



Quality Program Description

Regional Quality Improvement Committee (RQIC)

Commercial, Marketplace, Medicare,
Maryland HealthChoice (Medicaid)

2019 – 2020

Kaiser Permanente of the Mid-Atlantic States, Inc.
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Introduction

Founded in 1945, Kaiser Permanente (KP) is an integrated health care system of not-for-profit health plans and hospitals and practitioners that serve over 12 million members. Kaiser Permanente consists of Kaiser Foundation Hospitals and subsidiaries (KFH), Kaiser Foundation Health Plan, Inc. (KFHP) and the Permanente Medical Groups (PMG).

Headquartered in Oakland, California, Kaiser Permanente operates in the following eight regions:

- Northern California,
- Southern California,
- Colorado,
- Georgia,
- Hawaii,
- Mid-Atlantic States (Virginia, Maryland and District of Columbia),
- Northwest (Oregon and Washington) and
- Washington.

KFHP and its subsidiary health plans contract exclusively with the Permanente Medical Groups (PMG), which are partnerships or professional corporations of physicians, represented nationally by The Permanente Federation, to provide or arrange medical services for KFHP members.

Kaiser Permanente Mid-Atlantic States, Inc. (KPMAS) Overview

The Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and the Mid-Atlantic Permanente Medical Group (MAPMG) are also known as Kaiser Permanente Mid-Atlantic States, Inc. (KPMAS). The Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. is a federally qualified HMO, as of May 1976.

The KPMAS region is comprised of three Service Areas: Northern Virginia (NOVA), District of Columbia/Suburban Maryland (DCSM), and Baltimore. Health care services are provided or arranged by KPMAS. The KPMAS region manages 31 medical office buildings, 1 freestanding imaging center and 1 freestanding behavioral health location. Hospital services are provided at over 30 affiliated community hospitals. KPMAS provides comprehensive health care for more than 770,000 people.

The lines of business with NCQA accreditation served by KPMAS include Commercial, Marketplace, Medicare Advantage, Medicare Risk, Maryland HealthChoice (Medicaid) and Virginia Medicaid (through partnership with Virginia Premier Health Plan [VPHP]).

Mission and Vision

Mission

To provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

Vision

We are trusted partners in total health, collaborating with people to help them thrive, creating communities that are among the healthiest in the nation, and inspiring greater health for America and the world.

The purpose of KFHP's Quality Program is the assurance of high quality, safe and appropriate health care, delivered in a culturally responsive manner for all Health Plan members across all settings of care. Health care quality involves care and service, patient safety and cost-effective utilization, as well as business practices that support patient care delivery. The Quality Program requires integration into clinical operations structure, systems and processes.

Kaiser Permanente's Quality Strategy is guided by the Institute of Medicine's Six Aims for Improvement:

- **Person-Centered:** Providing respectful and responsive care that is designed to give our patients the best possible experience.
- **Safe:** We are the safest system in which to receive and provide health care. This means avoiding harm to patients from the care that is intended to help them.
- **Effective:** Providing services based on scientific knowledge to all who could benefit.
- **Efficient:** Achieving top quality outcomes through evidence-based clinical practices that reduce waste and promote efficiency.
- **Equitable:** Providing personalized and inclusive care for all members and patients.
- **Timely:** Respecting the value of time for both patients and each other.

KPMAS Vision

To be the trusted partner in total health for 1.3 million satisfied members receiving affordable, quality and convenient care and exceptional service.

National and Regional Quality Structure

Board of Directors

Kaiser Foundation Health Plan, Inc. (KFHP) is a California not-for-profit public benefit corporation, which is governed by a Board of Directors ("Board"). As the governing body, the Board has the ultimate accountability and responsibility for overseeing quality, risk, utilization management, patient safety, satisfaction and credentialing in all Kaiser regions nationally. The same board members serve for both health plan and hospital entities. The Board meets at least four times a year.

Quality and Health Improvement Committee (QHIC)

The Board of Directors oversees quality through the national Quality and Health Improvement Committee (QHIC). The QHIC consists of three or more Directors, who are selected by the Board and who serve as members of the QHIC at the pleasure of the Board. The QHIC meets at least four times per year and reports its decisions, actions, and recommendations to the Board. Staff support is provided by the National Health Plan and Hospitals Quality Department.

The Quality and Health Improvement Committee (QHIC) provides:

1. Strategic direction for quality assurance and improvement systems.
2. Oversight of systems designed to ensure that quality care and services are provided at a comparable level to all members and patients throughout the Program and across the continuum of care.
3. Oversight of the Program's quality assurance, improvement systems and organizational accreditation and credentialing.

Kaiser Permanente National Quality Committee (KPNQC)

The mission of the Kaiser Permanente National Quality Committee (KPNQC) is to establish, guide, and support the National Clinical Quality Strategy, which will set uniform measures and targets, eliminate unwarranted variation, spread successful practices, and facilitate the delivery of safe, timely, effective, equitable, efficient and patient-centered clinical care by the Kaiser Permanente Medical Care Program, in furtherance of the Quality Programs, developed collaboratively with Kaiser Foundation Health Plan, Kaiser Foundation Hospitals and the Permanente Medical Groups.

KPNQC is accountable to and acts at the direction of QHIC. As part of its oversight responsibilities, KPNQC reviews annual program descriptions, work plans and evaluations, as well as quality reports and minutes from each region. KPNQC meets no fewer than four (4) times per year and is a peer review body.

KPMAS Quality Structure

The KPMAS Regional Quality Improvement Committee (RQIC) is chartered to perform quality oversight for KPMAS and MAPMG. The RQIC is co-chaired by the MAPMG Associate Medical Director and the KFHP Vice President Quality, Regulatory and Risk Management. The RQIC is comprised of Health Plan and MAPMG leadership with direct accountability and responsibility for quality assessment and improvement, utilization

management, risk management, access, service, patient safety, infection control, and behavioral health (BH). A BH practitioner (psychiatrist) is involved in the BH care aspects of the QI Program. The RQIC reports on clinical quality activities and service quality activities to the KFHP Board of Directors addressing initiatives covering each member. Annually, the RQIC approves the Quality Program Description, Annual Work Plan Evaluation, and Annual Work Plan as defined by the regulatory and accreditation requirements. See RQIC Charter (Appendix D) for the ongoing performance monitoring and evaluation approach. The Charter provides the listing of the medical and behavioral health physicians who oversee the Quality program, as well as a description of their roles. Appendix E identifies the Quality Program's functional area resources and analytic support.

Annual Work Plan and Evaluation Description

The Regional Quality Program includes yearly prioritized Quality Improvement (QI) activities for performance improvement projects including but not limited to quality and safety of clinical care and service quality. The Annual Work Plan includes timeframes for each activity's completion; staff members responsible for each activity; monitoring of previously identified issues; and evaluation of the quality program. The Annual Work Plan is a dynamic document which is used for reporting, trended analysis, and edited as required to address organizational priorities. KFHP assesses and documents the activities, accomplishments, and barriers from the previous year in the Annual Work Plan Evaluation. The annual evaluation summarizes a comprehensive assessment of the organization's completed and ongoing quality program effectiveness and organization's progress to achieving safety and quality clinical practice goals based on quantitative and qualitative analysis (including trended QI data analysis).

