Kaiser Permanente
Mid-Atlantic States
2015 Regional Quality Program Description
Regional Quality Improvement Committee (RQIC)
2015 (Revision Approved 6/17/15)
(All Lines of Business)
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OVERVIEW
Kaiser Foundation Health Plan and Kaiser Foundation Hospitals (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. They determine and adopt policy to guide the organization, adopt and monitor strategic goals and performance, and select key executive leadership.

The Board established the Quality and Health Improvement Committee (QHIC) to: (1) provide strategic direction for quality assurance and improvement systems; (2) provide 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 and (3) provide oversight of the Program's quality assurance, 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 of care and services provided to members. These include core documents such as:

- Regional quality oversight committee minutes
- National Quality Committee minutes
- Regional quality program descriptions, annual quality work plans, annual quality program evaluations
- Joint Commission core measures, Leapfrog, HCAHPS and KP- other available inpatient quality data from our contracted providers
- Sentinel events and complaints
- National quality and population management results (HEDIS)
- Ambulatory Surgery Center Annual Report

The Kaiser Permanente National Quality Committee (KPNQC) is composed of KFHP and KFH senior quality leaders and 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 improve continuously the quality of clinical care and services provided by the organizations that constitute the Kaiser Permanente Medical Care Program.

Kaiser Permanente Mid-Atlantic States - 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 KPMAS President and TPMG Associate Executive Director in collaboration with the KPMAS Vice President of Quality Resource Management and the Associate Medical Director of Quality, and Service Area leadership:

- Establish a quality program and structure of committees that provide effective oversight and review;
- Hold KFHP and MAPMG physicians, managers, and staff responsible for functions related to quality management, patient safety, behavioral health care, credentialing, risk management, utilization management, monitoring and resolution of member complaints and appeals, assessment of member satisfaction, peer review, departmental quality review, medical records review, regulatory, and accreditation compliance;
• Establish annual strategic quality goals and objectives as well as quality performance targets for Commercial Non-Market Place, Commercial Market Place, Medicare and Medicaid (Virginia and Maryland) service areas as applicable;
• Direct action (including QI program structure changes) as necessary to improve the quality of care and Non-Market Place, Commercial Market Place, Medicare and Medicaid (Virginia and service in Commercial Maryland) service areas as applicable;
• Establish quality of care and service expectations, standards, and priorities; and
• Receive and review regular written regional quality reports, make inquiries and take action as appropriate (including the oversight and approval of the regional annual quality program description, quality work plan and the quality evaluation).

Regional Quality Strategy and Goals
The quality program of KPMAS seeks to promote and support continuous improvement in the delivery of care and service. The program relies on physician and staff understanding and accountability for quality, reliance on measurement and continuous improvements in care and service delivery processes. The Regional Strategic Imperatives’ five objectives are based on our vision, mission, values and business plan.

Regional Strategic Platforms (Attachment A: See Advance our Mission on Affordability)
1. Health Care Transformation – Continuous improvements and innovation in quality of care, patient experience, and health outcomes while delivering highly reliable care
2. Sustainable Growth – Above market growth and new growth opportunities that best leverage our assets and enable ongoing investment in our mission and strategy
3. One KP – “The best” that KP has to offer to our patients, members and purchasers, regardless of where they are and how they access KP

Regional Quality Improvement Committee (RQIC) (Attachment C)
RQIC is chartered to perform quality oversight for KPMAS and MAPMG. RQIC is Co-Chaired by MAPMG’s Associate Medical Director for Quality and KFHP’s Vice President Quality Resource Management. The RQIC reports on clinical activities and functions to the KFHP Board of Directors addressing initiatives covering Commercial Non-Market Place, Commercial Market Place, Medicare and Medicaid (Virginia and Maryland) service area member as applicable (per accreditation and regulatory requirements).

The RQIC is comprised of physician and non-physician MAPMG and KFHP leadership with direct accountability and responsibility for quality assessment and improvement, utilization management, risk management, access, service, patient safety, nursing practice, and behavioral health (BH). A BH practitioner (psychiatrist) is involved in the BH care aspects of the QI Program in Commercial Non-Market Place, Commercial Market Place, Medicare and Medicaid (Virginia and Maryland) service areas as applicable. Note: BH is carved out of the benefits

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BEHAVIORAL HEALTH by Line of Business

2015 QUALITY PROGRAM DESCRIPTION
(All Lines of Business)
KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATE AND MID-ATLANTIC PERMANENTE MEDICAL GROUP
Confidential
Annually, the RQIC approves the Quality Program Description(s) as defined by the regulatory/accreditation requirements, Program Evaluation(s), and Work Plan(s) as required by product line that also include any recommendations from QHIC. The Annual Work Plan includes activities with goals (new, modified from prior years, and ongoing), targets, monitoring timeframes, responsible person, and planned reporting. The Annual Evaluation documents and assesses the activities, accomplishments, and barriers from the previous year.

The KPMAS annual evaluation includes a comprehensive assessment of the organizations quality program effectiveness and the organization’s progress to achieving safe clinical practice goals based on quantitative and qualitative analysis. The summary of the quality program’s effectiveness addresses:

- Adequacy of QI program resources.
- QI committee structure
- Practitioner participation and leadership involvement in the QI program
- Need to structure or change the QI program for the subsequent year.

The RQIC assigns certain responsibilities to subcommittees that are required to report to RQIC at least quarterly, or more often as necessary. The RQIC subcommittees have the accountability to review and approve reports that do not require RQIC review or action. Communication regarding actions and recommendations flows between the RQIC and the subcommittees.

The KPMAS is comprised of three Service Areas, Northern Virginia (NOVA), District of Columbia/Suburban Maryland (DCSM), and Baltimore. All of the Service Areas have their own quality steering/executive committee. 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 through the service line quality committees and the health care team (HCT) meetings.

KPMAS expanded services 2013-present to the Market Place/Exchanges (DC, MD, and VA), Virginia Medicaid and Maryland Medicaid managed care (HMO) lines of business. MAPMG quality leaders achieved and maintain ongoing quality oversight and management of the majority of MAPMG primary care practitioners that have received NCQA Diabetes Recognition and NCQA PCMH Recognition in all of the medical centers which represent the locations where a majority of our managed care (HMO) members receive their care.

PROGRAM OVERSIGHT PRACTICES

Minutes
The RQIC document their deliberations, decisions, and actions through contemporaneous minutes. Meeting minutes are reviewed and approved by members at subsequent meetings. The minute’s format include: Topic, Discussion, Conclusion/Action, and Follow-up/Responsible Person. The RQIC minutes are submitted for information-sharing purposes to the QHIC. The minute’s format provides for tracking of unresolved issues and reporting of follow-up. The minutes are confidential, privileged, and protected from discovery according to state and federal legal regulations.

Effectiveness of the Program
An annual evaluation of KPMAS’s Quality, Utilization, Risk, Patient Safety Programs, and Access, and Service is conducted. This includes a review and revision of the Program Description, Work Plan and Evaluation as well as evaluating the structure, patient safety program, deployment of resources, prioritization of activities, the effectiveness of clinical care, and quality of services
provided to members. KPMAS informs members that QI program processes, goals and outcomes related to member care and services is available upon request in member handbooks, newsletters, and on the website (with web-link information in publications) about the QI program processes, goals and outcomes related to member care and services, in language that is easy to understand (English and Spanish). Practitioners and contracted entities are also informed that QI program processes, goals and outcomes related to member care and services information is available upon request and web link information is included in published materials (Provider Manual, Provider and Practitioner Newsletter at least annually).

The RQIC reviews and approves the regional program documents including committee charters before they are submitted to the Boards’ QHIC. The KFHP Boards QHIC evaluates KPMAS’s Program through a designated process. In addition the National Committee for Quality Assurance (NCQA) conducts external evaluations.

Delegation Statement
A mutually agreed upon document is constructed to describe the delegated activities, responsibilities of KPMAS and the delegated entity, the frequency of reporting to KPMAS, an evaluation process of the entity’s performance and remedies available if the entity does not fulfill its obligations. 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 is accountable for the oversight of the delegated activities.

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.

KPMAS performs delegation oversight of management functions delegated to outside entities by monitoring reports, and analyzing data and corrective actions implemented as necessary based on area and function. KPMAS has established limited delegation of specific functions including: credentialing, limited UM delegation for pharmacy claims. No quality improvement functions are delegated. . Regular updates as applicable are provided as frequently as quarterly to the MASCAP/RQIC and pharmacy committee.

Prior to delegation, KPMAS assembles a team to evaluate the entity’s capacity to perform the delegated activities, review and approve the delegated entity’s work plan and program description and evaluate regular reporting needs.
PURPOSE
The purpose of this section is to inform both internal and external audiences how KPMAS supports the Program’s commitment to assessing and improving performance on a continuous, systematic, and outcome-oriented basis. The Kaiser Permanente Mid-Atlantic States (KPMAS) Quality Program is based upon the organization’s mission.

Components of the Quality Program
The KPMAS Quality Program defines quality care as that which:
- Meets the expectations of our members;
- Is consistent with the state of medical evidence and subject to continuous improvement;
- Enhances overall wellness, increases the likelihood of positive outcomes and provides a supportive environment when a positive outcome is not possible;
- Exceeds the performance established by accreditation bodies and public agencies and
- Allows all the people of KPMAS to agree that the organization is providing superior clinical care and compassionate, customized service.

The Quality Program:
- Provides resources to staff and support for KPMAS’s quality-related committees, teams, and activities
- Provides programming, analytic support, and other needed resources to measure results;
- Conducts medical record/administrative data reviews for quality improvement;
- Sets standards for the peer review processes;
- Directs initiatives to improve member and practitioner satisfaction;
- Directs initiatives to improve the adequacy and access to services;
- Directs initiatives to improve quality oversight of behavioral health services;
- Performs oversight for prevention and health promotion;
- Directs initiatives to improve continuity and coordination of care;
- Directs initiatives to improve linkages with utilization management initiatives;
- Performs oversight of new technology;
- Directs initiatives to improve patient safety throughout the organization;
- Ensures linkages with risk management findings;
- Ensures linkage with Member Services related to member concerns regarding quality of care;
- Ensures compliance with regulatory and accreditation requirements;
- Prepares and presents Performance Improvement data/reports and
- Provides oversight of delegated responsibilities.

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 for example laboratory, radiology and pharmacy. Physicians and staff also serve on Quality Program Committees across the region. The activities include, but not limited to:
### Accreditation:
- Health Plan Accreditation (NCQA)
- Patient Centered Medical Home (NCQA)
- Market-Place/Exchange Accreditation (NCQA) and non-Market-Place/Exchange Accreditation (NCQA)
- Accreditation Association for Ambulatory Health Care (AAAHC)
- Compliance with federal, state, payor, and accreditation standards/requirements/regulations

### Other regulatory, management monitoring, reporting:
- Practitioner and Provider site audits
- Hospital services management processes
- State and federal reporting as required by contract
- Utilization Management
- Member Services
- Credentialing/Re-credentialing Board Certification
- Monitoring/analysis and reporting of care and service provided by delegated provider/vendor

### Clinical Indicators:
- Ancillary Services: Laboratory Services, Pharmacy, and Radiology, E-Clinical Services
- Quality of care concerns
- Medical record documentation and clinical information service
- Health education and Health Promotion and Women’s Health (reporting per contract, accreditation, and regulatory requirements)
- High risk and high volume services
- Effectiveness of care measures
- Clinical outcome measurements
- Behavioral Health Services (reporting per contract, accreditation, and regulatory requirements)
- Accreditation and regulatory audit findings
- High Risk Event Management
- Utilization patterns
- Disease and population management program reporting
- Risk Management/ Patient Safety Program
- NCQA Medicaid HEDIS® Measures (Contract Specific: VA Medicaid and VA FAMIS)
- Physicians PCP with Diabetes Recognition
- Medicaid Performance Improvement Projects (PIPS)
- Case Management (CM) Services
  - Adult/Pediatric CM
  - Pediatric Complex CM
  - Perinatal CM
  - Adult Complex CM
- Outreach
  - Screening and follow up:
    - High Risk Perinatal

### Service Indicators:
- Consumer Assessment of Healthcare Providers and Systems (Medicaid CAHPS®: Adult & Child)- Medicaid, Medicare and Commercial 5.0
- Patient Satisfaction Survey
- Practitioner Satisfaction Survey
- Member Operations Call Abandonment
- Member Operations Average Speed to Answer (Timeliness)
- Complaint resolution, tracking and trending
- Appeals and grievance resolution, tracking and trending/analysis
- Service performance measures
- Clinical practice and preventive care guidelines
- Practitioner and staff satisfaction
- Member and patient satisfaction (e.g. complaints, satisfaction survey findings)
- Access and availability of practitioner
- Health plan online and phone interactive consumer and patient resources
SECTION 2- Quality Management Program

- Smoking, ETOH and substance abuse during pregnancy
- Childhood Immunizations
- Well-Child Visits 1st 15 Months
- Lead Screening
- EPSTD/EQRO and SPR
- Disease Management (DM) Initiatives/Programs:
  - Asthma
  - Diabetes
  - Heart Disease
  - Childhood Weight Management and Nutrition
  - Heart Disease
  - Chronic Obstructive Pulmonary Disease (COPD)
- Chronic Care Patient Survey (Specific to Disease Management populations)
- Ambulatory Surgery Center services
- Peritoneal Dialysis
- Continuity of care

CONFIDENTIALITY AND CONFLICT OF INTEREST

Privacy and Confidentiality
The Compliance Controls Committee was formed and sponsored under the auspices of the Regional Quality Improvement Committee (RQIC). The Privacy and Security Program of Kaiser Permanente of the Mid-Atlantic States is charged with education of our members and workforce regarding privacy and security standards; monitoring of compliance with departmental privacy, confidentiality and security policies; and investigation of reported privacy and security concerns and the elimination or mitigation of substantiated privacy and security violations. The Privacy Program expanded to incorporate and address the mandates under Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and American Recovery and Reinvestment Act (“ARRA”)/ Health Information Technology for Economic and Clinical Health Act (“HITECH”).

