Quality Program Description

Regional Quality Improvement Committee (RQIC)

Commercial, Marketplace, Medicare Cost 2018 - 2019

Kaiser Permanente Mid-Atlantic States, Inc.
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KAISER PERMANENTE®

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TABLE OF CONTENTS

SECTION 1 - INTRODUCTION

OVERVIEW

Kaiser Foundation Health Plan and Kaiser Foundation Hospital (KFHP/H) Boards of Directors are the national governing bodies accountable for quality, risk, patient safety access, service and utilization. KFHP/H each have a separate Board, however the same individuals serve on both Boards. The Board determines and adopts policy to guide the organization, adopt and monitor strategic goals and performance, and select key executive leadership.

The KPHP/H Board established the Quality and Health Improvement Committee (QHIC) to: (1) provide strategic direction for quality and safety management and improvement systems; (2) provide oversight of systems designed to ensure that safe, quality care and services are provided at a comparable level to all members and patients throughout the Program and across the continuum of care, and (3) provide oversight of the Program's quality and safety management, health improvement systems and organizational accreditation and credentialing. The QHIC meets at least four times per year and reports its decisions, actions, and recommendations to the Board.

The QHIC receives and reviews routine system-wide, regional and hospital-specific data and reports to perform its responsibility for oversight of the quality and safety of care, treatment and services provided to members. These include core documents such as:

- Regional Quality Oversight Committee minutes: The RQIC minutes are submitted for information-sharing purposes to the QHIC. The meeting minute format provides for tracking issues to resolution and reporting follow-up.
- National Quality Committee minutes
- Regional Quality Program Descriptions, Annual Work Plans, Annual Program Evaluations
- Joint Commission Core Measures, Leapfrog, HCAHPS and other KP inpatient quality data from contracted providers
- Sentinel events and complaints
- National quality and population management results (HEDIS). HEDIS is a set of standardized performance measures designed by NCQA to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans.
- Ambulatory Surgery Center annual reports
- CAHPS, NCQA, other survey data

The Kaiser Permanente National Quality Committee (KPNQC) is composed of KFHP and KFH senior quality leaders and Permanente Medical Group (PMG) medical directors for quality from every region. The KPNQC is accountable to and acts at the direction of QHIC and the Federation Executive Committee. Its' mission is to provide leadership, direction, and oversight of processes to continuously improve the quality and safety of clinical care and services provided by the organizations that constitute the Kaiser Permanente Medical Care Program.

National and Kaiser Permanente Mid-Atlantic States (KPMAS) Regional Structure

Regional Quality Structure, KPHP Structure, and MAPMG Structure

The national KFHP and Hospital Boards hold the regional KPMAS President and the TPMG Associate Executive Director accountable and responsible for the quality of care and service provided in the Region. The Regional Quality Improvement Council (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 Commercial, Marketplace, and Medicare Cost subscriber. 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 - Attachment C)

SECTION 1 - INTRODUCTION

The quality program includes yearly planned Quality Improvement (QI) activities and objectives for performance improvement including but not limited to: quality and safety of clinical care quality of service. The KPMAS quality program processes, goals, and outcomes related to member care and service are available on the website and communicated in member publications. 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 and analysis, and is edited as required to address organizational priorities.

KPMAS assesses and documents the activities, accomplishments, and barriers from the previous year in the Annual Work Plan Evaluation. 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 in the Annual Work Plan Evaluation. Also, the Annual Work Plan Evaluation includes trending of QI measures over time (using charts, graphs, and/or tables to display) and comparison against external benchmarks and performance objectives defined within the program description.

Regional Quality Strategy and Goals

The quality program of KPMAS seeks to promote and support continuous improvement in the delivery of care, treatment, and service. The program is executed with physician and staff understanding and accountability for quality, driven by data measurement and continuous improvements, care and treatment, service delivery processes and outcomes.

Regional Strategic Platforms (Attachment A1)

1. Perform - Drive performance through care, quality, safety, and service at lower cost, enabled by Kaiser Permanente's people, places, and technology.
2. Grow - Pursue core and new growth with an increasing focus on consumers.
3. Lead - Lead national health care change through Kaiser Permanente's expertise, trust, and relevance.

Kaiser Permanente's mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

Regional Clinical Quality Strategy (Attachment A2)

The Clinical Quality Strategy is how we ensure the best delivery of health and health care. Being the best means putting patients and members at the center of all we do and supporting health of the mind, body and spirit, preventing disease, managing acute, complex and chronic conditions, and leading in technology enabled care.

PROGRAM OVERSIGHT PRACTICES

The KPMAS region is comprised of three Service Areas, Northern Virginia (NOVA), District of Columbia/Suburban Maryland (DCSM), and Baltimore. Each of the Service Areas has a Quality Improvement Committee devoted to carrying out the Region's quality priorities and other activities including quality improvement activities. The Quality Management Department, in collaboration with MAPMG and other quality leaders help establish and communicate-quality and service priorities. This is communicated to all medical office building staff.