The effectiveness of the Quality Program and Work Plan and achievement of goals and objectives are reviewed at least annually. The Program, Work Plan and Evaluation are distributed to regulatory and accreditation bodies after final approval by the RQIC committee. The KPMAS updates on quality program processes, goals, and outcomes related to member care and service are available on the website and communicated in member publications. KPMAS summarizes a comprehensive assessment of the organization's completed and ongoing quality program effectiveness and organization's progress to achieving safety and quality clinical practice goals based on quantitative and qualitative analysis.

KPMAS Clinical Quality

Health Plan Oversight of New or Changed Clinical Services

KPMAS reviews and approve the provision of new services or a change in the manner in which services are provided. The KP National process "Quality Oversight Plan for a Change or Internalization of Clinical Services" takes into consideration critical quality elements that ensure a service or program is launched successfully and that services are monitored for sustained performance. Any new or changed service in KPMAS is required to receive approval from the KFHP Board of Directors prior to its implementation.

Quality of Care Performance

The Kaiser Permanente Mid-Atlantic States (KPMAS) Quality Program was developed based upon the organization's mission that Kaiser Permanente exists to provide high-quality, affordable health care services to improve the health of our members and the communities we serve. The KPMAS programs drive initiatives to improve the quality of care and service to improve the health status of Kaiser Permanente members and to optimize the quality of care and services delivered. KPMAS staff and practitioners coordinate high quality and effective medical management for members, striving continuously to improve the care and service. The KPMAS Quality Program monitors and evaluates significant aspects of the clinical care, member services, and administrative services provided to members across multiple approaches of care delivery. The program integrates cross-functional activities using interdisciplinary teams and member/patient voice of the customer participation whenever possible.

HEDIS (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. HEDIS measures are an integral part of the NCQA health plan accreditation and performance is reported to the RQIC annually. Selected HEDIS measures by line of business are tracked monthly and widely shared internally.

Virginia Medicaid

To the extent required under KPMAS' contract with VPHP, KPMAS will:

- Cooperate with VPHP's quality improvement requirements and demonstrate compliance with agreed upon quality standards.
- Assist with VPHP's quality improvement activities (including Performance Improvement Project Validation, Performance Measure Validation, Operational Systems Review, Quality Collaboratives) conducted in accordance with CMS recommended protocols and the processes used by the Virginia Department of Medical Assistance Services or its designated External Quality Review Organization.
- Assist with the VPHP's NCQA accreditation renewal process.
- Submit, annually, a written description of its ongoing quality assessment and the performance improvement program to VPHP. At a minimum, this description will define the quality improvement structure and include all of Element A (QI Program Structure) and all of Element B (Annual Evaluation) from the most recent version of NCQA's standards.

Maryland Medicaid

KPMAS will continue to implement its ongoing comprehensive quality assessment and performance improvement program for the services furnished to its Maryland HealthChoice members that includes, but is not limited to performance improvement projects, collection and submission of performance measurement data, mechanisms to detect underutilization and overutilization of services, and mechanisms to assess the quality and appropriateness of care furnished to Maryland HealthChoice members with special health care needs.

In addition, KPMAS will participate in annual Quality Meetings with the Maryland Department of Health (MDH) to evaluate KPMAS performance and operations; quality improvement activities, including but not limited to Systems Performance Reviews and Maryland Healthy Kids audits; and annual validation and evaluation of MCO provider networks.

KPMAS will maintain NCQA accreditation and provide MDH with a copy of its most recent NCQA accreditation, including: Accreditation status, survey type, and level; Accreditation results (including recommended actions or improvements, corrective action plans, and summaries of findings); and expiration date of accreditation.

KPMAS will cooperate with any corrective actions and intermediate sanctions arising from MDH's Performance Monitoring Policy, dated November 5, 2015.

KPMAS Crossing the Quality Chasm

In the fourth of quarter of each year, TPMG/MAPMG identifies a group of focus areas (Clinical Quality Goals) for the coming year. Within KPMAS, Crossing the Quality Chasm is the clinical quality performance tracking program used in KPMAS. Goals are determined by the significance of the impact on members' and community health, ability to improve overall performance, and ability to reduce undesirable variation. Performance monitoring includes a comparison of results from prior quarters for the region overall and on the local level (service areas and medical centers). Quality Chasm Goal results are reviewed by the relevant Leadership Groups on an ongoing basis for each measure at a local level and reported to RQIC.

Confidentiality and Non-Discrimination

Confidentiality Statement

As part of the organization's quality and organizational oversight programs, the activities conducted by the KPMAS Regional Quality Improvement Committee, (RQIC) committees and sub-committees (including, minutes, reports, recommendations, memoranda, and documented actions created under the auspices of the Quality Program and its peer review processes) are subject to the protection of laws governing the confidentiality of peer review and/or quality assurance information, and federal and state privacy and security laws. All records are maintained in a manner that preserves their integrity to assure that member and practitioner confidentiality is protected. All staff receive training on privacy and security of confidential business and protected health information at the time they are hired and annually, thereafter.

Non-Discrimination Statement

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. KFHP provides cultural competency, sensitivity, and diversity training to staff, providers and sub-contractors 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.

Health Plan Delegation

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 pre-delegation assessments 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. These agreements are kept in a central, easily accessible location. KFHP conducts annual reviews to ensure the delegate's continuing ability to meet requirements and expectations. Additionally, there is at least semiannual review of reporting requirements and performance through submitted documents and activity reports, according to the reporting submission requirements.

KFHP retains the right to revoke delegation if the delegated entity does not fulfill its obligations.

KPMAS Quality Delegation

KPMAS does not delegate Quality or Population Health Management. In accordance with NCQA standards, KPMAS delegates Utilization Management (Pharmacy) and Credentialing.

Visiting Member Program

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

KFHP has created credentialing, quality improvement and utilization management processes and policies, in compliance with regulatory and accreditation requirements, to protect members when they are seeking services not in their host region. Program Offices representatives from National Quality, Credentialing and Utilization Management performs delegation oversight in all regions as it pertains to the Visiting Member Program.

Practitioner Participation and Credentialing**Authority**

The health plan's Board of Directors has ultimate responsibility for credentialing practitioners and providers that provide care to members. The Board of Directors delegates authority to the Credentialing Committee to act on its behalf for decisions regarding participation in the network. The Board of Directors retains its authority to make an ultimate decision regarding the credentials of any practitioner or provider, or to delegate authority for corrective actions to other Health Plan committees or executives as it deems necessary to act on its behalf.

Roles and Responsibilities

The health plan President is accountable for sufficient Health Plan oversight processes within the Quality Program to assure a consistently effective Credentialing program that is accountable to the Health Plan. The President will collaborate with the Executive Director of the Permanente Medical Group to assure that all participants in the credentialing process carry out their respective roles and to assure the efficient credentialing and recredentialing of practitioners and providers that meet Health Plan credentialing standards.

The credentialing function is carried out through one or more Credentialing Committees established by the health plan. The Credentialing Committee is a subcommittee of the quality oversight committee. The Credentialing Committee serves as a coordinating committee for other Health Plan Credentialing Committees. The Credentialing Committees are peer review bodies with members from the range of practitioners participating in the network. The Credentialing Committee implements and oversees credentialing policies and processes, and assures compliance with applicable legal, regulatory and accreditation requirements. The Credentialing Committee makes a final credentialing decision for those practitioners within its scope of authority, including, but not limited to, the approval, denial, suspension, termination, limitation and revocation of credentialing of practitioners, subject to any retained or otherwise delegated authority by the Board of Directors.