MEDICAL SERVICES QUALITY

Practitioner Participation
Practitioners participate in quality processes through administrative and patient 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, in updates through the member communication(s), and in the Provider Manual. Practitioners are given regular updates on the status of health plan quality activities through the numerous internal web sites, The Permanente Journal, Network News 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 regional 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 and practitioner training by providers’ 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 (individuals) and providers (facilities). The department is also responsible for oversight of all delegated functions.

**Practitioner**
The credentialing process is a formal system designed to query, verify, investigate, track and report all information regarding the competency of health care practitioners who have a contract with MAPMG or KFHPMAS to provide care to Kaiser Foundation Health Plan members.

The credentialing process is designed to ensure that all licensed independent practitioners and allied health practitioners are qualified, appropriately educated, trained, competent and able to deliver high quality care in accordance with the organization’s standards of care as well as all appropriate state and federal regulatory agency guidelines.

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 recredentialing are part of the practitioner contract process. Recredentialing of contracted practitioners is carried out at least every two to three years. The Mid-Atlantic States Credentialing and Privileging Committee oversees all credentialing, recredentialing, 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 for 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.

We have de-centralized our larger departmental peer review committees in order to bring the findings and educational opportunities closer to the geographical area of the practitioners. The decentralized committees are known as Peer Review Committees by Service Area and specialty.

**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, as determined under that inappropriate or substandard services are furnished, or services that should have been furnished were not. Quality of care concerns are forwarded to the Quality Department from AECE/Member Services and through Unusual Occurrence Reporting for review, investigation, and determination.

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. Examples might include: i. Re-hospitalization within 72 hours for the same or related condition; ii. A second visit for the same diagnosis or chief complaint within 72 hours of an initial office or emergency department visit due to suspected wrong or missed diagnosis or inadequate treatment; iii. A second opinion that might differ from the
opinion of the initial treating physician for the same presenting symptoms; iv. Delay in receiving breathing treatment or pain relief and v. A misread of radiological procedure (e.g. x-ray, MRI).

- Suspicion of a potential prescribing and/or dispensing error for medication or durable medical equipment (DME)
- An access issue that may have resulted in an adverse outcome for the patient. Examples might include: i. Cancer diagnosis when member had been unable to schedule a timely screening exam; ii. A hospitalization or re-hospitalization because follow-up tests were not scheduled or completed timely.

Substantiated quality of care concerns lead to: i. a written remedial/corrective action plan; ii. specific actions to be taken; iii. provision of feedback to appropriate health professionals, providers and staff; iv. the schedule and accountability for implementing corrective actions; v. the approach to modifying the corrective action if improvements do not occur; and vi. 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 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.

Pharmacy Quality
Through various methods of evaluation, the Pharmacy Department monitors compliance with safety standards for medication storage, labeling, dispensing and compounding in the outpatient, mail order, and infusion pharmacies as well as medication areas in the Medical Office Buildings.

The Pharmacy Patient Safety and Quality Chief is responsible for evaluating quality monitors and assessing the need for system modifications to enhance quality of care. Concerns around medication use safety (medication errors and/or close calls) are submitted for review via the Unusual Occurrence Reporting (UOR) system. Pharmacy Patient Safety and Quality Chief oversees the tracking and trending of the medication events which are used to help identify system issues, identify barriers and develop a performance improvement plan. The Pharmacy department supports a Culture of Safety where pharmacy staff members can feel comfortable reporting medication errors and close calls to enhance patient safety.

Regional Health Information Management Systems (RHIMS)
Medical records are to be maintained in a manner that is current, detailed and organized, and that permits effective and confidential patient care and quality review. KPMAS has policies describing 1) confidentiality of medical records, 2) medical record documentation standards, 3) an organized medical record keeping system and standards for the availability of medical records and 4) performance goals to assess the quality of medical record keeping. The HIMS Quality Improvement program evaluates the organization’s effectiveness and efficiency in meeting the standards mandated by regulatory and accreditation agencies as well as Kaiser Permanente of Mid-Atlantic States (KPMAS) internal quality improvement (QI) performance measures. The organization’s electronic medical record, KP HealthConnect™, is the primary source of information for HIMS quality improvement activities. Bi-annual coding and documentation assessments are conducted to determine compliance with KPMAS standards and are reported at least annually to the RQIC.

Clinical Quality of Care Performance
The quality systems used throughout Kaiser Permanente are based on what has been called the “Big Q”, which includes Quality, Patient Safety, Risk Management, Resource Stewardship, 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.

QUALITY
Several areas within KPMAS provide staff, technical, and analytic resources to assist in meeting Mid-Atlantic States Regional, Service Area and Product Line goals with respect to quality. These include the key MAPMG Departments and KFHP Quality Departments. In addition, support is provided by a variety of other departments which are significantly related to quality improvement.

Crossing the Quality Chasm (Quality Goals)
In the third quarter of each year, TPMG/MAPMG identifies a group of focus areas (Clinical Quality Goals) for the coming year. Quality Chasm 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 Service Areas. Quality Chasm Goal results are reviewed by the relevant Leadership Groups on an ongoing basis and by the relevant leadership for each measure at the medical center and reported to RQIC. The 2014 Quality Chasm goal focus areas are specified in the 2014 Work Plan.

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 in order to align quality activities and strategic priorities, and to identify opportunities for improvement. Performance measures, benchmarks, thresholds, targets, data display and analysis, root cause analysis, risk prioritization, and failure modes and effects analysis 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, frequency, and for most indicators, data are reported at least annually. The methodology for data collection is dependent on 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 more appropriately at the regional level. Emphasis is placed on linking quality assessment and improvement activities with other closely aligned management functions.

Performance Improvement Institute / Advisors
The Improvement Institute is a seven-day fellowship program designed to assist healthcare delivery system leadership execute high-priority initiatives. Institute participants are staff selected by executive leadership teams who are dedicated improvement advisors to the team. This program is designed to provide Improvement Advisors with the knowledge and skills to guide the development and implementation of Performance Improvement (PI) projects throughout the organization. Improvement Advisors are selected by their Executive Leadership teams and must have dedicated time allocated for their PI work. Participants are required to attend the entire seven day program delivered in two sessions offered 8-10 weeks apart.

HEDIS (Healthcare Effectiveness Data and Information Set)
HEDIS 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. This data allows users to both evaluate the quality of different health plans along a variety of important dimensions, and to make their decisions about health plans based upon demonstrated value rather than simply on cost. The performance measures in HEDIS are
related to many significant public health issues such as cancer, heart disease, smoking, asthma, and diabetes. HEDIS measures are an integral part of health plan accreditation by NCQA and performance is reported to the RQIC annually. Selected HEDIS measures are tracked monthly and widely shared internally.

KPMAS Analytical Support
The Medical Group Operations Support (MGOS) in the Mid-Atlantic Permanente Medical Group, together with the Accreditation, Regulatory and Licensure (AR&L) Reporting from the Quality Department in the Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. provides KPMAS primarily with clinical analytic services regarding HEDIS measures, NCQA reporting, Care Management Institute reporting and various other clinical and analytical reporting needs of the organization. It also provides reports and information to satisfy the various regulatory requirements for Commercial Non-Market Place, Commercial Market Place, Medicare and Medicaid (Virginia and Maryland) service areas as applicable. The KPMAS Data Warehouses (DW and Clarity) are the primary source of data for reporting.

To assure accuracy, timeliness and completeness of data MGOS/AR&L staff employ a series of quality checks for each analytical work product or report prior to its release. For example, for projects that involve monthly reporting, each new month’s work product is compared with previous monthly reports to detect and resolve potential errors before the report is released. Clinical reports are given to the program owner for review and comment prior to release and feedback and questions are encouraged at any point during the analytic process. Member and patient lists are shared with users and physicians to help validate the results.

The Population Care Management Program maintains registries of members for numerous disease management programs including Diabetes, Asthma and Coronary Artery Disease. Daily the registries are updated and monitored for accuracy and completeness of clinical information, and completeness of clinical information.

System Resources for Quality
Mid-Atlantic States KFHP and MAPMG advocate for the best use of information technology in medical care and clinical operations. Support is provided for clinicians and other staff in getting the most benefit from the information systems and tools they use. Information technology tools are available that:
- Assist clinicians in their practice;
- Improve member access and service;
- Enhance the patient’s experience;
- Support Service Area operations and
- Promote local innovation.

Diversity and Inclusion
The Diversity and Inclusion Department produces and maintains numerous programs, diversity related policy, and cultural awareness trainings to ensure the of delivery of culturally and linguistically appropriate care and services (CLAS) that meet the needs of our 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 Diversity and Inclusion Department seeks to promote, support, and assist in the coordination of key diversity business needs with a strategy to meet the following objectives:
- Provide culturally proficient care and service to eliminate disparities and demonstrate equity.
- Optimize and as needed adjust workforce diversity and cultural proficiency at every level and create inclusive environments.
• Provide the most compelling value for our diverse populations.
• Build diverse and thriving communities.

**Equitable Care**
Kaiser Permanente continues our commitment to continually improving methods for collecting member demographic data on race, ethnicity, and language preference. In addition, to the member self-disclosed demographic/race-ethnicity-language data, KP has innovative tools like our electronic health record, KP HealthConnect, with our Geographically Enriched Member Socio-demographics (GEMS) datamart. These tools have produced a granular collection of reported and imputed data on our members' racial, ethnic, geographic, linguistic, and socioeconomic characteristics. By linking that information with care quality and utilization data, KP has increasingly been able to measure the scope of existing health disparities among our members, as well as improve our understanding of their causes and our progress in reducing them.

**Clinical Care Experience/Service Data Performance**

**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 is translated into specific information which is used to provide relevant member feedback for services delivered at every level in the organization.

KPMAS aggregates member complaint data on a quarterly basis derived from the Member Services categorization of feedback that was received during the prior quarter. Causes of member dissatisfaction are reported in 10 general categories:

- Access concerns
- Benefit / Service Delivery Option concerns
- Billing / Financial concerns
- Care Experience concerns
- Claim concerns
- Communication concerns
- Compliance Related concerns
- Eligibility / Enrollment / Contract concerns
- Kp.org / HealthConnect Online concerns
- Service concerns

KPMAS uses a number of tools to measure satisfaction. These include, but are not limited to:
2. Complaint and Appeal data,
3. **Member Experience Tracking Evaluation and Opinion Research (METEOR)**
4. Member Patient Satisfaction Survey (MPS)
5. Skilled Nursing Facility Survey (SNF)

The Market Research Department coordinates and conducts the detailed analyses of the results member and patient surveys including but not limited to the Consumer Assessment of Health Plans Survey (CAHPS) and Member Experience Tracking and Evaluation and Opinion Research (METEOR) Surveys. Routine analysis includes, but is not limited to showing trends in the Region's performance over time, 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 at the Program Office is responsible for analysis of the data.
Account Engagement and Customer Experience/Member Services

The Account Engagement and Customer Experience (AECE)/Member Services Department is comprised of three units and provides members several convenient ways to contact a representative for assistance. Members are able to telephone in concerns, mail in concerns or type in a message within kp.org. MACESS (Member And Customer Electronic Service and Support) is the department’s software system which allows Member Services to comprehensively collect, analyze and report concern and appeal data on a quarterly basis. These operational reports allow the organization to identify improvement opportunities and interventions. The data is derived from Member Services collection and categorization (including but not limited to the NCQA recommended categories) of information received from members and practitioners.