Effectiveness of the Program

The annual evaluation includes an assessment of overall effectiveness of the quality of the program. The effectiveness assessment monitors the Quality Programs' progress in achieving goals, including quality and safety of clinical practice.
The summary of effectiveness addresses: adequacy of quality program resources; quality committee structure; practitioner participation and leadership involvement in the quality program; and need to restructure or plan changes in the quality program for the next year.

SECTION 2 – QUALITY MANAGEMENT PROGRAM OVERVIEW

PURPOSE

The purpose of this section is to describe how KPMAS supports the Program's commitment to assessing and improving performance on a continuous, systematic, and evidenced-based basis. The Kaiser Permanente Mid-Atlantic States (KPMAS) Quality Program is based upon the organization's mission.

Scope

The KPMAS Quality Program provides quality oversight to the patient care delivery system of Kaiser Permanente Mid-Atlantic States. The program addresses all medical, behavioral health and service activities provided throughout the continuum of care, including medical office, hospital, home health, hospice, skilled nursing care, and ancillary services, including laboratory, radiology and pharmacy. Physicians and staff also serve on Quality Program Committees across the region. The activities include, but are not limited to:

Accreditation, Recognition, and Distinction: - Accreditation Association for Ambulatory Health Care (AAAHC) - Diabetes Recognition Program (DRP) - Health Plan Accreditation: Commercial, Marketplace, Medicare Cost (NCQA) - Marketplace Health Plan Accreditation (NCQA) - Medicaid Health Plan Accreditation (NCQA) - Multicultural Health Care Distinction (NCQA) - Patient Centered Medical Home Recognition (NCQA)	Other Regulatory, Management Monitoring, Reporting: - Practitioner and Provider site audits - Credentialing/Re-credentialing Board Certification - Hospital services management processes - Member Services - Monitoring/analysis and reporting of care and service provided by vendors - State and federal reporting as required by contract - Utilization Management
Clinical Indicators (including but not limited to): - Clinical outcome measurements - NCQA HEDIS® Measures for Health Plan Accreditation: Commercial Marketplace, Medicare Cost	Service Indicators (including but not limited to): - Consumer Assessment of HealthCare Providers and Systems (CAHPS®: Adult) –Commercial, Medicare Cost - Member Satisfaction with Case Management Services - Member Patient Satisfaction

SECTION 3 – QUALITY MANAGEMENT PROGRAM KEY COMPONENTS

The key components of the KPMAS Quality Program are identified below.

CONFIDENTIALITY

All Quality of Care Committee members are responsible for the confidentiality of patient and physician/staff information and for the protection of that data from unauthorized use, access, disclosure, and loss. All Quality of Care Committee members, along with all workforce members' must sign a Regional Confidentiality Statement annually and are expected to comply with federal, state laws and organizational policies and procedures regarding the safeguard and protection of confidential information. Upon hire and annually thereafter, all workforce members must complete compliance training that addresses the confidentiality and protection of patient information.

The Compliance Department monitors and assesses the effectiveness of confidentiality protection in all areas, including information shared outside Kaiser Permanente. Where appropriate, the Regional Privacy and Security Officer is involved in the planning and/or evaluation of the privacy and security components of the Compliance Program to ensure adherence with federal and state confidentiality and privacy requirements, as well as company policies and procedures.

DELEGATION OVERSIGHT

Delegation occurs only in instances in which KPMAS has predetermined the delegate's capability and capacity to perform the functions and meet KPMAS requirements and expectations. KPMAS 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. Based on the results of the pre-delegation evaluation, a final decision to approve or deny delegation is made.

Under certain circumstances, KPMAS may delegate responsibility for conducting one or more functions to a provider, provider group, agency, facility or other supplier with whom it contracts. A mutually agreed upon document is constructed that describes the delegated activities, responsibilities of KPMAS and the delegated entity with specific defined frequency of reporting, an evaluation process relative to performance goals and remedies available if the delegate does not fulfill its obligation. KPMAS performs delegation oversight of management functions delegated to outside entities through report monitoring, and analyzing data and corrective actions implemented (as necessary based on area and function). In addition, KPMAS annually or more frequently if indicated, evaluates whether delegated activities are being conducted in accordance with KPMAS expectations and NCQA standards. A designated oversight group/department and/or committee are accountable for the oversight of the delegated activities.