The Chairpersons of the Credentialing Committees are directly responsible for oversight of credentialing processes. One chairperson is Physician Leader for Credentialing; the other Chairperson is a Health Plan quality leader designated for credentialing. Their accountabilities include, but are not limited to, chairing the Credentialing Committee meetings, serving as consultants to the Chairs of other Credentialing Committees, answering questions related to adherence to policies and procedures, qualifications of practitioners, quality of care concerns, proctoring, peer review and practice reviews.

All practitioners employed by or affiliated with KP must be initially credentialed and thereafter recredentialed to verify that they are qualified, appropriately educated and competent in their field of expertise and that they meet the standards established by KP and all applicable regulatory and accrediting agencies.

Peer Review/Practitioner Oversight

The Practitioner Performance Review and Oversight Program (PPRO) ensures that mechanisms are in place to continually assess and improve the quality of care provided to members and patients to promote their health and safety through a comprehensive and effective program to evaluate practitioner's performance. The peer review process is a mechanism to identify and evaluate potential quality of care concerns or trends to determine whether standards of care are met and to identify opportunities for improvement. The process is used to monitor and facilitate improvement at the individual practitioner and system levels to assure safe and effective care. Peer review provides a fair, impartial and standardized method for review, whereby appropriate actions, if required, can be implemented and evaluated.

Care Experience

One KP is a national initiative to ensure members, patients, and customers experience KP's best at every location at every time, by putting them first and collaborating as one team. The goal is to provide a superior experience every time anyone interacts with the organization. The One KP standards are organized under a framework that invokes the member's collective voice: Respect Me, Know Me, Guide Me. The One KP standards define how members and patients should feel when they interact with Kaiser Permanente, everywhere, every time.

Complaints and Grievances

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

KPMAS Complaints and Grievances

KPMAS provides information to members on how to file a complaint via telephone, mail or online within kp.org. Members can file an appeal for an adverse decision or a complaint/grievance when dissatisfied with care and/or service. The appeal can be filed (i.e. in response to an adverse decision letter; verbally through the clinical and service contact centers; or via the kp.org website.)

Complaints grievances and appeals are forwarded to the Member Services Appeals and Complaints Resolutions department (Member Services) and go through intake and triage. Quality or Risk oriented complaints are shared with those staff respectively. This process allows for review of cases that need urgent handling to be expedited. In addition, members may also use Facebook, Yelp and Twitter to file a complaint.

The Member Services department comprehensively collects, reports, and analyzes concern and appeal data which are reported to RQIC. These operational reports allow the organization to identify improvement opportunities and interventions.

Member Services coordinates with content owners to conduct timely reviews and updates, which ensures the accuracy of the information.

Care Experience Assessment

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

- CAHPS
- Complaint, grievance, and appeal data
- Member Experience Tracking Evaluation and Opinion Research (METEOR) Survey
- Member Patient Satisfaction Survey (MPS)
- Customer Service Stars Survey (KPMAS)

KPMAS Satisfaction Surveys

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

METEOR is a supplemental survey for CAHPS conducted twice a year that allows KPMAS to analyze results at the service area level. The survey is the same as CAHPS and data is collected in a similar fashion.

The Customer Service Stars survey is a KPMAS specific ad hoc survey conducted for all lines of business to evaluate KP's customer service across multiple member touchpoints. Touchpoints include in person, phone, and email. The survey is fielded online. The questions are meant to expand upon the two Customer Service questions in the CAHPS questionnaire to provide more actionable information. Survey topic areas include first contact resolution, issue resolution satisfaction, and contact type.

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

Access to Care

KFHP partners with PMG to engage in a variety of performance improvement interventions and strategies aimed at enhancing the availability and accessibility of health care services and increasing satisfaction of its members. Strategic service priorities are set based on identified areas of opportunity to address the service needs of members. Comprehensive strategies and measurements are assessed at least annually to assure the effectiveness of strategic goals and imperatives relating to improving member access and satisfaction. KFHP has established access and availability standards as required by State or Federal statutes and/or regulations. KFHP assures the adequacy and availability of its network by establishing and monitoring performance of:

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

KPMAS Access to Care

KPMAS has established access standards. These access standards include parameters for regular/routine appointments, urgent care appointments, and after-hours care. Member Services Contact Center and the Clinical Contact Center (Appointment and Advice) leadership developed telephone services standards, that are monitored regularly through operational reports, member satisfaction surveys, and reported to the RQIC. Comprehensive strategies and measurements are assessed at least annually to assure the effectiveness of strategic goals and imperatives relating to improving member access and satisfaction.

Equity, Inclusion and Diversity

KP established the national diversity and inclusion function in 1997 to operationalize the company's diversity and inclusion strategy across the organization. In 2018 the name was changed to National Equity, Inclusion, and Diversity to reflect the increasing focus on equity for members, patients, employees, and communities. This department leads efforts to implement KP's equity, inclusion, and diversity strategy through the development of key initiatives and expert consultation throughout the enterprise.

Equity, Inclusion and Diversity (EID) councils exist at both the national and regional levels. They are responsible for engaging employees in EID initiatives and program and are accountable for achieving diversity-related goals.

KPMAS Equity, Inclusion and Diversity

The KPMAS Equity, Inclusion, and Diversity Department produces and maintains numerous programs, diversity related policy, and cultural awareness, trainings to ensure the delivery of culturally and linguistically appropriate care and services (CLAS) that meet the needs of the diverse membership and comply with federal CLAS Standards and/or other legal and accreditation requirements. Annually, the department performs assessments of the membership (by product type), practitioner and employee race, ethnicity and language. Based on the analysis of annual data the Equity, Inclusion, and Diversity Department seeks to promote, support, and assist in the coordination of key diversity business needs with strategy to meet the following objectives:

- Provide culturally proficient care and service
- Eliminate disparities and demonstrate equity
- Optimize and adjust workforce diversity and cultural proficiency at every level and create inclusive environments
- Provide the most compelling value for diverse populations
- Build diverse and thriving communities.

Population Health Management (or Population Care Management)**Patient-Centered Medical Home (PCMH)**

KFHP supports the PCMH model. The PCMH model develops relationships between primary care providers, their patients and their patients' families. 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 medical home team; which may consist of nurses, pharmacists, nurse practitioners, physicians, physician assistants, medical assistants, educators, behavioral health therapists, social workers, care coordinators, and others will take the lead in working with the patient to define their needs, develop a plan of care, and update a plan of care as needed.

Care coordination includes the following activities:

- Determine and update care coordination needs
- Create and update a proactive plan of care
- Communication across transitions of care and collaborative with other practitioners
- Connect with community resources
- Align resources with population needs based upon assessment to address gaps and disparities in services and care.

KPMAS Population Health Program Overview

The Kaiser Permanente Mid-Atlantic States integrated care delivery model is at the center of our quality program. The population health management strategy contributes to quality across the KPMAS care continuum - from caring for our healthy members, to those at-risk, or have chronic and complex conditions or health needs. Across this continuum we provide prevention, disease management, education and complex care coordination and support to our members.

- Our Vision is to transform lives by supporting and inspiring people to thrive.
- Our Mission is to provide expertise in population interventions that includes; providing a cohesive plan of action that addresses member needs across the continuum of care, utilize knowledge of best practices to develop innovative educational programs to foster relationships between the health care team, specialists, members and patients.

KPMAS Program, Goals and Objectives

The KPMAS Population Health Management Program includes programs and services from the Population Care Management, Health Education and Health Promotion and the Case Management departments. The Patient Centered Medical Home is the foundational care model that the Population Health Programs support. KPMAS demonstrates value and health improvement to our members, care teams and employer customers through coordinated population-based programs offered to all lines of business (Commercial, Medicare Cost, Medicare Advantage, Marketplace, Virginia Medicaid and Maryland HealthChoice).