The Member Services is able to collect and aggregate data and thus more fully understand the issues impacting our members. Data include:

- The number of contacts resolved on first contact
- The overall number of inquiries, concerns and appeals received from members and practitioners as well as any trends in volume across quarters
- Overall types and numbers of contacts filed by members with opportunities identified to improve communications or processes
- The types and numbers of concerns received about a particular center or department for focused analysis
- Reasons for appeals and the overturn rate.

Member Services coordinates with content owners to conduct timely reviews and updates, which ensure the accuracy of the information housed in Resource Central (Member Services internal website with work tools).

COMPONENTS OF SERVICE AND ACCESS STANDARDS

KPMAS has established access standards through a variety of surveys. The appropriate chiefs groups and the subgroups for Access and Service established the primary care and specialty standards for Access and Service (see the work plan for more details). The standards for access to care are for regular/routine appointments and urgent care visits. Member Services Call Center and the Appointment and Advice Call Center leadership develop telephone services standards which are monitored regularly through operational reports, member satisfaction surveys, and the RQIC.

Access and Service Program

Clinical Contact Center: Teleservices, Medical Advice and Specialty Appointments

The Teleservices and Medical Advice Departments goal is to provide KPMAS members with convenient telephone service and advice care.

Teleservices

The Teleservices Department operates seven days a week, with staff responsible for booking appointments in primary care and some specialty care areas; and for messaging the health care team (HCT) with patient questions and requests. Additionally, the Teleservices staff monitors the KP.org web site for electronic requests for appointments.

The Teleservices Representatives (TSRs) follow physician directed appointment booking guidelines to ensure appropriate booking. Scripts have been developed by the physicians to identify patients who may be experiencing urgent/emergent needs for care. For example, if the member states to the Teleservice Representative that they have a symptom that is identified within the script as urgent/emergent, the Teleservice Representative will transfer the member directly to the Emergency Line advice nurse.
If a member requests self-care information or cannot wait for a call back from the Health Care Team the member will be transferred to the Advice Nurse line. For all other calls, the Teleservice Representative will make the next available appointment or will route a message via KP HealthConnect to the PCP (primary care physician) and Health Care team. Activities in the department are centered on strengthening the bond between the member and their physician.

Medical Advice
Medical Advice is a 24 hours a day, 7 days a week service staffed with registered nurses responsible for providing medical advice by physician approved online protocols and assisting members in determining the appropriate level of care. This may include providing routine medical advice, scheduling an appointment, directing a member to emergency care or coordinating care with the health care team. Advice nurses are tightly linked with the personal physician, via KP HealthConnect, and have access to the online medical record, pharmacy and laboratory information. Advice nurses have telephonic access to Clinical Contact Center physicians to coordinate care when needed.

Specialty Appointments
Internal referrals are placed by MAPMG physicians through an electronic system “eConsult”. The physician placing the referral has the ability to “direct book” the appointment for the member while the member is in the office. If the member prefers to book the specialty appointment after the visit, they may call the Clinical Call Center who will book the consult appointment using the “eConsult” system.

My Health Manager/KP.org
My Health Manager is a KP.org service on the Kaiser Permanente web site that offers the member the ability to manage a variety of health plan services online including: appointments, prescriptions, and laboratory results. Members are able to book routine appointments with their primary care physicians for OB/GYN and primary care and some specialists with whom they have an ongoing relationship. The member may also confirm and cancel appointments on this web site as well as review future appointments. All may be accomplished with the knowledge that the information is secure and access is immediate.

Resource Stewardship
Resource Stewardship begins when the Member is admitted to the hospital or SNF and continues throughout the stay. Its purpose is to capitalize on inpatient admissions as triggering events to kick off a new set of multidisciplinary activities that support care post discharge and ensures the Members safe transition between care venues while preventing readmissions and medication errors. Our transitions care management covers: transitions from hospital to home and transitions from skilled nursing facility to home.

Vision: “Every Member going from hospital to home will understand their follow up plan, understand their medications, know who to call with questions and what to expect at home”.

The Patient Care Coordinators work with the attending physician and the health care team to ensure the Member’s transition needs are anticipated and met. The keys to safe and proactive transition management are: (1) early assessment and needs identification/anticipation; (2) development of a realistic and sound plan of care based on clinical evidence; (3) establishing open communication with the Member and/or authorized representative and the health care team; and (4) coordination with all players involved (5) ensuring members have a timely follow-up appointment with their Primary Care Physician (6) ensuring post-acute services are delivered as ordered and (7) ensuring our high risk members who are discharged home have the opportunity for telephonic medication reconciliation with a Kaiser Permanente clinical pharmacist.
For continued inpatient stays, the Patient Care Coordinator evaluates the patient’s unique needs by partnering with the member and his/her family, the attending physician and the healthcare team. Transition of care is initiated on admission and regularly revisited based on the clinical status and specific needs of the patient. The Member or family, the attending physician, and the appropriate hospital staff are regularly engaged in the transitions of care decision-making activities throughout the Member’s hospital stay. Most importantly, the Member and/or the authorized representative are included in decision-making. UM Policy 13: Transition of Care describes the processes involved in coordinating care for members who are transitioning from acute hospital inpatient, acute rehabilitation, and Skilled Nursing Facilities (SNF).

During the transition care process, the following factors are taken into consideration to ensure the member’s unique clinical needs are assessed based on the characteristics of the local delivery system:

- Availability of skilled nursing facilities, sub-acute care facilities, home care, DME, palliative care or timely access to KPMAS’ internal services within the service area to support the patient after hospital discharge where needed
- Coverage of benefits for skilled nursing facilities, sub-acute care facilities, home care, DME, or services available within the KPMAS medical centers where needed
- Local hospitals’ ability to provide recommended services where needed

Continuity and Coordination of Medical Care

Continued Access to Practitioners

KPMAS offers an approach across the health care delivery system for coordination of care when coverage ends. Coordination of Care for medical care received by a KPMAS member ensures continuity throughout the transition of care, termination of practitioner and termination of health plan benefits.

Continuation of treatment is provided by KPMAS through the current period of active treatment, or for up to 90 calendar days whichever is less, for members undergoing active treatment for a chronic or acute medical condition or in accordance with the line of business benefit. If the terminating practitioner is a Specialist, the member is allowed to see the Specialist until the end of the episode of illness or 90 days, whichever is shorter or in accordance with line of business. In addition, Members who are in their pregnancy can be seen by the Specialist until the post-partum period is completed or in accordance with the line of business benefit (See Attachment E to see continued access provisions by Line of Business: Commercial, Market Place, Medicare and Medicaid).

Members with a terminal illness and receiving Hospice/Palliative care will be allowed to continue with their terminated PCP in accordance with the line of business benefit. Any member who is under an active course of treatment for an acute exacerbation of a chronic medical condition or an acute behavioral health condition may continue to receive treatment from a terminated practitioner for a sufficient period of time to allow for adequate transition and continuity of care in accordance with the line of business benefit. Continued treatment may be allowed for up to 90 calendar days depending upon the goals agreed on in the transition plan in accordance with the line of business benefit. KPMAS members who have pre-authorized care scheduled with a practitioner who terminates from the member’s KPMAS provider panel will be allowed to continue care with the practitioner if the appropriate UM physician determines that the same care cannot be provided by a contracted practitioner in accordance with the line of business benefit.

1 2014 and 2015 NCQA Health Plan Standards and Guidelines Q110: Continuity and Coordination of Medical Care, Element E: Continuity Access to Practitioners, and Attachment E HealthChoice Benefits
**Transition to Other Care**² (NCQA QI-10F)

KPMAS assesses and monitors activities related to the transition from inpatient care to other levels of care. Transitional care can be implemented for members whose benefits are exhausted, no longer entitled to coverage, or whose benefits have changed. These members must be active members receiving approved services prior to the benefit change or benefits being exhausted. Members whose benefits change, and if the member still meets criteria for continued care, will be provided information on alternative resources. Members who are in an out-patient or ambulatory setting requiring assistance in accessing resources for continued care will be referred to the Case Management Department following policies outlined in: (a) Case Management; (b) Pediatric Case Management; and (c) Renal Case Management. Interventions activated by the Case Managers include the following: (not an all-inclusive list)

- Assess and identify qualified members
- Recommend and provide available local community resources
- Refer members as appropriate to available resources such as the Medical Financial Assistance and Pharmacy Waiver Program. Provide materials in culturally linguistic fashion as appropriate.

**Integration of Care in KPMAS Patient Centered Medical Home (PCMH)**

The PCMH model develops relationships between primary care practitioners and providers, their patients and their patients’ families. In the PCMH model, primary care teams promotes cohesive coordinated care by integrating the diverse, collaborative services a patient may need. This integrative approach allows primary care practitioners 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.

Appropriate care coordination depends in large measure on the complexity of needs of each individual patient or population of patients. Factors that increase complexity of care include multiple chronic care conditions, acute physical health problems, the social vulnerability of the patient, and the involvement of a large number of primary and specialty care practitioners and providers involved in the patient’s care. Patients’ preferences and their ability to organize their own care can also affect the need for care coordination.

The medical home team or Health Care Team (HCT), that may consist of nurses, pharmacists, nurse practitioners, physicians, medical assistants, case managers, 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, within KPMAS PCMH model, includes the following components:

- **Determining and updating care coordination needs**: Coordination needs are based on a patient’s individual health care needs and treatment recommendations and plan that reflect physical, psychological, and social factors. Coordination needs are also determined by the patient’s current health and health history; functional status; self-management knowledge and behaviors; and need for support services.

- **Create and update a proactive plan of care**: Establish and maintain a plan of care, jointly created and managed by patients, their families and/or caregivers, and their health care team including case manager. The patient-centered plan of care outlines the patient’s current and long term needs and goals for care, identifies coordination needs,

² NCQA 2015 Health Plan Standards and Guidelines QI10: Continuity and Coordination of Medical Care, Element DF: Transition to Other care.
and addresses potential gaps. The care plan anticipates routine needs and tracks current progress towards patient goals.

- **Communication**: Communication allows for the exchange of information, preferences, goals, and experiences among participants in a patient's care. Communication may take place in person, by phone, in writing, and/or electronically. Communication is especially critical during transitions in care. Primary care practitioners and providers are included in the transfer of information during transitions. Examples of transition include from the inpatient hospital or skilled nursing facility (SNF) to the ambulatory setting (i.e. physician's office).

- **Align resources with population needs**: Assess the needs of populations to identify and address gaps and disparities in services and care. Care coordination and feedback from practitioners, providers and patients should be used to identify opportunities for improvement (i.e. smoking cessation, weight management, self-management for diabetes, or health coaching).

KPMAS’ 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 with complex and chronic conditions. To achieve this goal, it is the expectation of the PCMH HCT to manage these members. The health plan is responsible for identifying patients who qualify for its disease management and complex case management programs, notifying the PCMH HCT about the identification, and maintaining a tracking mechanism that includes these members. Notification to the PCMH HCT is conducted for each patient when they qualify for the disease management or complex case management programs, if they are identified outside of the PCMH. The care coordinators of respective disease management or complex case management programs route this information via KPMAS’s electronic health record (KP HealthConnect). In addition, patients, their family members, or anyone on the health care team, may refer a patient for complex case management or disease management programs.

**Clinical Care Programs - Population Care Management**

Population-based Care Management (PCM) is one of the foundations of the Kaiser Permanente MAS clinical care strategy that provides evidence-based, systematic support to the health care teams and physicians who care for members within all lines of business including: Commercial (non-Market Place/DC-MD-VA), Commercial (Market Place/DC-MD-VA), Medicare Cost, Virginia Medicaid and Maryland Medicaid). The PCM strategy is used to support care delivery to populations of members with chronic diseases and conditions and augments the PCMH model of care. The PCM program complements the Health Education and Health Promotion program interventions and programs. The PCM strategy is based on several key concepts, including:

- Evidence-based care supported via Clinical Practice Guidelines (reviewed/revised and approved every two years) posted online and distributed to new practitioners upon hire and to ongoing practitioners every two years;
- 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 their own care;
- Interventions and care designed and tailored to address specific and special needs of patients; and
- Performance metrics for program, Service Area, Medical Center, Medical Office Building, and physician feedback.