MEDICAL SERVICES QUALITY

Practitioner Participation

Practitioners participate in quality improvement and evaluation activities through administrative and care processes. The Kaiser Permanente practitioner contract includes requirements for contracted practitioners to comply with the Quality Improvement Program. MAPMG and affiliated/network practitioners agree to provide Kaiser Permanente with access to medical records and to participate in QI Program activities. The Quality Improvement Program information is shared with practitioners via intranet/internet access, e-mail updates, and in the Provider Manual. Practitioners are given regular updates on the status of health plan quality activities through numerous internal web sites, network newsletters, and other practitioner mailings.

Kaiser Permanente encourages practitioners to participate in the QI Program through membership and participation in Quality Improvement Committees at the service area and/or service line level. Practitioners are also encouraged to provide feedback to QM staff through practitioner satisfaction surveys.

Kaiser Permanente provides ongoing educational services to practitioners through new practitioner orientation materials, provider manual updates, practitioner meetings, continuing medical education seminars and practitioner training by provider's education staff.

Practitioner and Provider Quality Assurance

The Practitioner and Provider Quality Assurance Department is responsible for the credentialing and re-credentialing of employed and contracted practitioners (individual) and providers (facilities). The department is also responsible for oversight of all delegated credentialing functions.

SECTION 3 – QUALITY MANAGEMENT PROGRAM KEY COMPONENTS

Practitioner Credentialing

The credentialing process follows state, federal and applicable accreditation agency guidelines such as those set forth by the National Committee for Quality Assurance (NCQA). Initial credentialing and re-credentialing are part of the practitioner contract process. Re-credentialing of contracted practitioners is carried out at least every two years for practitioners with privileges and every three years for other practitioners. The Mid-Atlantic States Credentialing and Privileging Committee (MASCAP) oversees all credentialing, re-credentialing, and privileging activities.

Practitioner Performance Review and Oversight

KPMAS has defined a systematic Practitioner Performance Review and Oversight (PPRO) Program for monitoring and evaluating practitioner performance through peer review activities. All providers, licensed independent practitioners (LIP) and allied health professionals (AHP) credentialed to provide care to members are subject to review by PPRO whether they are employed by the medical group or health plan or contracted into the network.

This program enhances the effectiveness of peer review by incorporating a systems approach into the process. It integrates data collection throughout the Mid-Atlantic Region to identify and address opportunities for improving the supporting processes that impact the delivery of healthcare. KPMAS de-centralized some of the departmental peer review committees to bring the findings and educational opportunities closer to the geographical area of the practitioners.

Quality of Care

KPMAS has defined systematic quality of care processes for review, monitoring, tracking, trending, and corrective action. KPMAS has written procedures for taking appropriate remedial action whenever is determined that inappropriate or substandard services are provided, or services that should have been provided were not. Quality of care concerns are forwarded to the Quality Department through the See it, Report it (SIRI) system for review, investigation, and determination and identified through data analysis at the individual practitioner level.

Quality of care concern criteria include but are not limited to:

- Suspicion of missed or delayed diagnosis and/or inadequate treatment or care based on review of chart documentation.
- Suspicion of a potential prescribing and/or dispensing error for medication or durable medical equipment (DME).
- An access delay that may have resulted in an adverse outcome for the patient.

Substantiated quality of care concerns leads to: (1) a written corrective action/remediation plan; (2) specific actions to be taken; (3) provision of feedback to appropriate health professionals, providers and staff; (4) the schedule and accountability for implementing correction actions and the approach to modifying the corrective action if improvements do not occur; and/or (5) procedures for terminating the affiliation with the health professional or provider.

Further, KPMAS monitors the effectiveness of corrective actions. As actions are taken to improve care, there is monitoring and evaluation of these corrective actions to assure that appropriate changes have been made. In addition, changes in practice patterns are tracked to ensure that actions for improvement have been effective.

Behavioral Health Quality

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 and 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 (licensures), monitoring the quality oversight structure for licensed Behavioral Health practitioners, oversight of continuity and coordination of care between Psych/CD, Primary Care and other departments, as well as reviewing of Behavioral Health quality of care/service initiative 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.

SECTION 3 – QUALITY MANAGEMENT PROGRAM KEY COMPONENTS

Clinical Quality of Care Performance

The quality systems used throughout Kaiser Permanente are based upon data that are called the *"Big Q"* which includes Quality, Patient Safety, Risk Management, Utilization Management, Service, and Equitable Care. It provides a coherent, top level view of clinical performance for senior leadership and the KFHP Board as well as an integrated, cascading measurement system for quality improvement and benchmarking. (See Attachment A2 for Clinical Quality Strategy).

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.

Utilization Management

The Utilization Management Program Description defines how the organization's health care delivery system is committed to assuring, assessing, and continuously improving the quality, care, and service delivered to its members through a systematic, integrated approach. Utilization Management within KPMAS is a collaborative partnership between MAPMG practitioners and health plan staff to ensure appropriate treatment and resources are utilized in the management of member's health care needs throughout the care continuum. The goal is to provide the right care in the right setting to the right patient every time.