The KPMAS Population Health Programs and Services are designed to augment and support the key relationship between the primary care physician and the patient. Programs are monitored, and opportunities are identified annually to improve continuity and coordination of care across settings and transitions of care. In addition, KPMAS provides coordination and continuity of care between behavioral health and primary care providers.

To improve outcomes, KPMAS assesses aggregated and trended membership data to prioritize the quality of care initiatives. Members are provided information via tailored communication (based on clinical recommendations for a target population) on how to use the services, how to participate, and how to opt in or out.

Four Areas of PHM Focus

1. Focus Area – Managing Members with Emerging Risk: Population Care Management Program - Diabetes Management.
2. Focus Area – Keeping Members Healthy: Health Education and Health Promotion Program - Influenza Vaccination to prevent flu.
3. Focus Area – Patient Safety Across Settings: Ambulatory Case Management Program - Medication review by case managers.
4. Focus Area – Managing Multiple Chronic Illnesses: Inpatient Case Management Program - ED Case Management to Reduce the 30-day readmission rate for members with more than 1 chronic illness.

KPMAS Population Care Management Overview

Population Care Management (PCM) is one of the foundations of the KPMAS clinical care strategy that provides evidence-based, systematic support to the physicians and health care teams who care for members. The PCM strategy is used to support care delivery to populations of members with preventive care and chronic diseases and conditions. It is explicitly designed to augment and support the foundational relationship between PCP and the member used in the PCMH model.

The PCM strategy is based on several key concepts, including:

- Evidence-based care supported by clinical practice guidelines (reviewed at least every 2 years);
- Member registries, based on claims, encounter, laboratory, pharmacy, and more, that support monitoring;
- Customized information technology to support the program with tracking and feedback
- Patient-centered medical home-based care that supports the physician-patient/member relationship
- Involvement of the member in his/her own care
- Interventions and care designed and tailored to address specific and special needs of members, including social determinants of health, age -specific opportunities, different abilities, and serious and persistent mental illness
- Monthly and annual performance assessments and annual population analysis regarding program resources and activities

Newly eligible members will receive either an electronic message or mailed letter within one month of entering diabetes registry that includes information about how to use KPMAS diabetes care management program and services, how they became eligible for the program, and how they can opt-out of the program.

Activities that are not direct member interventions that support the PHM programs and focus areas include: data and information sharing with physicians and physician leadership, documentation integrated into the electronic medical record for all care providers to document and review and decision support tools at the point of care.

KPMAS Case Management Program (Outpatient and Inpatient) Overview

Kaiser Permanente's Case Management program provides a comprehensive approach to care coordination throughout the care continuum. An overall performance goal is to improve the quality and efficiency of health care for members with complex and chronic conditions.

The overall goal of complex case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up. Case Managers work directly with members and caregivers, primary and specialty care teams as well as our patient teams, palliative care and our national transplant network to provide high-quality care coordination to ensure high-risk members receive much needed assistance in achieving their optimal health goals.

Core elements of the case management programs include the following:

- Foster relationships between practitioner/care team and members
- Promote and coordinate consistent care across the delivery system
- Ensure equitable and compliant care

KPMAS offers a variety of case management programs including inpatient case management, ambulatory case management for adults and pediatrics, behavioral health, perinatal care, transgender, chronic kidney disease, end stage renal disease and complex case management to its members and does not limit eligibility to one complex condition or to members already enrolled in the organization's Population Care Management (PCM) program. In addition to stratifying our population into subsets for population assessment and risk stratification, KPMAS utilizes multiple referral avenues to minimize the time between identification of a need and delivery of complex case management services.

KPMAS Health Education/Health Promotion Program Overview

The Health Education and Health Promotion Program helps ensure that Kaiser Permanente members learn appropriate and effective prevention and self-care through evidence-based medicine. The program provides members with the information, skills, and confidence in a variety of settings or online platforms to prevent or manage specific health problems through an active partnership with their health care team. The program utilizes screening tools to identify members with wellness and prevention needs and facilitates referrals to healthy living classes, community-based resources and allied health professionals.

Health Education and Health Promotion (HE/HP) utilizes screening tools to identify members with wellness and prevention needs and facilitates referrals to healthy living classes, community-based resources and allied health professionals.

The HE/HP Program helps ensure that Kaiser Permanente members learn appropriate and effective prevention and self-care through evidence-based medicine and provides members with the information, skills, and confidence to prevent or manage specific health problems through an active partnership with their health care team.

Mental Health and Wellness

Across Kaiser Permanente, meeting the mental and behavioral health needs of members is a top priority. Mental Health and Wellness encompasses an array of services — from emotional wellness and prevention to specialized care for conditions and addictions. The approach to providing high quality behavioral health services mirrors that of other clinical services. It is based on providing care that is safe, timely, convenient, evidence-based, equitable, and of high quality.

KP is creating and providing more evidence-based care for mental health and wellness and providing better access to mental health care. Our knowledge of population health combined with data drawn from our electronic health records, informs our evidence-based care. For example, we can apply predictive analytics to identify patients at risk of self-harm. We also encourage emotional wellness and prevention of more serious conditions by giving members and their families the tools and support they need to improve their physician and mental health. We have formed partnerships with community partners and advocacy organizations and use technology to accelerate our work around mental health and wellness.

KPMAS Mental Health and Wellness

KPMAS has a Behavioral Health Quality Committee which functions to oversee and monitor the performance of Behavioral Health quality of care and service delivered in inpatient and outpatient settings. The Behavioral Health Leadership along with the Behavioral Health Quality Committee oversee and guide ongoing compliance for all applicable regulatory and accreditation requirements. This includes but is not limited to HEDIS, state regulatory requirements (licensure), monitoring quality oversight structure for licensed Behavioral Health practitioners, oversight of continuity and coordination of care between Behavioral Health Services (Mental Health & Chemical Dependency), Primary Care and other departments, and reviewing Behavioral Health quality of care/service initiatives with trending and analysis for improvement. Quality improvement initiatives focus on opportunities to improve behavioral health care outcomes and improve care coordination between behavioral health and primary care as part of the patient centered medical home; for example, metabolic monitoring for patients with behavioral health disorders and behavioral health screening for pregnant women. Note that all specialty mental health and substance abuse services are carved out of the Maryland HealthChoice product line of benefits and are managed by Beacon Health, which has an exclusive contract with State of Maryland Department of Health (MDH) for BH services. KPMAS coordinates care with Beacon Health, and a BH practitioner (psychiatrist) is involved in the BH care aspects of the QI Program.

Resource Stewardship/Utilization Management

KP members and providers partner to optimize the health of our members, organization, and communities as measured by patient, employee, and community satisfaction. Resource Stewardship is the process of responsibly managing resources while improving the quality and safety of health care. It encompasses activities such as:

- Ensuring the right care is provided in the right place at the right time
- Eliminating waste, inefficiency, and unnecessary variation
- Providing quality care, the first time, eliminating rework
- Ensuring we are practicing evidence-based medicine
- Ensuring the care, we are providing is covered by a members' benefit package

KPMAS Utilization Management

The Quality Program Description and the Utilization Management (UM) Program Descriptions for all Lines of Business, ALOB, documents the KPMAS management and process alignment with the organization's mission, vision, and values. In addition, the KPMAS UM Program Descriptions define how the organization's health care delivery system is committed to an ongoing process of acting to continuously improve the quality, care, and service it delivers to its members through a systematic, integrated approach to planning, designing, measuring, assessing, and improving the quality of care and services to members. The goal is to provide the right care in the right setting to the right patient/member every time.