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 same interventions may not be used on all members of a specific population; instead, interventions are determined by the specific
health and/or risk of the individual member. Interventions include medical care; self-management resources and skill-building; communication and materials from the PCM program; referrals and coordination with case management, ancillary services, specialty care, and/or other health care practitioners and professionals; and collaboration with schools, employers, and community offices.

Although the programs develop and foster innovative relationships between various team members and patients, these relationships are explicitly designed to augment and support the key relationship between the primary care practitioner and the patient used in the PCMH model. This is a key value of all aspects of the PCM Program.

Separate components of the KPMAS Care Management program target differing types of populations:

- **Population Care Management** that includes disease management programs targeted towards large populations with chronic illness(es) such as diabetes, asthma, CAD, and depression or who need cancer screening.
- **Department-based care management programs** that target small volume populations of very high-risk patients such as patients with organ transplants, end stage renal disease on dialysis, or anticoagulation use.

Although all components use the key concepts in organizing and monitoring care delivery, the structures differ and will be described in separate sections.

### Linkage of Population Care Management to Clinical Operations

Population Care Management programs collaborate with stakeholders in Specialty and Primary Care as well as content experts in the area, such as diabetes educators, allergists, endocrinologists, and cardiologists.

The Population Care Management Department is linked to the Service Area leadership via the Regional Quality Improvement Committee and direct collaboration between PCM staff and service line leadership, both health plan and medical group. Primary linkages exist between PCM leadership and the 3 Service Area-based Assistant Physicians-in-Chief for Quality.

#### Clinical Pharmacy Support

- Clinical pharmacology intervention and support to the Primary Care Team and the patient are integral to the Population Care Management programs. They act as content experts to PCM and as direct support to clinicians.
- The Pharmacy department employs clinical pharmacy specialists.
- Clinical pharmacy specialists support anticoagulation management and heart failure programs. In addition, clinical pharmacists are available in most medical offices to support the care teams with complex patients on multiple medications and are involved in many clinical department initiatives.

#### Data Support

- The data analysts of the Medical Group Operations Support (MGOS) in the Mid-Atlantic Permanente Medical Group, together with the Accreditation, Regulatory and Licensure (AR&L) staff collect outcome data for use within the region and for program-wide reporting.
- MGOS supports Population Care Management analysis and reporting.
- The analysts use the patient population information from the panel management tool, CarePOINT along with data from our electronic medical record and claims-based data, to query various population disease and condition states and allows analysis and reporting at regional, Service Area, Medical Center, Medical Office Building, and
physician levels on health status of patients in Population Care Management programs.

Participating Providers
In the participating provider model, Population Care Management works directly through the MAPMG Associate Medical Director for Networks and the Practitioner and Provider Quality Assurance Department. Components of these programs that can be applied to the affiliated networks are extended to the affiliates, including:

- Diabetes, CAD, HTN, and Asthma Registry,
- Preventive care monitoring,
- Condition-specific information about KPMAS members served by the affiliated medical groups,
- Participation in HEDIS data collection and analysis.

Functional Linkage between Population Care Management and Primary Care

Primary Care service line
- The physician-patient relationship is the foundation of the delivery system and the PCMH model. Registries, guidelines, innovative delivery strategies and other interventions are designed to support, enhance and reinforce the key relationship between patient and primary care practitioner.
- The Primary Care service line collaborates with Population Care Management with prioritizing, scheduling and implementing changes that are intended to enhance and support the PCP. This collaboration is designed to minimize disruption of patient care during intervention implementation.
- The Primary Care service line contributes clinician time to multiple areas involved in the planning and implementation of population care management programs including:
  - Content expertise and guidance for various populations and disorders,
  - Guideline evaluation
  - Nursing and/or Clinical Pharmacologist protocols, orders and supervision,
  - Input into the development of patient education materials and strategies,
  - Input into change management and initiative implementation, and practitioner feedback design.

Prioritization

Population Care Management works with the Associate Medical Director of Quality, Vice President of Quality, Assistant Physician-in-Chiefs for Quality, Primary Care Service Chiefs, and the Region's operational leadership, including service line directors and Clinical Operations Managers, to prioritize multi-year initiatives and/or new programs based on criteria, including:

- Federal, Commonwealth of Virginia, State of Maryland, and District of Columbia regulations and requirements;
- Alignment with regional quality priorities;
- Current performance on outcomes (HEDIS, Medicare Stars, MCSP, PIP, and others, as needed);
- Burden of disease in the population;
- Employer group concerns over their employees' health, as appropriate; and
- Feasibility of identifying the population.
Case Management

KPMAS’ 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 with complex and chronic conditions. To achieve this goal, it is the expectation of the PCMH HCT to manage these members. The health plan is responsible for identifying patients who qualify for its disease management and complex case management programs, notifying the PCMH HCT about the identification, and maintaining a tracking mechanism that includes these members. Notification to the PCMH HCT is conducted for each patient when they qualify for the disease management or complex case management programs, if they are identified outside of the PCMH. The care coordinators of respective disease management or complex case management programs route this information via KPMAS’s electronic health record (KP HealthConnect). In addition, patients, their family members, or anyone on the health care team, may refer a patient for complex case management or disease management programs.

Kaiser Permanente has been operating an integrated model of care for decades before the term was coined. Kaiser Permanente’s Case Management program provides a comprehensive approach to care coordination throughout the care continuum. Case Managers work directly with members and caregivers, primary and specialty care teams to provide the best care coordination to ensure our high-risk members receive much needed assistance in achieving their optimal health goals.

Goals of the case management programs include the following:
- Foster relationships between practitioner/care team and patients;
- Promotion and coordination of consistent care across the delivery system;
- Decrease re-hospitalizations and increase appropriate utilization of service and
- Ensure equitable and compliant care across disease management programs.

A professional social work clinical screener screens all members referred to case management. The clinical screener, with information from the referral source and the electronic health record, assesses the case to determine the program best suited to meet the member need. The clinical screener then routes the case to the appropriate case manager. Notification to the PCMH HCT is conducted for each patient when they are identified as being qualified for the case management (including complex case management) programs if they are identified outside of the PCMH. The care coordinators of respective case management (including complex case management) programs route this information via KPMAS’s electronic health record (KP HealthConnect) with the expectation of a response from the PCMH HCT on whether they intend to engage the patients on the list if appropriate.

The primary care coordinator, who is the primary care practitioner (PCP), is recognized as the main point of contact for our members. The case manager for all of our programs works with the PCP or primary specialist through referrals, email, and phone calls to facilitate communication with the member and to coordinate care within the integrated health care team. Therefore, the PCP is notified in real-time of all of their paneled patients who are in case management. The KP HealthConnect (EHR) is regularly reviewed to ensure services are provided, follow-up occurs, and also to prevent duplication of work.

Referrals to community-based resources/services which are not covered are coordinated and evaluated by the assigned case manager and documented in the EHR. Documentation of the case management activities, including any consultations, interactions, case conferences, referrals, revisions, correspondence and other activities related to the case management services is made in the member’s EHR.
Each member of the health care team involved with the case is copied on notes made in the EHR. The member is informed about the plan of care and their involvement/self-management in the plan of care is highly encouraged. Family members/caregivers are included, if agreed to by the member, and interactions with them are also documented in the EHR. Communication to all parties is made through e-mail, in person and/or by phone.

Follow-up and monitoring is done by the responsible parties assigned to the case and reviewed by the case manager with the member. Education and interaction with the member/family or caregiver is made as needed. Case conferences are held whenever necessary either face to face, telephonic or electronic. Feedback is provided to the PCP. The case manager also helps to facilitate and encourage the member’s participation in their own care and to express any concerns about the care provided.

**Complex Case Management Care Connect Program**

CareConnect is our complex case management program. The focus of CareConnect is to support the social and medical needs of our most vulnerable members. Core features include a comprehensive assessment, detailed care plan and self-management plan. Care is coordinated with all providers across the health care team to maintain an integrated care plan and holistic approach to the member’s care. The CareConnect Program Description will explain the core components and processes across the Mid-Atlantic region noting differences between our Integrated Delivery System (IDS) and the Network Affiliated System (NAS). Enrollment into complex case management is voluntary and members must give consent to participate. Typically cases are opened for 4 to 6 months depending on need.

Care Connect Case management is provided by Registered Nurses and Licensed Certified Social Workers. These case managers assess and coordinate care in collaboration with providers to ensure care management needs for members with complex needs are met.

The CareConnect Program consists of the following goals:
- Increase access for high-risk members to care, services, and Kaiser Permanente resources.
- Proactively identify members who have experienced a critical event or new diagnosis with an expected need for intense coordination of care.
- Proactively identify members with chronic conditions that have multiple and complex needs.
- Coordinate services for members with complex conditions and facilitate access to needed resources.
- Ensure quality of care outcomes using evidence based guidelines and algorithms.
- Provide caregiver support when possible in the management of members with complex conditions.
- Coordinate with all providers across the health care team to maintain an integrated care plan and holistic approach to the member’s care.

Objectives for our members with complex needs include:
- provide case management teams
- improve access to PCP and SCPs
- coordinate care for members with receive multiple services

**Ambulatory Case Management**

The Ambulatory case management team consists of Registered Nurses, Licensed Certified Social Workers and Community Navigators. This team is located within the Medical Offices and support the patients and the Primary Care teams. The focus of ambulatory case management is to meet immediate needs a member and/or caregiver may have-such as transportation, home care set up, financial needs or a piece of durable medical equipment. Typically, the ambulatory case management need will be assessed and service completed in less than 1 week.
Pediatric Case Managers are a team of specialized pediatric RNs and LCSWs to assist our pediatric patients that have special needs and/or complex medical diagnosis. This team is also located in the Medical offices and partners with the Pediatric providers, families and care givers to ensure that appropriate care and resources are delivered to these members.

Special Needs Programs
The goals of our special needs programs are to coordinate care across the care continuum, tailoring interventions based on member need and special condition. Case managers track appointment and care plan compliance through HealthConnect and reach out to members with assistance when follow-thru with the care plan is poor or members have complex needs that require extensive care intervention to promote and maintain optimal health and functioning. Special needs case managers are available to the following at risk populations: high risk OB and postpartum women, substance abuse treatment and behavioral health diagnoses, HIV/AIDS, foster and adoption children, children with special health care needs, homeless, physical and developmental disabilities.

Behavioral health case management is also provided for those VA Medicaid Patients with severe persistent mental illness to ensure patients are connected with appropriate resources and counseling.

Renal Case Management
Our Chronic Kidney (CKD) disease case management program focuses on early identification of kidney disease with the goal of assessing care needs, designing a care plan to improve/maintain kidney function and education about options if kidney function doesn’t improve. Our CKD program consists or RN case managers. End Stage Renal Disease Case Management addresses care coordination and modality needs for members with a diagnosis of end stage renal disease. The RN and LCSW case managers are for both programs are located in the Medical offices.

Care Coordination with Population Care management
Functioning as part of the health care team the case managers also use CarePOINT, (a care delivery tool that uses established criteria and evidence-based guidelines and reports members by PCP panel, demographics, and chronic conditions) to focus the health care team outreach to specific members with care gaps.

The case managers, health care team, practitioners and staff are responsible for follow-up on case management interventions. Case managers document care plans and interventions within HealthConnect, the standard tool used by primary care and specialty care physicians, complex case managers, dietitians, call center (advice line) nurses, care managers, utilization management nurses, pharmacists, and other clinical and ancillary staff. Case Management programs measure program effectiveness through a variety of health outcomes and HEDIS measures. Below are some examples of performance metrics used to evaluate effectiveness of programs.

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<th>Maternity Members</th>
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<td>• Birth Weight</td>
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<td>• Gestational Term</td>
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<td>• Incidence of pre-gestational diabetes</td>
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<th>Pediatrics Members</th>
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<td>• Inpatient Days</td>
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<td>• Readmission Rates</td>
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<td>• Average Length of Stay</td>
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### SECTION 2- Quality Management Program

**Mental Illness (children age 6 and over and adults)**

- **ER Utilization**
- **Appointment Compliance**

Physicians (MAPMG) routinely run reports from the Panel Management tool to identify members who may have gaps in care due to missed appointments or lack of follow-up. These reports provide detailed information on a member's last visit and upcoming visit in any department, including primary or specialty care, including radiology. Very specific care information is provided to assist with medication refill and adherence concerns, immunizations, ER or hospitalizations, medication intolerances, lab information, BMI and tobacco use. Physicians and teams use this tool to query their population and identify members who need care, and then call or mail letters to encourage the members to get the needed care.