Transition care management covers transitions from hospital to home or skilled nursing facility/and/or from skilled nursing facility to home. The member or family, his/her attending physician, and the appropriate hospital staff are regularly engaged in the transitions of care shared decision-making activities throughout the member's hospital stay. 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 see the complete 2018-2019 Utilization Management Program Description.

Performance Improvement

KPMAS considers opportunities for improvement in leadership, work environment, clinical care, resource management, and service. Relevant services, departments, teams, and individuals participate in establishing performance expectations, with teams specifically considering expected impacts on performance. KPMAS measures regional and medical center performance to align quality activities and strategic priorities, and to identify opportunities for improvement. Performance measures, benchmarks, thresholds, targets, data, display and analysis, Causal Factor identification, risk prioritization, and Failure Modes and Effects Analysis (FMEA) form the basis for the conversations, plans, and actions that improve care and service, and for measuring processes and outcomes and highlighting opportunities for improvement.

Each clinical indicator has a specified data collection methodology that is designed for the type of indicator and data availability. Data validation is part of the data collection process. Some quality functions and activities are performed primarily at the medical office buildings, while others are executed at the regional level. Emphasis is placed on linking quality assessment and improvement activities with other closely aligned management functions.

KPMAS Analytical Report

The Medical Group Operations Support (MGOS) in the Mid-Atlantic Permanente Medical Group, together with Accreditation, Regulatory and Licensure (AR&L) reporting group from the Quality Department in the Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. provide KPMAS with clinical analytic services. To assure accuracy, timeliness and completeness of data MGOS/AR&L reporting staff employ a series of quality checks for each analytical work product or report prior to its release.

Diversity and Inclusion

The Diversity and Inclusion 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.

SECTION 3 – QUALITY MANAGEMENT PROGRAM KEY COMPONENTS

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 Diversity and Inclusion 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

Pharmacy Quality

Through various methods of evaluation, the Pharmacy department ensures compliance with regulatory and safety standards for medication storage, labeling, dispensing, and compounding in the outpatient, mail order, and infusion pharmacies. The Pharmacy department monitors medication storage in medication areas in the clinics and supports safe medication practices in the Medical Office Buildings. The Pharmacy Patient Safety and Quality Chief supports the department through evaluation of applicable quality metrics and recommending system modifications to enhance quality of care.

The Pharmacy department supports a Culture of Safety where pharmacy staff members can confidently report medication-related events with the goal to enhance patient safety. Medication errors and close call reports are submitted for review via online through the See It, Report It (SIRI) system and are addressed individually and trended. The Pharmacy Patient Safety and Quality Chief oversees the tracking and trending of reported medication events and these reports help identify system or workflow concerns and potential barriers to patient safety.

Complaints, Grievances and Appeals

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.

COMPONENTS OF SERVICE AND ACCESS STANDARDS

KPMAS has established access standards (see the Annual Work Plan for more details). These access standards include parameters for regular/routine appointments, urgent care appointments, and after-hours care. Member Service 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.

SECTION 4 – POPULATION HEALTH MANAGEMENT

OVERVIEW

The KPMAS 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).

Our mission is to provide expertise in population interventions, knowledge of best practices, and to develop innovative relationships between the health care team, specialists, members and patients. Programs are designed to augment and support the key relationship between the primary care physician and the patient. Programs are monitored and opportunities are identified 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 reviews and assess aggregated and trended Commercial, Marketplace, and Medicare Cost membership data to prioritize the quality of care initiatives. Members are provided information for how to use the services, how to participate and how to opt in or out.

Our comprehensive delivery system programs include:

1. Patient Centered Medical Home

KPMAS' Patient Centered Medical Home (PCMH) model of care is designed to improve the quality, appropriateness, timeliness, and efficiency of care coordination including clinical decisions and care plans.

An overall performance goal is to improve the quality and efficiency of health care for members across the continuum from wellness to prevention to managing members with complex and chronic conditions. To achieve this goal, it is the expectation of the PCMH Health Care Team (HCT), led by the Primary Care Physician (PCP), to manage the health of these members. The health plan is responsible for identifying patients who qualify for its wellness, prevention, disease management and complex case management programs, notifying the PCMH HCT about the identification, and maintaining a tracking mechanism that includes these members.

Care coordination, within KPMAS PCMH model, includes the following components:

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

2. Population Care Management Team

Population Care Management is one of the foundations of the KPMAS clinical care strategy that provides evidence-based, systematic support to the health care teams and physicians who care for Commercial, Marketplace, and Medicare Cost beneficiaries. 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 patient used in the PCMH model.

The PCM strategy is based on evidence-based care supported via Clinical Practice Guidelines (reviewed/revised and approved at least every two years).