Transition care management covers transitions from hospital to home or skilled nursing facility/and/or from skilled nursing facility to home, or any time care is transitioned from one level to another. The member, family, or authorized representative, attending physician, and the appropriate staff are regularly engaged in the transitions of care shared decision-making activities throughout the member's episode of care. During the transitions of care process, the member's unique clinical needs are assessed, members receive outreach (visits and calls) and care is coordinated. For more details, refer to the Utilization Management Program Descriptions.

Pharmacy Quality

KFHP pharmacy services are an integral part of our high-quality care. To support Kaiser Permanente National Pharmacy's mission to improve the health of members and communities through the safe and effective use of medications, Pharmacy Quality & Medication Safety is working collaboratively with Pharmacy, Permanente Medical Group, and Kaiser Health Plan partners to provide the highest quality and safest care for members.

KP excels at the effective use and management of medications, resulting in high-quality at a lower cost. To reduce waste and ensure members receive the right medication, KP uses technologies to improve visibility into how we prescribe, dispense, and manage inventory. We are working to deliver superior member experiences by reducing variation among pharmacy sites. At the same time, we must also drive for affordability. We are pursuing efforts in strategic purchasing, formulary alignment, and evidence-based prescribing and management of specialty drugs.

As specialty drugs with limited clinical-effectiveness data and high prices enter the market, our Emerging Medications and Therapeutics program provides standardized guidance for the appropriate use of new therapies and medications. We've established consultative panels of interregional physician specialists that review specialty drugs and provide recommendations. This guidance includes metrics around monitoring and outcomes.

KPMAS Pharmacy Quality

Using standardized workflows and various methods of evaluation, the KPMAS Pharmacy department ensures compliance with state pharmacy regulatory and safety standards for medication storage, preparation and dispensing in each outpatient, mail order, and infusion pharmacy. To support safe medication storage practices in the clinical areas, pharmacy staff, in conjunction with nursing staff, perform routine inspections of medication areas in each medical office building.

The KPMAS Pharmacy department supports a Just Culture and a Culture of Safety wherein pharmacy staff can confidently report medication-related events and concerns with the goal to enhance patient safety. Medication-related events are submitted for review via the online reporting system and are addressed individually and trended. The Pharmacy Safety and Quality Team reviews all reported pharmacy-related medication events; These reports help identify system or workflow concerns, potential barriers to patient safety with the goal of developing and implementing system modifications to enhance overall quality of care.

Patient Safety and Risk Management Programs

KP’s Patient Safety and Risk Management program goal is that Kaiser Permanente is a national leader in patient safety. To reach this goal, care must be provided that is patient-centered, effective, efficient, and above all else, safe. This objective is founded on a philosophy that believes patient safety is every patient’s right and every leader’s, employee’s, physician’s and patient’s responsibility. It is an ongoing and relentless commitment to “do no harm” by building safer systems and preventing the preventable.

KPMAS Patient Safety and Risk Management Programs

The Patient Safety and Risk Management Program goals and objectives are to:

- Continuously improve patient safety and minimize/ and or prevent the occurrence of errors, events, and system breakdowns leading to harm to patients, staff, visitors, and others through proactive risk management and patient safety activities.
- Minimize adverse effects of errors, events, and system breakdowns when they do occur.
- Minimize losses to the organization overall by proactively identifying, analyzing, preventing, and controlling potential clinical, business, and operational risks,
- Facilitate compliance with regulatory, legal, and accrediting agency requirements.
- Protect human and intangible resources (e.g. reputation)

Patient Safety and Risk Management Program

KEY ENABLERS	OUTCOME	KEY DRIVERS
Culture Leadership Capacity Operational Links Data Measures	Anticipation No Preventable Harm Containment All possible Repair We exist to support the organization in its pursuit of safe, reliable, and patient-centered care. We are committed to collaborative problem solving and continuous performance improvement toward an end-state of no preventable harm for our patients. If harm does occur in order to achieve all possible repair for the patient/family, provider/staff and organization we will be honest with our patients, open with our colleagues and ourselves, and able to handle such occurrences with sympathy and empathy.	Maintaining relationships Preventing harm Responding to Injury

The KPMAS Regional Risk and Patient Safety Management Program is an integral part of the organization’s overall Quality Program. The program focuses on healthcare delivery strategies throughout Virginia, Maryland and DC to improve safety, promote quality care, as well as to protect the assets of the organization. Our organization is on the journey to becoming a Highly Reliable Organization (HRO). The Patient Safety and Risk Management Programs enable our organization to focus attention on emergent problems and to deploy the right set of resources to address those problems. We do not try to hide failures, but rather celebrate them as opportunities to learn from and assist in preventing recurrence.

The Risk Management and Patient Safety Program activities are reviewed for effectiveness by the Regional Patient Safety and Risk Management Committee, Regional Quality Improvement Committee (RQIC) and the Quality Committee of the MAPMG Board. The Patient Safety and Risk Management Program supports the Kaiser Permanente Health Plan (KPHP) philosophy that patient safety and risk management is everyone’s responsibility. Teamwork and participation among management, providers, and staff are essential for an efficient and effective patient safety and risk management program. The program will be implemented through the coordination of multiple organizational functions and the activities of multiple departments.

KP supports the establishment of a just culture that emphasizes implementing evidence based best practices, learning from error analysis, and providing constructive feedback, rather than blame and punishment. In a Just Culture, unsafe conditions and hazards are readily and proactively identified, medical or patient care errors are reported and analyzed, mistakes are openly discussed, and suggestions for systemic improvements are welcomed. Individuals are still held accountable for compliance with patient safety and risk management practices. As such if evaluation and investigation of an error or event reveal reckless behavior or willful violation of policies, disciplinary actions can be taken.

The KPHP Patient Safety and Risk Management Program drives the development, review, and revision of the organization's practices and protocols considering identified risks and chosen loss prevention and reduction strategies. Principles of the Plan provide the foundation for developing key policies and procedures for day-to-day patient safety and risk management activities, including:

- Development and sustainment of a speak up culture
- Developing Reliability in Healthcare through science
- Purposeful process design
- Provider and staff education, competency validation, and credentialing requirements
- Risk assessment
- Event investigation, cause analysis, and action planning to prevent reoccurrence
- Data analytics: Enough data to engage and react
- Trend analysis of events, near misses, and claims
- Reporting and management of adverse events and near misses
- Safety Attitude Questionnaire administration, analysis, and team engagement
- Claims management
- Complaint resolution

Enhancements are made to the Patient Safety and Risk Management Program when appropriate. The Patient Safety and Risk Management Program is administered through the Senior Director Patient Safety and Risk Management and/or designee who reports to the Vice President Quality, Regulatory, and Risk Management. The Senior Director interfaces with administration, staff, medical providers and other professionals and has the authority to cross operational lines to meet the goals of the program. The Senior Director chairs the activities of the Regional Patient Safety and Risk Management Committee in partnership with the Regional Medical Director for Medical Legal Affairs, Risk Management, and Patient Safety. The Committee's activities are an integral part of the patient safety and quality improvement and evaluation system.