- No-shows are reported in our “failure to keep appointment reports” (FTKA) and followed up for healthy and at-risk members by our clinical staff
- During all face-to-face clinical encounters (primary, specialty, pharmacy, urgent care, nurse) care gaps are identified on the spot and addressed while the member is in the facility
- In addition, regardless of upcoming face-to-face appointments, at-risk members are contacted by mail and phone to arrange for closure of their care gaps

Clinical staff at the health centers or case managers perform outreach for all notifications of gaps in care related to missed appointments, or missed Early and Periodic Screening, Diagnosis, and Treatment Services/EPSDT periodic required appointments (Note: EPSDT is a Federal Medicaid required periodic appointment schedule). If KPMAS is unsuccessful in its outreach attempts, KPMAS will notify the local health department (LHD) in the jurisdiction where the member lives for assistance in returning the member to care. In the instances where a member of a special needs population has been unresponsive for appointments or has not followed the outlined plan of care cannot be reached, KP case managers, health care team and providers may notify the LHD for assistance in locating and contacting the member.

Within 10 days of either the third consecutive missed appointment, or the provider becoming aware of the member's repeated non-compliance with a regimen of care, whichever occurs first, the provider will make, a written referral to the LHD using the LHD form. The LHD will assist in locating and contacting the member for the purpose of encouraging them to seek care. After referral to the LHD, KPMAS administration and MAPMG practitioners will work with the LHD to bring the member into care.

The method of contact will depend in large part on the time sensitivity, i.e., no-show members who have conditions that place them in an at-risk health status may receive a face-to-face home visit by a member of the case management team if necessary. All contracted PCPs and specialists practicing in the community are contractually required to notify KPMAS if they find that a member has missed an appointment. In addition, we are exploring reports and tracking mechanisms that would alert us to no-shows. Once no-shows have been identified the case manager will coordinate outreach to the member which may include verbal and written communication in addition to a potential home visit.

The effectiveness of the case management processes will be evaluated using the following measures.

- **Timeliness of service** 75% of cases will be responded to within 48 business hours from time of receipt (defined as Case Manager responding from time of Case Manager receives referral)
• Achievement of goals and objectives: 75% of files audited (ongoing audits summarized annually) will show Case Management timely assessments and documentation of progress to goals with next steps.

Case management member satisfaction scores are another method used to assess and improve the effectiveness of the program based on members’ experiences. Member satisfaction is measured annually through an outreach telephonic survey. All members enrolled in CareConnect (complex case management) Case Management at any time over the previous 12 months are included as candidates to be contacted for a telephonic survey which seeks to determine the level of member satisfaction with the program. The survey is conducted by an outside vendor; results are compiled, and then forwarded to the Case Management team for review and analysis. The Manager of Outpatient Continuing Care is responsible for detailing an analysis and trending for the development of action plans geared toward program improvement.

An annual analysis of complaints and inquiries relevant to the CareConnect Case Management program is conducted in concert with information received from Member Services Analysts. Following each quarter, the complaints and inquiries are categorized by type and reported to the manager. The manager utilizes the report to evaluate, track, and trend the complaints and inquiries for the purpose of creating action plans to improve case management member satisfaction.

Member satisfaction with visit experience is measured following all health clinic encounters through a mailed member satisfaction survey specific to satisfaction with practitioners and the health care team. Feedback reports are provided to practitioners on a monthly basis. KPMAS’s Manager of Outpatient Continuing Care is responsible for oversight and guidance for the CareConnect Case Management program staff.

Compassionate End of Life Program/Palliative Care
Compassionate End of Life or Palliative care is a growing initiative in the region. It is a program that supports members living with a deteriorating medical condition, who are at risk for needing symptom management. The focus of care is on patient comfort, clarification of goals and advanced care planning. This approach to care promotes quality of life and does not require members to give up any aggressive treatment.

There are three key components of this initiative:

Inpatient Palliative Care Consult service (IPC)
The IPC program is designed to provide one to two consultative visits for patients with life limiting illness in the acute care setting. This model includes an interdisciplinary team service comprised of a palliative care physician, nurse, social worker and chaplain. The team meets with the member and family to assess their understanding of the illness, to discuss realistic outcomes of treatments, and identify member’s goal of care. The team also addresses pain and symptom management and provides consultation to hospital physicians and staff on end of life care. We currently practice IPC in five core hospitals in DCSM and Northern Virginia.

Advance Illness Coordinated Care (AICC)
The AICC program, first implemented in 2010, is available to members with any life-limiting diagnoses. Available in all service areas, this model Engelhardt, Josheph. Tobin, Daniel, Effectiveness of care coordination and health counseling in advancing illness, accepted for publication by the American Journal of Managed Care, Fall 2009, builds on and integrates with existing efforts in end-of-life care. In AICC, a Care Coordinator (MSW) facilitates specific end of life conversations including advanced care planning. The program involves six focused meetings with members and families with specific goals for each meeting.
The overall result is that members and families have a better understanding of their illness and make more informed choices. The Care Coordinator is also a resource for community services. The AICC model has demonstrated increased hospice utilization and length of stay as well as improved quality of life for individuals facing advance illness and end of life situations.

**Skilled Nursing Facility (SNF) Palliative Care Program**
The SNF Palliative Care program is a RN consultative model and is available to members the Mid-Atlantic service area. The Palliative Care RN works closely with the SNFs health care team. Members in the SNF setting are similar to those in the in-patient setting in terms of medical complexity and social needs, therefore the goals of this model are similar to the IPC consult model.

**The National Transplant Network, HUB and Central East HUB**
The Kaiser Permanente National Transplant Services (NTS) provides members with access to a network of transplant programs located at premier medical centers (Centers of Excellence) where successful outcomes are predictably high. Case Management, Network management and Quality Management are provided and coordinated through Kaiser Permanente NTS hub operations, and have a dotted line responsibility to Mid-Atlantic States Utilization Management department. KPMAS is part of the Central East Hub. Transplant services are provided to MAS members who require organ or blood and marrow transplants include: heart, liver, heart/lung, lung, kidney, small bowel, simultaneous Kidney-Pancreas, bone marrow, and stem cell transplants. A KPMAS member determined to be a potential transplant candidate is referred by a KP specialist or primary care practitioner for Transplant Case Management. The physician and transplant coordinator work together to ensure the member meets the patient selection criteria and coordinate the care of the member throughout the transplant process, from referral through the life of the transplanted graft.

Patient and center selection criteria for each organ type are developed by a national NTS Clinical Management subcommittee that is comprised of Permanente physicians with expertise in the field of transplant. The criteria are reviewed annually and updated based on the current clinical evidence. KPMAS adopted the use of the Kaiser Permanente National Transplant Services Transplant guidelines. These guidelines are annually reviewed and approved by Regional Utilization Management Committee (RUMC), RQIC and filed with the State of Maryland.

**Member Participation**
The Consumer Advisory Board (CAB) members will consist of enrollees and enrollees' family members, guardians, or caregivers; and be comprised of no less than one third representation from KFHP-MAS’s special needs populations or their representatives. Criteria used to select CAB members will be related to race/ethnicity, age, gender identity, sexual orientation, disability, geographic location, and cultural diversity, to ensure that the CAB is representative of the Medicaid population we serve. KFHP-MAS’s Special Needs Coordinator will serve on the CAB as one representative of the special needs population. The KFHP-MAS Manager of Medicaid and CHIP Operations for the state is responsible for administrating the support of the Consumer Advisory Board (CAB). This individual will ensure that resources are available to the consumers and consumer advocate members of the board. Mechanisms and processes will be in place for the CAB to provide input to KFHP-MAS leadership.

The CAB members will regularly review KFHP-MAS’ marketing materials, flyers and brochures, orientation information, and other member materials for effectiveness, relevance to the target population, and cultural and linguistic appropriateness. Routine reporting to the CAB membership will be provided prior to meetings. In-person CAB meetings will be the norm, and the use of call-in numbers will only be as necessary to accommodate members who otherwise may not be able to participate. CAB members will be asked to participate in often complex Medicaid discussions; attend meetings; assist with development of meeting agendas and compile meeting materials; and
make referral/recommendations regarding issues raised by committee members to appropriate health plan staff for research and implementation of recommendations, as needed. Minutes of each CAB meeting will be taken and reviewed by the CAB at each subsequent meeting, to ensure discussions and recommendations are captured appropriately for necessary follow-up. The CAB will submit to the KFHP-MAS Medicaid Office any reports or recommendations it develops related to program policy, design, and activities. Such reports and/or recommendations will be submitted regularly for executive review during quarterly meetings. The CAB will annually report its activities and recommendations to the Secretary of the Department of Health and Mental Hygiene.
Patient Safety
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’s 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 members.

OVERVIEW
Risk Management
The Risk Management Program is an integral part of the organization’s overall Quality Program. The program focuses on healthcare delivery issues throughout Virginia, Maryland and DC in order to improve safety, promote quality care, as well as to protect the assets of the organization.

Risk Management Department
The department monitors the care delivery processes for continuous process improvement. The department reviews and manages risks reported through the Unusual Occurrence Report (UOR) process. Individual cases are reviewed, tracked, and referred to operational leadership or the quality process as necessary. We provide investigation, consultation and analysis of events and systems failures and identify evidence-based best practices to inform our care processes. We support safe care by developing and providing risk management/patient safety training and resources to providers and staff. Our focus is on the conditions that allow positive events to propagate within a culture of safety while we work on identifying barriers to safe performance and creating systems that support the delivery of care. We offer coaching to enable empathetic disclosure and early resolution resources to our members in response to adverse events recognizing that going back and picking up communication that has been dropped can bring healing to a difficult situation. We enable the care team to inhabit their best version of themselves by being honest and transparent in their communications consistent with Kaiser Permanente mission, vision and values.

Methodology
Regional Risk Management and Patient Safety Program
The Risk Management and Patient Safety programs' activities are reviewed for effectiveness by the 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 the purpose of facilitating appropriate changes in clinical practice and healthcare team performance.
BIG Q DASHBOARD: Care Experience Program

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.

Infrastructure Capabilities to Optimize
In order to accomplish our aim we build upon the foundations of our people, our processes and our systems by:

- Targeting our performance expectations at being the best in the industry by benchmarking our individual and collective performance against the industry, reducing variation in our 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 our staff and clinicians. Initially we will focus on the frontline staff, but move to increasing the performance improvement skills of our mid-level and senior managers as well.
- Leveraging KP HealthConnect and other health informational tools to make it easy to do the right thing at the right time for all of our patients and members.

Taking full advantage of our research programs to advance our knowledge in clinical effectiveness, patient safety, and member engagement and transferring those findings effectively within our program and to our community partners.

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 to monitors initiatives; reviews the results of member satisfaction, employee and clinician satisfaction surveys, and monitors appointment access and availability metrics. The customer service satisfaction data is gathered from a variety of sources including: member satisfaction surveys (e.g. METEOR, MPS, CAHPS, HH, SNF surveys), customer complaint reports, member appeals reports and patient satisfaction survey results.

Satisfaction surveys are conducted monthly, quarterly or annually, depending on the survey instrument. Results from CAHPS, METEOR surveys, and patient satisfaction surveys are reported to the Regional Quality Improvement Committee. Additionally, the RQIC uses the information reported to prioritize quality improvement initiatives in collaboration with the Delivery System Council set performance targets for the region.
**Big Q Dashboard Scope**
In order 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 time for appointments in primary care or in specialty care
- Members will be satisfied with the and overall phone services associated with their visit to a clinic
- Members will be satisfied with their care experience in their office visit.

**COMPONENTS OF SERVICE AND ACCESS STANDARDS**
KPMAS has established access standards through a variety of surveys. The appropriate chiefs groups and the subgroups for Access and Service established the primary care and specialty standards for Access and Service (see the work plan for more details). The standards for access to care are for regular/routine appointments, urgent care visits and after-hours care. Member Services Call Center and the Appointment and Advice Call Center leadership develop telephone services standards which are monitored regularly through operational reports, member satisfaction surveys, and the Quality Oversight Committee.

**Access and Service Program**

**Behavioral Health (BH)**
Members with a Behavioral Health benefit may access Behavioral Health care without a referral. Their physician may also request a consultation for the member through the electronic medical record system via a system known as eConsult.

Members contact the Behavioral Health Contact Center via a toll-free phone number Monday through Friday 8:30AM to 5 PM. The Behavioral Health Contact Center is available to book all initial evaluations and is staffed with both licensed clinicians (RNPs and Social Workers) and non-licensed Behavioral Health trained scheduling staff. The telephone menu allows members who feel they are in crisis to connect directly to a licensed clinician. If the member has not opted to speak with a clinician, initial calls are answered by the non-licensed scheduling staff.