Member registries, based on claims, encounter, laboratory, pharmacy, health appraisal data, 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 relationship.
- Involvement of the patient in his/her own care.
- Interventions and care designed and tailored to address specific and special needs of patients, 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.

The tools and interventions that arise from these key concepts are targeted across the region at areas of need and potential impact. For each program, the interventions are determined by the health and/or risk of the individual and population.

KPMAS will identify and manage Commercial, Marketplace, and Medicare Cost members with emerging risk based of the population health assessment. An example includes managing glycemic control for people with diabetes to control A1c levels.

3. Case Management Program

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.

Core elements of the case management programs include the following:

- Foster relationships between practitioner/care team and patients
- Promote and coordinate consistent care across the delivery system
- Decrease re-hospitalizations and increase appropriate utilization of service
- Ensure equitable and compliant care

KPMAS offers a variety of case management programs including 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.

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.

4. Health Education/Health Promotion Program

The Health Education and health Promotion (HE/HP) utilizes screening tools to identify members with wellness and prevention needs and facilities referrals to a 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. An example includes the flu vaccination outreach program to all eligible Commercial, Marketplace, and Medicare Cost members.

For full details of each of the above PMH programs (PCMH, PCP, Case Management, HE/HP) see the respective program descriptions.

SECTION 5 – PATIENT SAFETY AND RISK MANAGEMENT

BIG Q DASHBOARD: PATIENT SAFETY AND RISK MANAGEMENT OVERVIEW

Risk and Patient Safety Management Program

The 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 Risk and Patient Safety Committee, Regional Quality Improvement Committee (RQIC) and the Quality Committee of the MAPMG Board. Enhancements are made to the clinical Risk Management/Patient Safety improvement activities when appropriate. Improvements in the Risk and Safety Programs are transferred through an environment of shared learnings on specific, preventable adverse outcomes for facilitating appropriate changes in clinical practice and healthcare team performance.

Patient Safety Program

The Patient Safety program's mission is to promote an interdisciplinary collaborative approach towards delivering patient-centered care. It is critical that the health care received by our members is timely, equitable, efficient, reliable, effective, and safe. This mission is founded on a philosophy that believes "patient safety is every patient's right and every leader's, employee's, physician's and patient' responsibility". Patient safety requires an ongoing and relentless commitment towards identifying opportunities for improvement, building safer care delivery processes and systems, and reducing harm to our patients. Our organization is on the journey to becoming a Highly Reliable Organization. Examples of patient safety initiatives for 2018 include but are not limited to: patient identification, specimen handling, demographic capture, fall prevention, medication reconciliation post hospitalization, and ambulatory surgery center simulations of high-risk events (e.g. Code Blue and Malignant Hyperthermia).

Risk Management Program

The Risk Management program monitors the care delivery processes for continuous process improvement. The department reviews and manages risks reported through the See It Report It! (SIRI) incident reporting system. Individual cases are reviewed, tracked, and referred to operational leadership for review and for leaders to act to prevent recurrence. SIRI reports and SIRI near miss reports are also trended and the data inform regional process improvements. The SIRIs may require that a quality of care review process is necessary and this item assists in coordination of that process. We provide investigation, consultation and analysis of events and systems failures and identify evidence-based best practices to inform our care processes. The team does so by performing Comprehensive Systematic Analysis (CSA) using Cause Mapping methodologies. We support safe care by developing and providing risk management/patient safety training and resources to providers and staff. We foster an environment that is free of blame in support of a Culture of Safety in which all staff feel safe to speak up and report any errors or concerns. We offer coaching to enable empathetic disclosure and early resolution resources to our members in response to adverse events. We promote the care team to being honest and transparent in our mission, vision, and values.

SECTION 6 – CARE EXPERIENCE OVERVIEW

Care Experience Overview

Member perceptions, experiences and requests drive quality improvement initiatives. Kaiser Permanente expects leaders, practitioners, and employees within its individual regions to consistently provide a satisfying care experience for members and patients. This is accomplished through operational programs designed to provide quality service processes addressing the care experience and by monitoring and improving key aspects of service. These include leadership and management practices, access and the availability of services, the work environment, and the perception of member/patient service quality. A National 2018 service initiative is a training program for all employees entitled *The One KP Experience.* The goal is for members to have the best experience everywhere and every time.

Infrastructure Capabilities to Optimize

To accomplish our aim, we build upon the foundations of our people, our processes and our systems by:

- Targeting performance expectations at being the best in the industry by benchmarking our individual and collective performance against the industry, reducing variation in out outcomes.
- Optimizing the inherent benefit of our organizational structure by ensuring an integrated approach to all our work efforts and care provided.
- Strengthening a culture of personal accountability from each of our clinicians, staff, and managers.
- Actively engaging our people in the work on performance improvement and providing performance improvement tools and skills to staff and clinicians. Initially we will focus on the frontline staff, but move to increasing the performance improvement skills of mid-level and senior managers as well.
- Leveraging KP HealthConnect and other health informational tools to make it easy to so the right thing at the right time for all the patients and members.