APPENDIX A

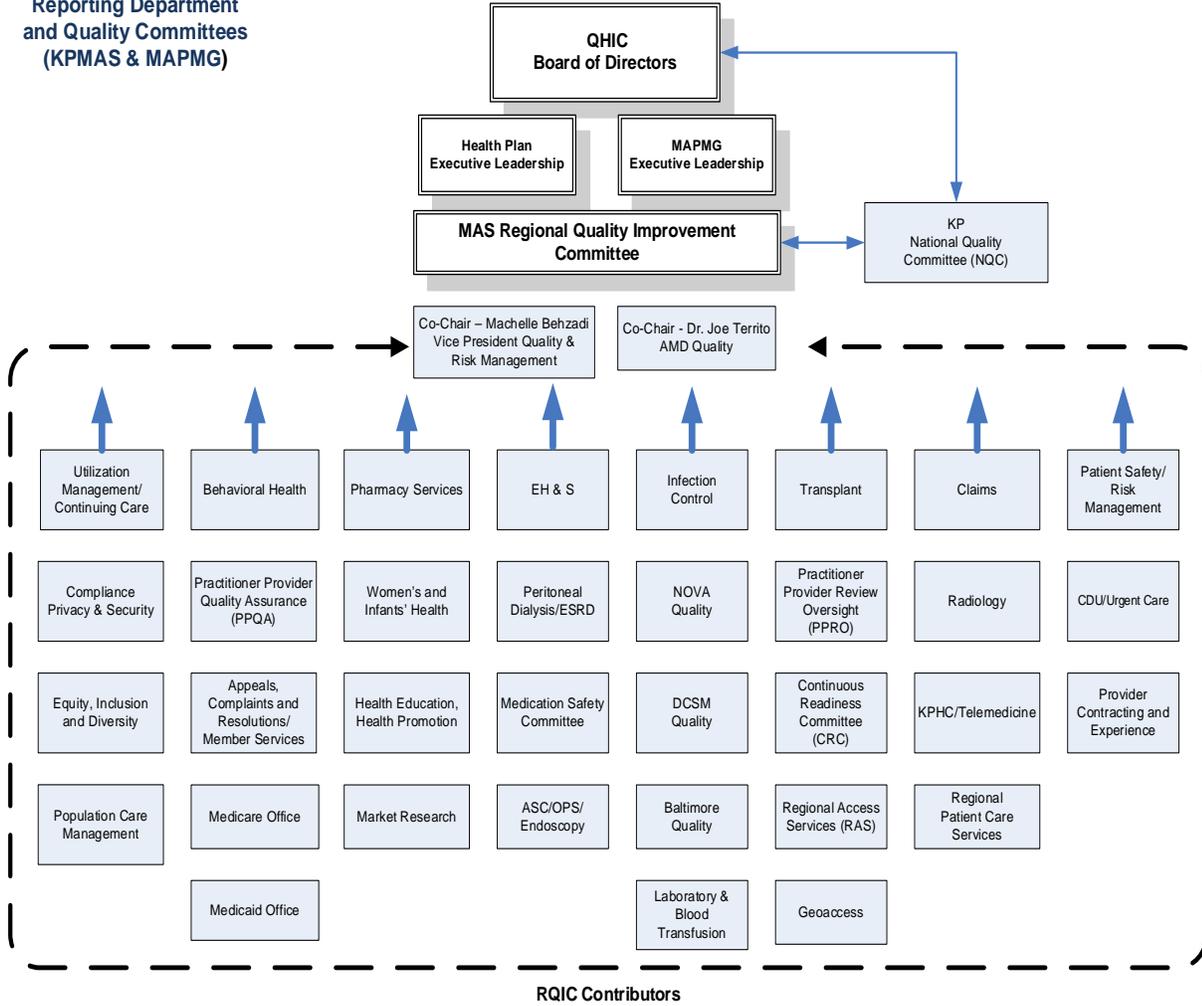
STRATEGIC PLATFORM



RQIC ORGANIZATION CHART – APPENDIX B

**ORGANIZATION CHART
RQIC – Quality Committees**

**RQIC
Reporting Department
and Quality Committees
(KPMAS & MAPMG)**



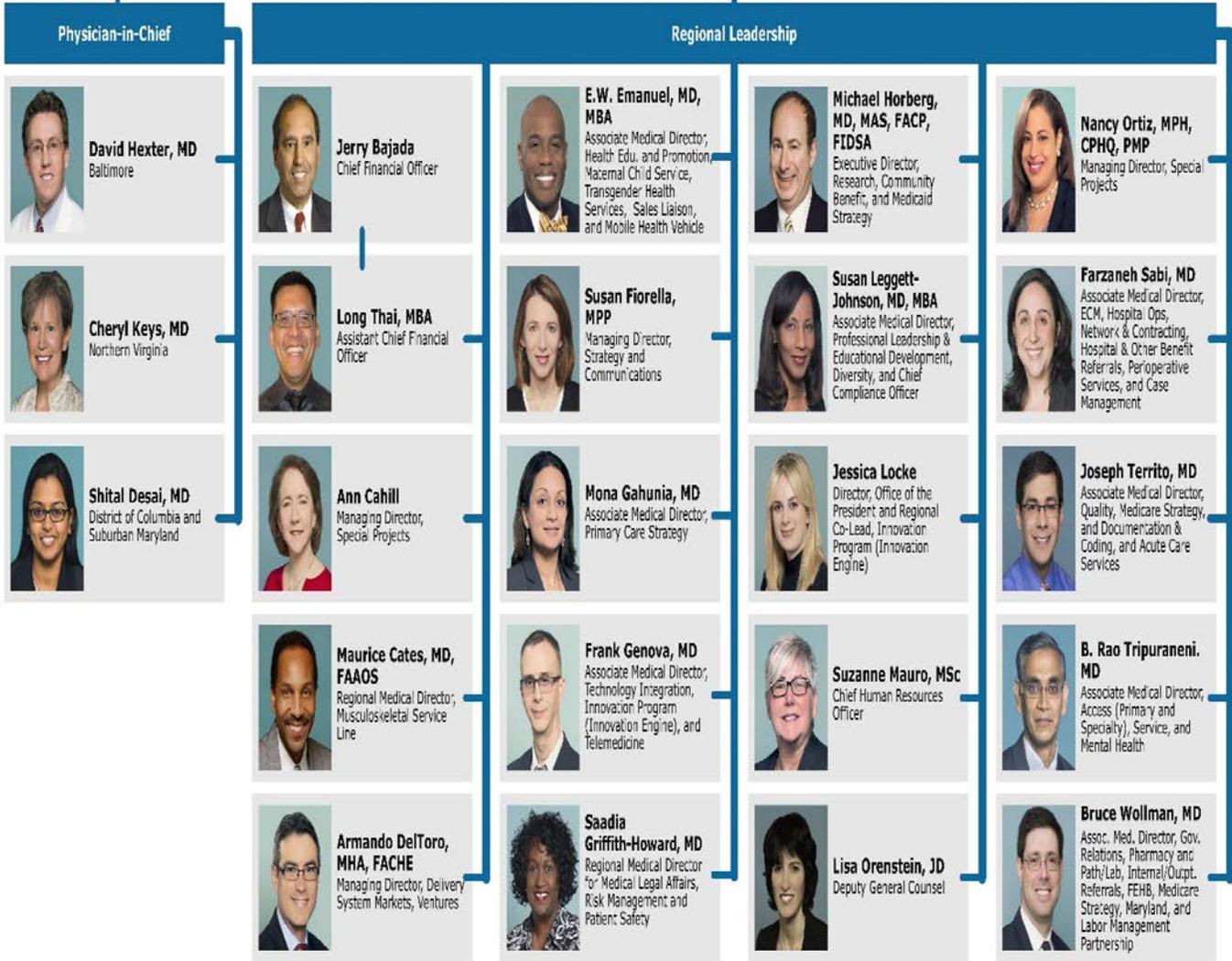
APPENDIX C

Organization Chart
MID-ATLANTIC EXECUTIVE LEADERSHIP TEAM



Executive Leadership Team

Richard McCarthy, MD
Associate Executive Director for the Mid-Atlantic States, The Permanente Medical Group