The Behavioral Health Intake Schedulers follow physician directed appointment booking guidelines and scripts to ensure appropriate scheduling. Scripts have been developed and reviewed by a team of Behavioral Health Practitioners (Psychiatrists, Psychologists, and Psychotherapists) to identify patients who may be experiencing urgent/emergent needs for care. For example, if the member states to the Behavioral Health Intake Scheduler that they have a symptom that is identified within the script as urgent/emergent, the Intake Scheduler will transfer the member directly to the Emergency Line Clinician.

Scripting also guides the Intake Scheduler to the appropriate practitioner for a routine evaluation based on the caller's response to questions... For example, if the caller answers "Yes" to questions regarding current drug use and/or potentially problematic alcohol use, an outpatient evaluation with a chemical dependency counselor will be offered.

The Intake Scheduler will transfer a member to a Behavioral Health Clinician when the script directs the transfer or if there is any doubt about the member’s need for service.

The Behavioral Health Clinicians provide clinical advice by physician approved online protocols and assist members in determining the appropriate level of care. This may include providing...
routine clinical advice, scheduling an appointment, directing a member to emergency care or coordinating care with the Behavioral Health Department. Behavioral Health Clinicians are tightly linked with the personal physician and Behavioral Health practitioners, via KP HealthConnect, and have access to the online medical record, pharmacy and laboratory information.

The established protocols guide the Clinician to dispositions including initiating a 911 call to the police or emergency medical personnel for life-threatening emergencies. Additionally, instances determined to be emergent without the risk to life guide the Clinician to arrange treatment within six hours at a Kaiser Permanente Critical Decision Unit/Urgent Care or hospital emergency room. If needed the clinician may request consultation with the on-call psychiatrist.

Each protocol for Behavioral Health and Substance Abuse is reviewed once in a two year period by the Chiefs of Psychiatry. If in the interim, changes are necessary based on feedback from Health Care Teams, the change request is taken to both Chiefs of Psychiatry for review and / or approval. Every change is tracked by date, reason and requestor.

Members are directed to schedule routine follow-up and medication management appointments by contacting the provider's office.

Access to urgent/emergency care after regularly scheduled hours is available through the KPMAS Advice Nurse system. An on-call psychiatrist is available 24 hours daily for consultation and to assist with hospitalization arrangements, if medically necessary.

Supervision

Clinical supervision is provided on-site by a Licensed Professional with more than 5 years post-master's experience in psychiatric treatment. Both Chiefs of Psychiatry are involved in the center’s operation and available for consultation by phone or in-person as needed. The Chiefs review, revise and approve all Behavioral Health-related protocols used by the Call Center.

Continuity and Coordination between Medical and Behavioral Healthcare

Exchange of information as indicated under policy BH 011, Co-existing Medical and Behavioral Health disorders: Members who sign a release of information allow their provider to communicate with primary care through a “visible encounter” within the Health Connect electronic medical record. Quarterly reports displaying percentage of approved release of information (ROI) with “visible encounters” is submitted to the Behavioral Health managers to share with appropriate staff.

Appropriate diagnosis, treatment and referral of behavioral health disorders are commonly seen in primary care. Based on communication with physician Leaders in Chemical Dependency and Primary Care increased appointment utilization and tracked to monitor increased screening and appropriate referrals which are indicators of collaboration with Primary Care and Behavioral Health for recognizing Chemical Dependency disorders.

Appropriate uses of psychopharmacological medications are monitored for HEDIS standards regarding ADHD medication and Antidepressant medication on a quarterly basis. Pharmacy reports are sent to chiefs to review with individual providers to ensure compliance.

Management of treatment access and follow-up for members with coexisting medical and behavioral disorders: Consultation and advice is available to any provider 24-hours a day. During business hours licensed clinicians with Behavioral Health experience are immediately available for assessment and triage. After hours, weekend and holidays, consultation is available via clinical contact center advice nurses who have access to a psychiatrist on call. The Behavioral Health department continues its efforts to develop and enhance services to special needs
populations. Examples are Post-Partum depression priority referrals and collaboration in Oncology case management.

Primary or secondary preventive behavioral health program implementation: Support screening and referral program for Post-Partum depression in coordination with Women’s Health and OB Department. Measured by percent of members referred from OB/GYN to Behavioral Health with successful evaluation.

**Geographic Access and Availability of Practitioners**

The Region is committed to ensuring that members have reasonable geographic access to primary, specialty care and behavioral health practitioners and hospitals. Geographic access standards, based on external market expectations and regulatory requirements, are used to measure and assess the geographic accessibility of our delivery system at least annually. KPMAS compares the distribution of its members to the distribution of its practitioners (primary care, specialty practitioners and high volume BH per covered benefit by line of business), and hospitals to determine if the standards are being met. At least annually, the availability of practitioners for primary care and high volume specialty care is analyzed and reported to the RQIC. Geographic availability of practitioners is analyzed at the state, line of business and regional area. If deficiencies are noted in the analysis, KPMAS identifies the cause of the deficiency and determines the appropriate business action necessary to achieve an adequate and accessible delivery system. The standards and procedures are reviewed on an annual basis to ensure that they are meeting quality performance and regulatory goals. The geographic analysis provides details such as the percentage of members who are within the required service areas (for Commercial Non-Market Place, Commercial Market Place, Medicare Cost and Medicaid (Virginia and Maryland) as applicable for geographic access.

**Member Satisfaction**

Measuring how well KPMAS meets or exceeds members’ expectations is a critical activity for quality assessment and improvement. Member Satisfaction is measured through a variety of sources. Data gathered from these sources is translated into specific information which is used to provide relevant member feedback for services delivered at every level in the organization. KPMAS uses a number of tools to measure patient satisfaction. These include, but are not limited to:

2. Complaint and Appeal data,
3. Member Experience Tracking Evaluation and Opinion Research (METEOR)
4. Member Patient Satisfaction Survey (MPS).

KPMAS conducts detailed analyses of the results of the CAHPS Survey as well as a set of internal surveys (e.g., MPS) to identify opportunities to improve member satisfaction. Routine analysis includes, but is not limited to showing trends in the Region’s performance over time, changes in performance and comparison to “best performing” KP Regions and/or non-member competitive performance. To support application of the data, National Market Research local staff within KPMAS and at the Program Office is responsible for special analysis of the data including identification of key drivers of member satisfaction. This information is used to focus improvement efforts for maximum positive impact on member satisfaction.

KPMAS aggregates member complaint data on a quarterly basis derived from the Member Services categorization of feedback that was received during the prior quarter. Causes of member dissatisfaction are reported in 10 general categories:

- Access concerns
- Benefit / Service Delivery Option concerns
- Billing / Financial concerns
- Care Experience concerns
• Claim concerns
• Communication concerns
• Compliance Related concerns
• Eligibility / Enrollment / Contract concerns
• Kp.org / HealthConnect Online concerns
• Service concerns.

MD CONNECT Physician Program
A major initiative associated with an opportunity to improve physician-patient communication and efficiency is fully implemented and continuing. MD CONNECT consists of two components: educational sessions and a physician coaching program where physicians have been trained to coach their peers in clinician patient communication, workflows, efficiencies, and KP HealthConnect. The physician peers observe their colleagues and offer suggestions to enhance practice efficiency. The educational programs include Tips for Time Management, Proficiency in KP HealthConnect (our electronic medical record), Nutritional Tips, Getting a Good Night’s Sleep, Back to School, Back to Stress working parent tips and others that help physicians balance their practice life with their home life.
Advance Our Mission on Affordability

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

Strategic Platforms

Health Care Transformation
Continuous improvements and innovation in quality of care, patient experience, and health outcomes while delivering highly reliable care

Sustainable Growth
Above market growth and new growth opportunities that best leverage our assets and enable ongoing investment in our mission and strategy

One Kaiser Permanente
“The best” that KP has to offer to our patients, members, and purchasers, regardless of where they are and how they access KP

Throughout this journey, there will be a focus on redesigning our capabilities to provide continuously improving quality and member experience, while increasing affordability.
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<th>Committee Members (Voting)</th>
<th>Roles</th>
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<tr>
<td>VP, Quality Resource Management KPMAS (co-chair)</td>
<td>Facilitates the work of the committee; provides expertise in quality of care and service; provides expertise in strategic guidance and infrastructure systems; provides expertise concerning internal and external regulatory standards.</td>
</tr>
<tr>
<td>Associate Medical Director, Quality, MAPMG (co-chair)</td>
<td>Facilitates the work of the committee; provides expertise in quality of care and service; provides peer review and practitioner credentialing expertise; provides contracting and network management expertise.</td>
</tr>
<tr>
<td>Associate Medical Director Hospital Operations, Ambulatory Surgery Centers, Urgent Care, Laboratory and Pharmacy</td>
<td>Promotes utilization strategies and activities, provide oversight of regulatory and accreditations standards, monitor utilization and facilitate performance improvement.</td>
</tr>
<tr>
<td>Associate Medical Director Access, Service, Mental Health and Labor Management Partnership</td>
<td>Provides oversight in the quality performance monitoring process to assure issues related to service and access are addressed. Provides behavioral health expertise. (Board Certified in Psychiatry).</td>
</tr>
<tr>
<td>Chief Operating Officer.</td>
<td>Provides expertise in operational decisions and potential impact of recommendations across regional clinical services including medical center and medical office building operations, behavioral health, laboratory, pharmacy and radiology services; accountable to insure implementation of committees’ decisions.</td>
</tr>
<tr>
<td>Vice President Health Plan Services Administration</td>
<td>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 committees’ decisions.</td>
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<tr>
<td>Designated Physician in Chief</td>
<td>Provides expertise in operational decisions and potential impact of recommendations across the delivery system; accountable to insure implementation of committees’ decisions.</td>
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<tr>
<td>Designated Area Administrator</td>
<td>Provides expertise in operational decisions and potential impact of recommendations across the delivery system; accountable to insure implementation of committees’ decisions.</td>
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<tr>
<td>VP MAS Regional Compliance Officer</td>
<td>Provides expertise on accreditation and regulatory standards; identifies gaps and opportunities for the region to meet the regulatory and accreditation standards.</td>
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<tr>
<td>Associate Medical Director</td>
<td>Provides expertise in emergency care management, governmental relations and community benefit.</td>
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**Facilitator and Recorder (non-voting)**
- Exec. Director Quality Management Operations | Facilitates work of the committee, provides expertise for accreditation and regulatory standards; provides expertise in quality management functions and infrastructure. |

**Non-Voting Members**
- Director Accreditation and Compliance | Provides expertise for NCQA Accreditation and Standards, State of Maryland and Commonwealth of Virginia quality regulations. |
- Director Clinical Accreditation | Provides expertise for Accreditation Association of Ambulatory Healthcare Standards and related regulations. |
- Physician Director for Risk Management/Medical-Legal Affairs | Provides expertise on steps to reduce medical-legal risks and educate physicians on these topics. |
- Physician Director Patient Safety, Physician Director of Pharmacy and Therapeutics | Provides expertise as an IHI Credentialed Patient Safety Officer and works with Patient Safety and Risk Management improve patient and medication safety. |
- Physician Director Practitioner Performance Review and Oversight | Provides expertise for peer review, credentialing; experience in the appeals process and member complaints. |
- Director, Practitioner Provider Quality Assurance and Practitioner Performance Review and Oversight | Provides expertise to meet the regulatory and accreditation standards in credentialing, delegation and peer review. |
• Director Risk Management/Patient Safety
  Provides oversight to increase patient safety and reduce possible harm in the delivery of health services across all care settings.

Routine Department Reports

• 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.

• EH&S and Infection Control
  Provides expertise on the requirements that personnel must meet in order to attain clinical accreditation and regulatory compliance with health, safety and infection control standards; review the environment of care issues.

• Health Information Management Services
  Provides expertise in the analysis of the coding data; medical record review standards; routine monitors.

• Laboratory Services
  Provides expertise in the analysis of the laboratory systems and process monitors and assessment; safety monitors and improvements; member satisfaction.

• Member Services Department
  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.

• Nursing Practice
  Provides expertise on the ambulatory care Nursing Practice Standards and assessment of the region's adherence to the standards.

• Pharmacy Services
  Provides expertise in the analysis of the pharmacy systems and process monitors and assessments; medication safety monitors and improvements; member satisfaction.

• Quality Measures and Analysis
  Provides expertise in quantitative and qualitative data analysis.

• Radiology Imaging Services
  Provides expertise in the analysis of the radiology systems and process monitors and assessment; safety monitors and improvements; member satisfaction.
- Regional Access Services: Provides expertise in the analysis of primary care, specialty care and behavioral health appointment and telephone access results; improvement activities; member satisfaction.

- Senior Services: Provides expertise in the analysis of the data and information through all components of Senior Services; recommend opportunities for improvement.