The KPMAS President and TPMG Associate Executive Director have the ultimate responsibility for the success of customer service activities. They, in turn, assign accountability to clinical and operations managers for customer service activities. The KPMAS Regional Quality Improvement Committee (RQIC) functions include monitoring initiatives; reviewing the results of member satisfaction, employee and clinician satisfaction surveys, and monitoring appointment access and availability metrics. The customer service satisfaction data is gathered from a variety of sources including: member satisfaction surveys (e.g. Member Experience, Tracking, Evaluation, and Opinion Research/METEOR, Member Patient Satisfaction/MPS, and Consumer Assessment of Healthcare Providers and Systems/CAHPS surveys), customer complaint reports, member appeals reports and patient satisfaction survey results. Additionally, the RQIC uses the information reported to prioritize quality improvement initiatives in collaboration with the Delivery System Council to set performance targets for the region.

Big Q Dashboard Scope

To meet the organization's mission of providing initiatives that result in improved member satisfaction, KPMAS executive leadership monitor key measures of effectiveness:

- Members will have a regular primary care physician or health care provider
- Members will have the ability to see their own physician or a familiar provider when they come in for care in primary care
- Members will be satisfied with the wait for appointments in primary care or in specialty care
- Members will be satisfied with the end and overall phone services associated with their visit to a clinic
- Members will be satisfied with their care experience in their office visit

Member Satisfaction

Measuring how well KPMAS meets or exceeds members' expectations is a critical activity for quality assessment and improvement. Member and patient satisfaction measurements are tracked through a variety of sources (surveys, complaints, inquiries and appeals). Data gathered from these sources are translated into actionable information which is used to provide relevant member feedback and improve services delivered at every level in the organization.

SECTION 6 – CARE EXPERIENCE OVERVIEW

KPMAS aggregates member complaint data on a quarterly basis derived from the Member Services categorization of feedback that was received during the prior quarter.

KPMAS uses many tools to measure satisfaction. These include, but are not limited to:
1. Consumer Assessment of Healthcare Providers and Systems (CAHPS)
2. Complaint and Appeal data
3. Member Experience Tracking Evaluation and Opinion Research (METEOR)
4. Member Patient Satisfaction Survey (MPS)
5. Press Ganey (Patient Experience Survey (Ambulatory Surgery Center)
6. Adhoc Focus Group Surveys

The Market Research Department coordinates and conducts the detailed analyses of the member and patient survey results, including, but not limited to the Consumer Assessment of Health Plans Survey (CAHPS) and Member Experience Tracking and Evaluation and Opinion Research (METEOR) Surveys, and adhoc focus group surveys. Routine analysis includes, but is not limited to showing trends in Region's performance overtime, changes in performance and comparison to "best performing" KP Regions, non-member survey analysis and competitive market performance. To support application of the data, the National Market Research local staff within KPMAS and the Program Office is responsible for analysis of the data.

STRATEGIC PLATFORM (A1)