APPENDIX D

REGIONAL QUALITY IMPROVEMENT COMMITTEE CHARTER

REGIONAL QUALITY IMPROVEMENT COMMITTEE	
Committee Sponsors: Regional Quality Improvement Committee	
Committee Members (Voting):	Roles
<ul style="list-style-type: none"> VP, Quality, Regulatory and Risk Management (KFHPMAS (co-chair) 	Facilitates the work of the committee; provides expertise in improvement processes for quality of care and service; provides expertise in strategic guidance and infrastructure systems; provides expertise concerning internal and external regulatory standards.
<ul style="list-style-type: none"> Associate Medical Director Quality, MAPMG (co-chair) 	Facilitates the work of the committee; provides expertise in quality of care and service; provides peer review and clinical documentation expertise.
<ul style="list-style-type: none"> Associate Medical Director Hospital Operations, Ambulatory Surgery Centers, Utilization Management 	Promotes utilization strategies and activities, provides oversight of regulatory and accreditations standards, monitor utilization and facilitates performance management improvement.
<ul style="list-style-type: none"> Associate Medical Director Government Relations, Medicare Strategy, Pharmacy and Pathology/Laboratory Services 	Provides oversight related to Government Relations, Medicare Strategy, Pharmacy and Pathology/Laboratory Services.
<ul style="list-style-type: none"> Associate Medical Director Access, Service, Mental Health and Labor Management Partnership (Psychiatrist) 	Provides oversight in the quality performance monitoring process to assure issues related to service and access are addressed. Provides leadership and direction in the development and implementation of the Behavioral Health needs and services across the region.
<ul style="list-style-type: none"> Vice President, Health Plan Services Administration 	Provides the member perspective on the care and service experience; oversight of the compliance of the member complaint, grievance and appeal process; identifies trends and opportunities that identify potential administrative system issues; accountable to ensure implementation of the committee's decisions.
<ul style="list-style-type: none"> Physician in Chief (3) 	Provides expertise in operational decisions and potential impact of recommendations across the delivery system; accountable to insure implementation of committees' decisions.
<ul style="list-style-type: none"> Regional Medical Director, Patient Safety, Risk Management and Medical-Legal Affairs 	Provides expertise on steps to reduce medical-legal risks and educate physicians on these topics. Provides expertise on provider credentialing and privileging.
<ul style="list-style-type: none"> Vice President, Operations (3) 	Provides expertise in operational decisions and potential impact of recommendations across the delivery system; accountable to insure implementation of committees' decisions.
<ul style="list-style-type: none"> Senior Director, Quality Management 	Provides expertise to meet the regulatory and accreditation standards in credentialing, delegation and peer review.

<ul style="list-style-type: none"> • Director, Accreditation, Regulation, Licensure and Quality • Director, Regional Patient Care Services 	<p>Provides expertise for accreditation, regulatory and licensure standards.</p> <p>Provides expertise on the ambulatory care Nursing Practice Standards and assessment of the region's adherence to the standards.</p>
Facilitators and Recorders (Non-Voting)	Roles
<ul style="list-style-type: none"> • Senior Director, Quality Management • Director, Accreditation and Compliance • Senior Project Manager, Accreditation, Regulation, and Licensure • Project Manager (MAPMG) 	Facilitates work for the committee
Non-Voting Members (Attendance Optional)	Roles
<ul style="list-style-type: none"> • APIC, Quality (MAPMG) (3) • Director, Accreditation and Compliance • Director, Encounter Infometrics and Operations (MAPMG) • Director, Population Care Management (MAPMG) • Director, Quality Improvement (MAPMG) • Manager, Infection Control • Physician Director, Pharmacy & Therapeutics/ Medication Safety • Senior Director, Patient Safety/Risk Management • Senior Director, Regional Clinical and Nursing Education 	<p>Provides quality of care perspective of physicians in the delivery system.</p> <p>Provides expertise for NCQA Accreditation and Standards, State of Maryland and Commonwealth of Virginia quality regulations.</p> <p>Provides expertise in the analysis of the coding data; medical record review standards; routine monitors.</p> <p>Provides expertise in the programs of population care management.</p> <p>Provides expertise in publicly reported clinical effectiveness of care measures.</p> <p>Provides expertise for infection prevention and control.</p> <p>Provides expertise related to Pharmacy and medication safety from the clinical perspective.</p> <p>Provides oversight to increase patient safety and reduce possible harm in the delivery of health services across all care settings.</p> <p>Provides expertise related to the educational needs of clinical staff delivering health services across all care settings.</p>
Reporting Documents	
<ul style="list-style-type: none"> • Ambulatory Surgery Services • Behavioral Health Services 	<p>Provides expertise in the analysis of the data and information though all components of the ASC; recommend opportunities for improvement.</p> <p>Provides oversight to the quality of care and services delivered; support continuous improvement; meet regulations and accreditation standards in Behavioral Health.</p>

<ul style="list-style-type: none"> • Equity, Inclusion and Diversity • Geoaccess Report • Health Education/Women’s Issues • Imaging Services and Radiation Safety • Infection Control • Laboratory Services • Medicaid • Medication Safety/Pharmacy Services • Member Services Department • Peritoneal Dialysis/ESRD • Population Care Management • Practitioner Performance Review Oversight • Practitioner and Provider Quality Assurance • Regional Access Services 	<p>Provides expertise to meet the regulatory and accreditation standards for Equity, Inclusion and Diversity.</p> <p>Provides reports that demonstrate adherence to the accreditation and regulatory geoaccess standards; recommend opportunities for improvement.</p> <p>Provides reports on member health education and women’s issues.</p> <p>Provides expertise in the analysis of the radiology systems and process monitors and assessment; safety monitors and improvements; member satisfaction.</p> <p>Provides expertise on the requirements that personnel must meet in order to attain clinical accreditation and regulatory compliance with infection control standards.</p> <p>Provides expertise in the analysis of the laboratory systems and process monitor and assessment; safety monitors and improvements; member satisfaction.</p> <p>Provides reports on membership, delegated vendor performance, care delivery initiatives, and quality improvement initiatives.</p> <p>Provides expertise in the analysis of the pharmacy systems and process monitor and assessments; medication safety monitors and improvements; member satisfaction.</p> <p>Provides expertise in the analysis of the member inquiry, complaint, and appeals data in order for the appropriate service programs, priorities and corrective action plans can be implemented.</p> <p>Provides reports on the functioning of the Peritoneal Dialysis Programs.</p> <p>Provides expertise in the analysis of the data and information through all components of population care management.</p> <p>Provides expertise on the requirements that personnel must meet in order to attain clinical accreditation.</p> <p>Provides reports that analyze the adverse events and near misses that occur in connection to the electronic medical record.</p> <p>Provides expertise in analysis of primary care; specialty care and behavioral health appointment and telephone access results; improvement activities; member satisfaction.</p>
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<ul style="list-style-type: none"> • Regional Patient Care Services 	<p>Provides expertise on the ambulatory care Nursing Practice Standards and assessment of the region's adherence to the standards.</p>
<ul style="list-style-type: none"> • Patient Safety/Risk Management 	<p>Provides expertise in the analysis of data and information through all components of Patient Safety and Risk Management; recommend opportunities for improvement.</p>
<ul style="list-style-type: none"> • Service Area Quality Committees 	<p>Provides expertise in quantitative and qualitative data analysis.</p>
<ul style="list-style-type: none"> • Urgent Care/Clinical Decision Unit 	<p>Provides reports on the functioning of the Urgent Care and Clinical Decision Units.</p>
<ul style="list-style-type: none"> • Utilization Management Committee/Continuing Care 	<p>Provides KPMAS standards leadership for accreditation and regulatory requirements monitor utilization and facilitate performance improvement related to Utilization Management.</p>

