over-under utilization of services
- implementation of performance improvement plans as needed
- mechanisms to communicate actions and results to key stakeholders
- monitor of measures of success related to performance improvement plans
- review and evaluation of other Health Plan committee proceedings

Develop, implement, and periodically review and revise UM policies and procedures in compliance with applicable federal and state requirements and accreditation standards.

Develop, implement, and annually review and update clinical criteria for UM decisions based on sound clinical evidence.

Periodic monitoring and oversight of the Utilization Management/Drug Utilization Review (DUR) program for Medicare Advantage (MA) and Prescription Drug Plans (PDP) in the SCAL region

**UMSC supports the effective implementation of the UM Program to include:**

- Removal of impediments to ensure an effective Utilization Management Program
- Foster optimal communication between all stakeholders regarding utilization management
- Charter performance improvement teams for specific high-priority utilization management issues/initiatives
- Make recommendations regarding resource allocation to ensure success of the Utilization Management program
- Develop and propose recommendations to the President of Kaiser Foundation Health Plan, Southern California Region, and the Southern California Quality Committee (SCQC) in support of and in compliance with all matters related to utilization management
- Coordinate, review and approve information communicated to or from the Southern California Quality Committee (SCQC) related to utilization management
### Membership

The membership of the Planning Group shall be approved annually by the Southern California Quality Committee.

The Voting Membership will include:

- Committee Chairperson(s)
  - Physician Advisors, KFHP
  - Regional Chief Administrative Officer, SCPMG
- Vice President, Value & Clinical Operations Support, SCAL Region, KFHP
- Executive Director, Utilization Management and Resource Stewardship, SCAL Region, KFH/HP
- Executive Director, Grievance Operations, California and Hawaii Member Services, KFHP
- Practice Leader, Regulatory Response, Health Plan Regulatory Services (HPRS), KFHP
- Director, Utilization Management, SCAL Region, KFH/HP
- Director, Case Coordination Center, SCAL Region, SCPMG
- Director, Survey Readiness Unit, Health Plan Regulatory Services, KFHP
- Physician Leader, Behavioral Health Care, SCAL Region, SCPMG
- Physician Leader, Utilization Management, SCAL Region, SCPMG
- Group Leader, Quality & Regulatory Services, SCAL Region, KFHP
- Coordinator, Autism & Developmental Disabilities, SCAL Region, SCPMG

### Confidentiality

All UMSC minutes, reports, recommendations, memoranda, and documented actions are confidential. They are maintained in accordance with KFHP Southern California policies and procedures, and are privileged and protected. All records are maintained in a manner that preserves their integrity in order to assure that patient and practitioner confidentiality is protected.

### Frequency

The Committee shall meet as often as necessary but at least six times per year.

### Agenda

A standing agenda shall be prepared annually to ensure that the committee oversees the utilization management activities required by regulating agencies.

### Minutes

The committee shall keep a permanent record of its proceedings and attendees. All committee minutes shall be provided to the Southern California Quality Committee.

### Assessment of Committee Performance

The performance of the committee relative to its charter shall be evaluated annually and shall be reported to the Southern California Quality Committee.

### Reporting Structure

The committee shall provide periodic reports on its activities to the Southern California Quality Committee.