ATTACHMENT

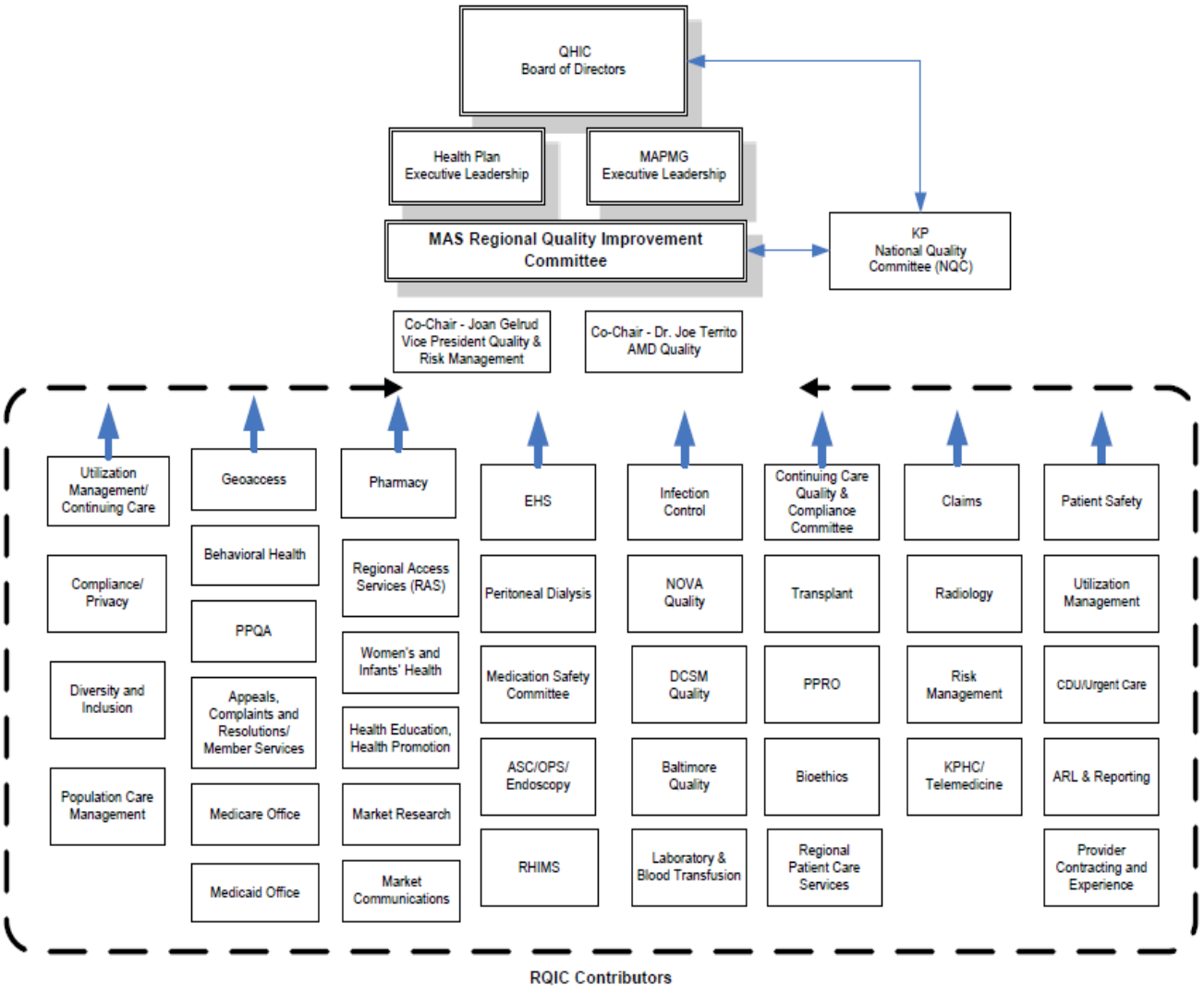
CLINICAL QUALITY STRATEGY (A2)

Our overarching goal is to advance Total Health to support people living their lives to the fullest possible extent. Our strategy is built on our integrated, inter-disciplinary care, led by Permanente physicians in partnership with our nurses, providers and care teams, and is based on the Institute of Medicine's Six Aims for Improvement.

- ✓ SAFE: We are the safest system in which to receive and provide healthcare. 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.
- ✓ PERSON CENTERED: Providing respectful and responsive care that is designed to give our patients the best possible experience.
- ✓ TIMELY: Respecting the value of time for both patients and each other.
- ✓ 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.

ATTACHMENT

ORGANIZATION CHARTS (B1)
RQIC – Quality Committees, KPMAS, and MAPMG



ATTACHMENT

Organization Charts (B2)
MID-ATLANTIC EXECUTIVE LEADERSHIP TEAM

ATTACHMENT

REGIONAL QUALITY IMPROVEMENT COMMITTEE CHARTER (C)

REGIONAL QUALITY IMPROVEMENT COMMITTEE	
Committee Sponsors: Regional Quality Improvement Committee	
Committee Members (Voting):	Roles
• 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 system provides expertise concerning internal and external regulatory standards.
• 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 and expertise.
• 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.
• 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.
• 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.
• 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.
• Physician in Chief (3)	Provides expertise in operational decisions and potential impact o recommendations across the delivery system; accountable to insure implementation of committees' decisions.
• 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 privileges.
• Vice President, Operations (3)	Provides expertise in operational decisions and potential impact o recommendations across the delivery system; accountable to insure implementation of committees' decisions.
• Senior Director, Quality Management	Provides expertise to meet the regulatory and accreditation Standards in credentialing, delegation and peer review.