Purpose:

- Evaluates the quality of care and services provided to KPMAS members in all settings, and identifies, prioritizes and chooses needed actions.
- Prioritizes decisions that need human and/or financial resources to implement required quality improvement activities.
- Implements quality initiatives consistent with regulatory, accreditation and strategic priorities for the Region and monitor performance. The committee provides oversight for issues across functional and service areas and other areas as appropriate related to quality care and service improvement initiatives.
- Provides oversight of new clinical services and programs and insures oversight from planning through implementation.
- Provides oversight for activities that are combined Health Plan Services Administration, Operations and Quality activities.
- Ensures the quality priorities are aligned and integrated with other key organizational strategic priorities.

Scope:

- Has authority to speak and act on behalf of the Health Plan Mid-Atlantic Permanente Group, including but not limited to the following:

Accountabilities for Regional/Service Area:

- Responsible for oversight of Clinical Risk Management, Safety, Service and Resource Stewardship.
- Evaluation of the quality of the clinical care and service across all settings and services provided.
- Make recommendations to senior leadership for actions to improve clinical and service quality.
- Commit the organization to action and monitors progress relative to the actions.
- Provide and document region wide clinical and service quality oversight as required by regulatory and accreditation agencies, purchasers, QHIC and NQC. Monitor performance to ascertain the Region/Service Areas meet or exceed the requirements for the following: legal, accreditation, licensing, internal or other external reporting requirements.
- Review regular reports and updates from all functional units, quality initiatives and programs within the overall quality program to include medical and behavioral health.
- Recommend policy changes and identifies when new ones are required.
- Approve the Quality Program Description, Annual Work Plan Evaluation and Annual Work Plan.
- Analyze and evaluate the quantitative and qualitative results of improvement activities in the committee's accountable areas.
- Ensure practitioner and staff participation in the quality improvement programs through planning, design, implementation or review.

- Establishes or makes recommendations to establish quality improvement priorities and QI activities.
- Oversee needed corrective actions and ensures follow up, as needed, based on quality improvement and patient safety priorities.
- Oversee integrity of key quality systems by reviewing quality of care and service indicators, such as, member satisfaction surveys, member complaints and appeals, internal and external surveys, accreditation reports, audit results, and self-assessment reports.
- Oversee compliance and accreditation and regulatory standards, including reporting requirements.
- Oversee credentialing process to assure only fully credentialed and qualified practitioners and providers provide care and services to KFHP members.
- Review sentinel events/adverse patient outcomes to assure objective, timely, thorough and consistent root cause analysis and appropriate corrective action plans are implemented with ongoing follow-up.
- Establish Regional QI and Patient Safety priorities and the priorities for QI studies and monitors implementation progress; to include Pharmacy Management.
- Evaluate changes in care delivery systems to assure member and patient interest are preserved in the Service Areas; including contracts, QOC evaluates through various reports e.g. METEOR, HH/Hospice, SNF satisfaction surveys, PEP-C (as applicable).
- Sets/supports regional standards and reviews performance across Service Areas for contract providers, networks, and service providers to assure that quality and service to members meet or exceed the Region's standards to include delegated activities.
- Annually, review adequacy of resources, committee structure, practitioner participation and leadership involvement in the QI Program. Determines changes needed for the QI Program for the subsequent year based on annual evaluation findings.

Term Limits: There are no limits though membership is assessed periodically.

Meeting Schedule: Meetings to be held 3rd Wednesday of every month no fewer than 10 in person meetings per year, 4 of which must be live (i.e., face-to-face or via Skype/WebEx/Telephone). At the discretion of the Committee Co-Chairs, meeting dates and/or number of required live meetings per year can be modified to ensure maximum Committee Member participation.

Quorum: A quorum will be composed of a simple majority of voting members.
Decisions of the Committee:

- Building actions may only be taken when a quorum is present.
- Decisions will be made in executive session with voting members only in attendance. Recorder will remain to accurately document the outcome of the decisions.

APPENDIX E

KPMAS QUALITY RESOURCES AND QUALITY MANAGEMENT

KFHP-MAS, Inc. Quality Management provides technical assistance, consultation and training to the various regions in the areas of quality improvement, risk management, patient safety, infection control, credentialing, delegation, accreditation and quality management. Assistance and integration are also provided in the areas of disease management through the Care Management Institute (CMI), evaluation of new technology and clinical practice and guidelines. In KPMAS under the direction of the Vice-President of Quality, Regulatory and Risk Management, consists of the following resources:

• Vice President, Quality, Regulatory and Risk Management	1.0 FTE
• Senior Director, Quality Department	1.0 FTE
• Director, Accreditation, Regulation and Licensure	1.0 FTE
• Director Accreditation and Compliance Oversight	1.0 FTE
• Senior Executive Consultant	2.0 FTE
• Senior Project Manager	2.0 FTE
• Senior Project Manager, HEDIS	1.0 FTE
• Clinical Accreditation Specialist, AR & L	2.0 FTE
• Data Management Support Coordinator	1.0 FTE
• Quality Improvement Specialist	4.5 FTE
• Senior Manager, Practitioner and Provider Quality Assurance	1.0 FTE
• Credentialing Coordinators	8.0 FTE
• Enrollment Coordinators	2.0 FTE
• Credentialing Assistants	2.0 FTE
• Analytical and Support Staff	1.0 FTE

Also, accountable to the Vice-President of Quality, Regulatory and Risk Management is the Senior Director, Risk Management/Patient Safety/Infection Control. Additional positions dedicated to quality improvement exist in Laboratory Services, Radiology, Utilization Management, Regional Health Information Management Services, Behavioral Health, Pharmacy, Member Services, and Claims Administration.

APPENDIX F

MEDICAL DIRECTOR OF MEDICARE COST AND PART D PHARMACY PLANS

The Medical Director of Medicare Cost and Part D Pharmacy Plans

- ensure clinical accuracy of coverage determinations involving “medical necessity”, for Medicare members
- provide oversight for Health Plan operations involving medical/utilization review for Medicare members
- provide oversight for Health Plan’s benefit, formulary and claims management activities affecting Medicare members
- provide oversight for Health Plan’s quality assurance affecting Medicare members

The Permanente Medical Group Medical Directors active in these areas are accountable to the Medical Director of Medicare Cost and Part D pharmacy plans for this work.

MEDICAL DIRECTOR OF MEDICARE ADVANTAGE AND PART D PHARMACY PLANS

The Medical Director of Medicare Advantage and Part D Pharmacy Plans

- ensure clinical accuracy of coverage determinations involving “medical necessity”, for Medicare members
- provide oversight for Health Plan operations involving medical/utilization review for Medicare members
- provide oversight for Health Plan’s benefit, formulary and claims management activities affecting Medicare members
- provide oversight for Health Plan’s quality assurance activities affecting Medicare members

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 this work.