- Utilization Management Department: Provides KPMAS standards leadership for accreditation and regulatory requirements, monitor utilization and facilitate performance improvement related to Utilization Management.

**Report at least Annually**

- Clinical Technology: Promote the systems and processes to purchase, monitor and maintain biomedical equipment; recommend areas for improvement; recommend opportunities for improvement.

- Diversity Programs Department: Provides expertise to meet the regulatory and accreditation standards to meet the regulatory and accreditation standards for diversity programs.

- Geoaccess Report: Provides reports that demonstrate adherence to the accreditation and regulatory geocaccess standards; recommend opportunities for improvement.

- KP HealthConnect: Provides reports that analyze the adverse events and near misses that occur in connection to the electronic medical record.

- Human Resources Department: Provides expertise on the requirements that personnel must meet in order to attain clinical accreditation.
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 of 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 and Mid-Atlantic Permanente Medical Group, including but not limited to the following.

Accountabilities:
- Responsible for oversight of the Big Q metrics, which include Clinical Effectiveness, 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.
- Review regular reports and updates from all functional units, initiatives and programs within the overall quality program.
- Recommend policy changes and identifies when new ones are required.
- Approve the Quality Program Description, Evaluation and Work Plan.
- Analyze and evaluate the quantitative and qualitative results of improvement activities.
- Ensure practitioner 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.

**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 may be electronic.

**Quorum:**
A quorum will be composed of a simple majority of voting members.

Decisions of the Committee:
- Binding 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 in order to accurately document the outcome of the decisions.
## DISEASE MANAGEMENT STRATIFICATION

### ADULT

#### COPD Risk Stratification

**November 2012**

<table>
<thead>
<tr>
<th>Risk</th>
<th>Criteria</th>
<th>HCT Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Risk</td>
<td>No co-morbidities AND FEV ≥ 80%</td>
<td>- Provide education for newly diagnosed members</td>
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<td></td>
<td></td>
<td>- Refer to health coaches</td>
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<tr>
<td></td>
<td></td>
<td>- Ask about smoking and/or smoke exposure. Smoking cessation counseling and plan</td>
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<td></td>
<td>if smoker- kp.org/breathe (online program to help quit smoking) and/or Commit to</td>
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<td></td>
<td></td>
<td>Quit</td>
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<td></td>
<td>- Refer to the online COPDEmmi® program for self-management training</td>
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<td></td>
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<td>- PCP surveillance visit at least twice per year</td>
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<td></td>
<td>- Check and document BP at each visit</td>
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<td></td>
<td></td>
<td>- Annual Flu vaccine</td>
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<td></td>
<td></td>
<td>- Pneumococcal vaccine if needed</td>
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<tr>
<td></td>
<td></td>
<td>- New Member Mailing re: COPD Program and Services (Monthly)</td>
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<tr>
<td></td>
<td></td>
<td>- Outreach calls for spirometry testing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Screen for depression</td>
</tr>
<tr>
<td>High Risk</td>
<td>At least 1 comorbidity (CAD, CVD, HF, DM) OR</td>
<td>All of the Above, Plus:</td>
</tr>
<tr>
<td></td>
<td>FEV &lt; 80%</td>
<td>- Short acting beta-agonist as needed</td>
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<tr>
<td></td>
<td></td>
<td>- Long acting bronchodilators</td>
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<tr>
<td></td>
<td></td>
<td>- Ask about barriers to adherence</td>
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<tr>
<td></td>
<td></td>
<td>- Long-acting anti-cholinergic: tiotropium – first line long-acting agent</td>
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<tr>
<td></td>
<td></td>
<td>- Screen for co-morbidities (CVD, diabetes, osteoporosis, cancer)</td>
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<tr>
<td></td>
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<td>- Oxygen evaluation if hypoxemic</td>
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<tr>
<td></td>
<td></td>
<td>- Discuss severity adjusted exercise options</td>
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<tr>
<td></td>
<td></td>
<td>- Review spacer holding technique</td>
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<td>- Nutrition assessment/referral</td>
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<td>- Review action plan</td>
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<td>- Report physician level and aggregate level</td>
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<td></td>
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<td>- Regular visits until risk factors are under control</td>
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<tr>
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<td>- Inhaled corticosteroid therapy</td>
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<td>- Inhaled glucocorticosteroid</td>
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<td></td>
<td>- Consult with clinical pharmacist to address medication adherence</td>
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<tr>
<td></td>
<td>Refer to case management</td>
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<tr>
<td></td>
<td>Specialty referral to pulmonary</td>
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<tr>
<td></td>
<td>Pulmonary rehabilitation, as needed</td>
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</tr>
<tr>
<td></td>
<td>Referral to Palliative Care program, as needed</td>
<td></td>
</tr>
<tr>
<td>Risk</td>
<td>Criteria</td>
<td>Interventions</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Low to Moderate Risk</td>
<td>All criteria must be met:</td>
<td>• Provide education for newly diagnosed members- Refer/Schedule and encourage attendance at “InSTEP” classes.</td>
</tr>
<tr>
<td></td>
<td>• No comorbidities present(CAD, CVD, HF, amputation, 2 or more positive microalbumin results, serum creatinine&gt; 1.5, GFR &lt;60 mg/dL, or visit for laser photocoagulation)</td>
<td>• Give diabetes literature in member's language of choice and refer to kp.org/carefordiabetes (online program to help manage diabetes) and kp.org/diabetes (living well with diabetes) and kp.org/diabetes/espanol for Spanish-speaking members (living well with diabetes).</td>
</tr>
<tr>
<td></td>
<td>• Not hospitalized in the last 12 months AND mean A1c &lt; 8% in the last 12 months</td>
<td>• Refer to the online DiabetesEmmi® program for self-management training</td>
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<tr>
<td></td>
<td></td>
<td>• If BMI greater than or equal to 25, refer to weight management Healthy Living class, kp.org/balance (online program to help lose weight), or health coach</td>
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<tr>
<td></td>
<td></td>
<td>• Ask about smoking and/or smoke exposure. Smoking cessation counseling and plan if smoker- kp.org/breathe (online program to help quit smoking), Commit to Quit, and/or health coach</td>
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<td></td>
<td></td>
<td>• PCP surveillance visit at least twice per year</td>
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<td></td>
<td></td>
<td>• Reinforce key messages from “InSTEP” class at each visit</td>
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<td></td>
<td></td>
<td>• Ask about barriers to adherence</td>
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<tr>
<td></td>
<td></td>
<td>• Check and document BP at each visit</td>
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<td></td>
<td></td>
<td>• Initiate self-monitoring of blood glucose</td>
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<td></td>
<td></td>
<td>• Recommend metformin</td>
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<td></td>
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<td>• Start ACE-I/ARB if age≥ 55</td>
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<tr>
<td></td>
<td></td>
<td>• Control BP &lt;140/90</td>
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<tr>
<td></td>
<td></td>
<td>• Consider ASA 81mg/day</td>
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<td></td>
<td></td>
<td>• Consider Lisinopril 10-40 mg/day</td>
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<td></td>
<td>• Consider Simvastatin-40 mg/day</td>
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<tr>
<td></td>
<td></td>
<td>• A1c every 6 months</td>
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<tr>
<td></td>
<td></td>
<td>• LDL annually</td>
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<tr>
<td></td>
<td></td>
<td>• Renal screening annually</td>
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<td></td>
<td></td>
<td>• If MAU ≥ 30, initiate ACE/ARB therapy</td>
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<tr>
<td></td>
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<td>• Retinal screening annually</td>
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<td>• Foot exam with monofilament annually</td>
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<td></td>
<td></td>
<td>• Screen for depression</td>
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<td></td>
<td></td>
<td>• Annual Flu vaccine</td>
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<td></td>
<td></td>
<td>• Pneumococcal vaccine if needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• New Member Mailing re: Diabetes Program and Services (Monthly)</td>
</tr>
<tr>
<td>High or Very High Level Risk</td>
<td>• At least 1 comorbidity is present (CAD, CVD, HF, amputation, 2 or more positive microalbumin results, serum creatinine &gt; 1.5, GFR &lt; 60 mg/dL, or visit for laser photocoagulation) OR • 1 or more hospitalization in the last 12 months OR mean HgbA1c &gt; 12.0% in the last 12 months OR • Mean A1c &gt; 12.0% in the last 12 months</td>
<td>• Complete Care Journal Notification to PCP (Daily) • Report physician level and aggregate level daily ▪ A1C control rates ▪ LDL control rates ▪ Blood Pressure control rates ▪ Retinal exam rates ▪ Renal screening rates ▪ Foot exam rates (aggregate only) • Proactive care reminders for patients due for lab tests and with adherence to medications not at ideal that may need adjustment to medication doses based on lab test results <strong>All of the Above, Plus:</strong> • Visit every three months until risk factors are under control • Inreach/outreach to achieve clinical quality targets • Control BP with thiazide-type diuretic, HCTZ or HCTZ/ACE-I or add beta-blocker if needed. • Consider adding insulin if 2 or more oral agents if glucose not controlled • A1C testing every 3 months • Consult with clinical pharmacist to address medication adherence • Refer to case management prn • Specialty referral to endocrine, Behavioral Health, podiatry, wound care, or nephrology • Care management by nurse practitioners</td>
</tr>
</tbody>
</table>
## Risk Criteria

<table>
<thead>
<tr>
<th>Risk</th>
<th>Criteria</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>All criteria must be met:</td>
<td>• Provide education for newly diagnosed members- Refer/Schedule and encourage attendance at &quot;Successful Living with Heart Failure” class.</td>
</tr>
<tr>
<td></td>
<td>• No comorbidities present (CAD, COPD, DM, HTN serum creatinine&gt; 1.5</td>
<td>• Give heart failure literature in member's language of choice and refer to kp.org/heart(living well with heart disease)</td>
</tr>
<tr>
<td>Level</td>
<td>AND Mean LDL-C &lt; 100 mg/dL in the last 12 months</td>
<td>• Ask about smoking and/or smoke exposure. Smoking cessation counseling and plan if smoker- kp.org/breathe (online program to help quit smoking), Commit to Quit, and/or health coach</td>
</tr>
<tr>
<td>Risk</td>
<td>AND Not hospitalized in the last 12 months</td>
<td>• Refer to the online Heart FailureEmmi® program for self management training</td>
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<tr>
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<td>• Provide education on sodium restriction and monitoring daily weights, as appropriate</td>
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<td></td>
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<td>• PCP surveillance visit at least twice per year</td>
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<td></td>
<td>• Ask about barriers to adherence</td>
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<tr>
<td></td>
<td></td>
<td>• Check and document BP at each visit</td>
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<td></td>
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<td>• Consider Simvastatin-40 mg/day</td>
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<td></td>
<td></td>
<td>• LDL testing annually</td>
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<td></td>
<td></td>
<td>• Screen for depression</td>
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<td></td>
<td></td>
<td>• Annual Flu vaccine</td>
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<tr>
<td></td>
<td></td>
<td>• Pneumococcal vaccine, if needed</td>
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<tr>
<td></td>
<td></td>
<td>• New Member Mailing re: Heart Failure Program and Services (Monthly)</td>
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<td>• Complete Care Journal</td>
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<td>• Notification to PCP (Daily)</td>
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<td></td>
<td>• Report physician level and aggregate level daily</td>
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<tr>
<td></td>
<td></td>
<td>• Proactive care reminders for patients due for lab tests and with adherence to medications not at ideal that may need adjustment to medication doses based on lab test results.</td>
</tr>
</tbody>
</table>