• Senior Director, Accreditation, Regulation, Licensure and Reporting	Provides expertise for accreditation, regulatory and licensure standards.
Facilitators and Recorder (non-voting) • Senior Project Manager AR & L (HP) • Quality Project Manager (MAPMG)	Facilitates work of the committee.
Non-Voting Members (attendance optional) • APIC, Quality (MAPMG) (3)	Provides quality of care perspective of physicians in the delivery system.
• Director Accreditation and Compliance	Provides expertise for NCQA Accreditation and Standards, State of Maryland and Commonwealth of Virginia quality regulations.
• Director, Encounter Infometrics and Operations (MAPMG)	Provides expertise in the analysis of the coding data; medical record review standards; routine monitors.
• Director, Population Care Management (MAPMG)	Provides expertise in the programs of population care management.
• Director of Quality Improvement (MAPMG)	Provides expertise in publicly reported clinical effectiveness of care measures.
• Manager, Infection Control	Provides expertise for infection prevention and control
• Physician Director, Pharmacy & Therapeutics/ Medication Safety	Provides expertise related to Pharmacy and medication safety fro the clinical perspective.
• Senior Director, Enterprise Risk Management/ Patient Safety	Provides oversight to increase patient safety and reduce possible harm in the delivery of health services across all care settings.
• Senior Director, Patient Care Services	Provides expertise on the ambulatory care Nursing Practice Standards and assessment of the region's adherence to the standards.
Reporting Departments • Ambulatory Surgery Services	Provides expertise in the analysis of the data and information through all components of the ASC; recommend opportunities for improvement.
• Behavioral Health Services	Provides oversight to the quality of care and services delivered; support continuous improvement; meet regulations and accreditation standards in Behavioral Health.
• Diversity & Inclusion Program	Provides expertise to meet the regulatory and accreditation standards to meet the regulatory and accreditation standards for diversity programs.
• Geoaccess Report	Provides report that demonstrate adherence to the accreditation and regulatory geoaccess standards; recommend opportunities for improvement.

• Health Education/Women's Issues	Provides report on member health education and women's issues.
• Imaging Services & Radiation Safety	Provides expertise in the analysis of the radiology systems and process monitors and assessment; safety monitors and improvements; member satisfaction.
• Infection Control	Provides expertise on the requirements that personnel must meet to attain clinical accreditation and regulatory compliance with infection control standards.
• Laboratory Services	Provides expertise in the analysis of the laboratory systems and process monitors and assessment; safety monitors and improvements; member satisfaction.
• Medicaid	Provides reports on membership, delegated vendor performance, care delivery initiatives, and quality improvement initiatives.
• Medication Safety/Pharmacy Services	Provides expertise in the analysis of the pharmacy systems and process monitors and assessments; medication safety monitors and improvements; members satisfaction.
• Member Services Department	Provides expertise in the analysis of the member inquiry, Complaint, and appeals data for the appropriate service programs, priorities and corrective action plans can be implemented.
• Peritoneal Dialysis	Provides reports on the functioning of the Peritoneal Dialysis Programs.
• Population Care Management	Provides expertise in the analysis of the data and information through all components of population care management.
• Practitioner Performance Review & Oversight	Provides expertise on the requirements that personnel must meet to attain clinical accreditation.
• Practitioner & Provider Quality Assurance	Provides reports that analyze the adverse events and near misses that occur in connection to the electronic medical record.
• Regional Access	Provides expertise in the analysis of primary care, specialty care and behavioral health appointment and telephone access results, improvement activities, member satisfaction.
• Regional Patient Care Services	Provides expertise on the ambulatory care Nursing Practice Standards and assessment of the region's adherence to the standards.

• Risk Management/Patient Safety	Provides expertise in the analysis of the data and information through all components of Risk Management and Patient Safety; recommend opportunities for improvement.
• Service Area Quality Committees	Provides expertise in quantitative and qualitative data analysis.
• Urgent Care/Clinical Decision Unit	Provides reports on the functioning of the Urgent Care and Clinical Decision Units.
• Utilization Management Committee	Provides KPMAS standards leadership for accreditation and regulatory requirements, monitor utilization and facilitate performance improvement related to Utilization Management.

Purpose

- Evaluates the quality of care and services provided to KPMAS members in all settings.
- 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.
- 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 participation in the Quality improvement programs through planning, design, implementation or review.
- 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.
- Establish 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).
- Review 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 of 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.

Term Limits:	There are no limits though membership is assessed periodically.
Meeting Schedule:	3rd Wednesday of every month no fewer than 10 in person meetings per year. At the discretion of the Committee Chair and Co-Chair, meetings maybe electronic.
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.

KPMAS QUALITY RESOURCES AND QUALITY MANAGEMENT (D)

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 is 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, Accreditation, Regulation, Licensure and Reporting 1.0 FTE
- Senior Director, Quality Management 1.0 FTE
- Director Accreditation and Compliance Oversight 1.0 FTE
- Data Analysts 4.0 FTE
- Senior Project Manager 2.0 FTE
- Senior Manager HEDIS 1.0 FTE
- AR & L Clinical Specialist 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 9.0 FTE
- Enrollment Coordinators 2.0 FTE
- Credentialing Assistants 2.0 FTE
- Analytical and Support Staff 2.0 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.

MEDICAL DIRECTOR OF MEDICARE COST AND PART D PHARMACY PLANS (E)

The Medical Director of Medicare Cost and Part D Pharmacy Plans is responsible to:

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

The Permanente Medical Group medical director’s active in these areas are accountable to the Medical Director of Medicare Advantage and Part D pharmacy plans for this work.