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2015 QUALITY PROGRAM DESCRIPTION
(All Lines of Business)
KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATE AND MID-ATLANTIC PERMANENTE MEDICAL GROUP
Confidential
<table>
<thead>
<tr>
<th>High Level Risk</th>
<th>All of the Above, Plus:</th>
</tr>
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<tbody>
<tr>
<td>• At least 1 comorbidity is present (CAD, DM, COPD, serum creatinine &gt; 1.5, AND)</td>
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<tr>
<td>• 1 or more hospitalization in the last 12 months OR</td>
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<tr>
<td>• 1 or more ER visits in the last 6 months</td>
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<tr>
<td>• Visit every three months until risk factors are under control</td>
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<tr>
<td>• Inreach/outreach to achieve clinical quality targets</td>
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<tr>
<td>• Control BP with thiazide-type diuretic, HCTZ or HCTZ/ACE-I</td>
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<tr>
<td>• Check adherence to beta-blocker</td>
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<tr>
<td>• LDL testing every 3 months</td>
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<tr>
<td>• Consult with clinical pharmacist to address medication adherence</td>
<td></td>
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<tr>
<td>• Refer to case management prn</td>
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<tr>
<td>• Specialty referral to cardiology</td>
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<tr>
<td>Risk</td>
<td>Criteria</td>
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</tr>
<tr>
<td>Low Risk</td>
<td>0-15% chance of CAD hospitalization in the next 6 months</td>
</tr>
<tr>
<td></td>
<td>• LDL &lt; 100</td>
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<td></td>
<td>• BP &lt; 140/90</td>
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<tr>
<td></td>
<td>• Non smoker</td>
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<td></td>
<td>• On lipid medication</td>
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<td></td>
<td>• On ACE/ARB</td>
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2015 QUALITY PROGRAM DESCRIPTION
(All Lines of Business)
KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATE AND
MID-ATLANTIC PERMANENTE MEDICAL GROUP
Confidential
<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Probability</th>
<th>Criteria</th>
<th>Actions</th>
</tr>
</thead>
</table>
| Moderate Risk | 15-25% chance of CAD hospitalization in the next 6 months. | • LDL > 100  
• BP >139/89  
• Smoker  
• Not on lipid meds  
• Not on ACE/ARB  
• At least 1 co-morbidity | • Start Beta blocker if patient is post MI, as appropriate  
• Control LDL < 100  
• LDL at a minimum annually, more often if uncontrolled  
• Evaluate for co-morbidities  
• Screen for diabetes  
• Screen for depression and anxiety  
• Encourage annual flu shot  
• Encourage pneumonia vaccine  
• Follow up care  
• Follow up at a minimum of annually, more often if perimeters are uncontrolled  

**All of the Above, Plus:**  
• Inreach/outreach to achieve clinical quality targets  
• Frequent contact with healthcare team at a minimum of quarterly to assess adherence to medications and reaching clinical targets (smoking cessation, LDL < 70, BP < 140/90)  
• Specialty referral, as appropriate (cardiology, nephrology, psychiatry, etc).  
• Summary report of LDL testing and control |
| High Risk    | >25% chance of CAD hospitalization in the next 6 months. | • At least 1 co-morbidity  
• LDL > 100  
• BP >139/89  
• Hospitalization in the last 12 months | • Refer to case management  
• Consult with clinical pharmacist to address medication adherence  
• Care management by nurse practitioners  

**All of the Above, Plus:**  
• Inreach/outreach to achieve clinical quality targets  
• Frequent contact with healthcare team at a minimum of quarterly to assess adherence to medications and reaching clinical targets (smoking cessation, LDL < 70, BP < 140/90)  
• Specialty referral, as appropriate (cardiology, nephrology, psychiatry, etc).  
• Summary report of LDL testing and control |
## Asthma Risk Stratification
### September 2012
(Ages 18-64 Years)

<table>
<thead>
<tr>
<th>Risk</th>
<th>Criteria</th>
<th>HCT Interventions</th>
</tr>
</thead>
</table>
| Low to Moderate Risk  | No asthma ED visits AND no hospitalization with asthma as principal diagnosis AND <15 canisters short-acting beta-agonists OR no oral steroids | - Provide education for newly diagnosed members.  
- Give asthma literature in member's language of choice and refer to kp.org/asthma or kp.org/asma (for Spanish-speaking members)  
- Refer to the online Asthma Emmi® program for self management training  
- If BMI greater than or equal to 25, refer to weight management Healthy Living class or kp.org/weight  
- Check and document BP at every visit  
- Ask about smoking and/or smoke exposure. Smoking cessation counseling and plan if smoker; refer to kp.org/quitsmoking and/or Commit to Quit Healthy Living class  
- Annual PCP surveillance  
- Ask about barriers to adherence  
- Teach proper technique for inhaler use, including MDI with spacer and/or discuss as appropriate  
- Review possible asthma triggers and appropriate management  
- Establish and maintain a written asthma action plan, including appropriate medications (inhaled corticosteroids) for persistent asthma  
- Screen for depression and refer to Behavioral Health if needed  
- Treat any concurrent GERD  
- Treat any concurrent rhinitis  
- Annual Flu vaccine  
- Pneumococcal vaccine for teens and adults  
- New Member Mailing re: Asthma Program and Services (Monthly)  
- Annual “Complete Care” booklet with an insert for patients with asthma  
- Complete Care Journal  
- Notification to PCP (Daily) |
| High Risk | 1 or more Asthma ED visit or hospitalization with asthma as principal diagnosis  
AND/OR  
>14 canisters short-acting beta-agonists  
AND  
1 or more canister equivalents of oral steroids |
|---|---|
| All of the Above, Plus: | • Report appropriate use of asthma medications by physician and aggregate level daily  
• Proactive care reminders for patients with low adherence to medications that may need adjustment to medication doses  
|  
|  
| • PCP visits every 1-2 months until asthma is controlled  
• Refer to Allergy for assistance in treatment, monitoring, and evaluation of trigger modification  
• ER follow up phone call by RN  
• PCP appointment scheduled upon hospital discharge  
• Nurse practitioner care management, as needed  
• Physician asthma champions distribution of lists of high risk patients to PCPs quarterly  
• Secure message or letter sent to high risk patients from PCP and/or asthma champion |
## Pediatric Diabetes Risk Stratification

### February 2012

<table>
<thead>
<tr>
<th>Risk</th>
<th>Criteria</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low to Moderate Risk</td>
<td>All criteria must be met:</td>
<td>• Provide education for newly diagnosed members</td>
</tr>
<tr>
<td></td>
<td>• No comorbidities present (CAD, CVD, HF, amputation, 2 or more positive microalbumin results, serum creatinine &gt; 1.5, GFR &lt; 60 mg/dL, or visit for laser photocoagulation)</td>
<td>• Give diabetes literature in member's language of choice and refer to kp.org/carefordiabetes (online program to help manage diabetes) and kp.org/diabetes (living well with diabetes) and kp.org/diabetes/espanol for Spanish-speaking members (living well with diabetes).</td>
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<tr>
<td></td>
<td>• Not hospitalized in the last 12 months AND mean A1c &lt; 8% in the last 12 months</td>
<td>• Refer to the online DiabetesEmmi® program for self-management training</td>
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<tr>
<td></td>
<td></td>
<td>• If BMI greater than or equal to 25, refer to weight management Healthy Living class or kp.org/balance (online program to help lose weight) for teens</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ask about smoking and/or smoke exposure. Smoking cessation counseling and plan if smoker- kp.org/breathe (online program to help quit smoking) and/or Commit to Quit</td>
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<tr>
<td></td>
<td></td>
<td>• PCP surveillance visit at least twice per year</td>
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<tr>
<td></td>
<td></td>
<td>• Ask about barriers to adherence</td>
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<tr>
<td></td>
<td></td>
<td>• Check and document BP at each visit</td>
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<td></td>
<td></td>
<td>• Initiate self-monitoring of blood glucose</td>
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<td></td>
<td></td>
<td>• Recommend metformin, as needed</td>
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<td></td>
<td></td>
<td>• Control BP &lt; 140/90</td>
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<tr>
<td></td>
<td></td>
<td>• A1c every 6 months</td>
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<tr>
<td></td>
<td></td>
<td>• LDL annually</td>
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<tr>
<td></td>
<td></td>
<td>• Renal screening annually</td>
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<td></td>
<td></td>
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<td></td>
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<td>• Foot exam, as needed</td>
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<td>• Screen for depression</td>
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<td>• Pneumococcal vaccine if needed</td>
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<tr>
<td></td>
<td></td>
<td>• New Member Mailing re: Diabetes Program and Services (Monthly)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Notification to PCP (Daily)</td>
</tr>
<tr>
<td>High or Very High Level Risk</td>
<td>Report physician level and aggregate level daily</td>
<td></td>
</tr>
<tr>
<td>------------------------------</td>
<td>-------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• A1c control rates</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• LDL control rates</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Blood Pressure control rates</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Renal screening rates</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Proactive care reminders for patients due for lab tests and with adherence to medications not at ideal that may need adjustment to medication doses based on lab test results.</td>
<td></td>
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</tbody>
</table>

- At least 1 comorbidity is present (CAD, CVD, HF, amputation, 2 or more positive microalbumin results, serum creatinine > 1.5, GFR < 60 mg/dL, or visit for laser photocoagulation) OR
- 1 or more hospitalization in the last 12 months OR mean HgbA1c > 12.0% in the last 12 months OR
- Mean A1c > 12.0% in the last 12 months

- Monitoring by a pediatric endocrinologist
- Visit every three months until risk factors are under control
- Inreach/outreach to achieve clinical quality targets
- Control BP
- Consider adding insulin if 2 or more oral agents if glucose not controlled
- A1C testing every 3 months
- Consult with clinical pharmacist to address medication adherence
- Specialty referral to Behavioral Health, podiatry, wound care, or nephrology
# Pediatric Asthma Risk Stratification

**February 2012**  
(Ages 5-17 Years)

<table>
<thead>
<tr>
<th>Risk</th>
<th>Criteria</th>
<th>Interventions</th>
</tr>
</thead>
</table>
| Low  | No asthma ED visits  
AND  
no hospitalization with asthma as principal diagnosis  
AND  
<15 canisters short-acting beta-agonists OR no oral steroids | • Provide education for newly diagnosed members.  
• Give asthma literature in member's language of choice and refer to kp.org/asthma or kp.org/asma (for Spanish-speaking members)  
• Refer to the online Asthma Emmi® program for self management training  
• If BMI greater than or equal to 25, refer to weight management Healthy Living class or kp.org/weight (teens)  
• Check and document BP at every visit  
• Ask about smoking and/or smoke exposure. Smoking cessation counseling and plan if smoker; refer to kp.org/quitsmoking and/or Commit to Quit Healthy Living class  
• Annual PCP surveillance  
• Ask about barriers to adherence  
• Teach proper technique for inhaler use, including MDI with spacer and/or discuss as appropriate  
• Review possible asthma triggers and appropriate management  
• Establish and maintain a written asthma action plan, including appropriate medications (inhaled corticosteroids) for persistent asthma  
• Screen for depression and refer to Behavioral Health if needed  
• Treat any concurrent GERD  
• Treat any concurrent rhinitis  
• Annual Flu vaccine  
• Pneumococcal vaccine for teens  
• New Member Mailing re: Asthma Program and Services (Monthly)  
• Notification to PCP (Daily)  
• Report appropriate use of asthma medications by physician and aggregate level daily  
  o Proactive care reminders with low adherence to medications and/or that may need adjustment to medication doses |
<table>
<thead>
<tr>
<th>High Risk</th>
<th>All of the Above, Plus:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 or more Asthma ED visit or hospitalization with asthma as principal</td>
<td>• PCP visits every 1-2 months until asthma is controlled</td>
</tr>
<tr>
<td>diagnosis</td>
<td>• Refer to Allergy for assistance in treatment, monitoring, and evaluation of</td>
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<tr>
<td></td>
<td>trigger modification</td>
</tr>
<tr>
<td>AND/OR</td>
<td>• ER follow up phone call</td>
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<tr>
<td>&gt;14 canisters short-acting beta-agonists</td>
<td></td>
</tr>
<tr>
<td>AND</td>
<td></td>
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<tr>
<td>1 or more canister equivalents of oral steroids</td>
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</tbody>
</table>
**Medical Director of Medicare Cost and Part D Pharmacy Plans**
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, and 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 Cost and Part D pharmacy plans for this work.

Attachment E
**KPMAS Quality Resources and QRM Organizational Chart**

KFHP, Inc. provides technical assistance, consultation and training to the various regions in the areas of quality improvement, risk management, patient safety, credentialing, delegation, accreditation, utilization management 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 guidelines.

In KPMAS under the direction of the Vice-President of Quality Resource Management, consists of the following resources:

- Executive Director Quality Management Operations (Vacant)  1.0 FTE
- Senior Director Accreditation, Regulation and Licensure  1.0 FTE
- Director Quality Improvement  1.0 FTE
- Director Accreditation, Regulation and Licensure Reporting and Improvement  1.0 FTE
- Director Accreditation and Compliance Oversight  1.0 FTE
- Director Accreditation, Regulation and Licensure  1.0 FTE
- Improvement Advisor  3.0 FTE
- Quality Improvement Specialist  3.0 FTE
- Senior Manager Practitioner and Provider Quality Assurance  1.0 FTE
- Credentialing Coordinators  9.0 FTE
- Credentialing Assistants  2.0 FTE
- Senior Quality Information System Administrator  1.0 FTE
- Analytical and support staff  2.0 FTE

Also accountable to the Vice-President of Quality Resource Management is the Senior Director, Risk Management/Patient Safety/Patient Safety. 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.

Attachment F