**Kaiser Permanente**
**Hawaii Market**

# 2024 Quality Program Description

| Reviewed and approved by: | Hawaii Market Quality Committee | February 8, 2024 |
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# I. Introduction

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

Headquartered in Oakland, California, Kaiser Permanente operates in the following eight markets:
- Northern California,
- Southern California,
- Colorado,
- Georgia,
- Hawaii,
- Mid-Atlantic States (Virginia, Maryland and District of Columbia),
- Northwest (Oregon and Washington) and
- Washington.

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

Kaiser Foundation Health Plan, Inc. (KFHP) Hawaii Market is a mixed model Health Maintenance Organization (HMO) serving over 271,000[1] members on the islands of Oahu, Maui, Hawaii, Kauai, Molokai and Lanai. The Market provides clinical care services in its own medical clinics on the islands of Hawaii (3); Maui (5), Oahu (10), and Kauai (1). On Molokai and Lanai, 480[1] members are cared for in private offices of a preferred provider network. The Market has one Kaiser Foundation Hospital (Moanalua Medical Center) on Oahu. Additionally, the Market contracts for care services with twenty-two acute care hospitals on all islands for inpatient services.

KFHP contracts with Kaiser Foundation Hospital (KFH) for inpatient services and the Hawaii Permanente Medical Group (HPMG) for professional services. The Market is collaboratively co-managed by KFHP (generally considered the insurer), KFH (generally considered the care facilities), and HPMG (generally considered the caregivers). Care of Hawaii Market members is provided by Hawaii Market 4161 employees and 611 HPMG practitioners.

# II. Mission and Vision

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

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

The purpose of KFHP's Quality Program is the assurance of high quality, safe and appropriate health care, delivered in a culturally responsive manner for all Health Plan members across all settings of care. Health care quality involves care and service, patient safety and cost-effective utilization, as well as

[1] December 2023 membership

business practices that support patient care delivery. The Quality Program requires integration into clinical operations structure, systems and processes.

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

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

# III. National and Market Quality Structure

## Board of Directors

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

The Permanente Quality Board, which provides oversight on quality issues that impact the Kaiser Permanente Medical Care Program, works in partnership with the national quality review body for the Kaiser Foundation Health Plan / Hospitals and the Health Plan Board's Quality and Health Improvement Committee (QHIC). The Permanente Quality Board meets quarterly.

## Quality and Health Improvement Committee (QHIC)

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

The Quality and Health Improvement Committee (QHIC) provides:

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

## Kaiser Permanente National Quality Committee (KPNQC)

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

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

### Medical Director of Medicare Advantage and Part D Pharmacy Plans

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

- ensure clinical accuracy of coverage determinations involving "medical necessity", for Medicare members,
- provide oversight for Health Plan operations involving medical/utilization review for Medicare members,
- provide oversight for Health Plan's benefit, formulary and claims management activities affecting Medicare members, 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 Advantage and Part D pharmacy plans for this work.

# IV. Hawaii Market Quality Program Structure and Approach

## A. Integrated Quality Program

Quality assurance and systems improvement are shared responsibilities of KFHP, KFH and HPMG. HPMG delivers medical care in an exclusive provider relationship in mutual collaboration with the KFHP and KFH. At all levels of the organization, Health Plan managers partner with physician managers to design, deliver, measure, and monitor quality care and service across the continuum of care – clinics, ambulatory surgery centers, hospital, skilled and intermediate nursing facilities, home health care, affiliated services, and membership business and support services. The summary of programs in this Hawaii Market Quality Program Description serve to inform internal and external audiences about how the Market is organized to support the organization's commitment to assessing and improving performance on a continuous systematic and outcome-oriented basis.

The Hawaii Market Quality Program is a systematic, integrated, widely deployed approach to planning, implementing, assessing, and improving clinical quality, patient safety, health outcomes, resource management / stewardship, clinical risk management, outside services, and service performance. All plans, goals, and initiatives align with the Kaiser Permanente (KP) National Strategy Six Aims of Improvement: Safe, Effective, Patient-centric, Timely, Efficient and Equitable, guided by the Market's mission and vision. Assessing group and member needs, responding to the voice of the customer, and monitoring quality of care and service are integrated into the Hawaii Market Quality Program. Also described are the responsibilities and relationship within the organization including the relationship between the Kaiser Foundation Health Plan/Hospitals (KFHP/H) Boards of Directors and the Quality and Health Improvement Committee (QHIC), which oversees quality KP program-wide. The Hawaii Market Quality Program is structured to enable KFHP, KFH, and HPMG to provide optimal quality and continuity of medical care and service to members of all lines of business (Commercial, Marketplace, Medicare and Medicaid). The quality structure establishes accountability through the HPMG Assistant Area Medical Director (AAMD) for Quality and Safety and the KFHP Quality and Safety Oversight Senior Director.

## B. Hawaii Market Quality Structure

The QHIC and HPMG Board of Directors hold the Hawaii Market's KFHP/H President and HPMG President accountable for the effectiveness of the Hawaii Market's quality program. The KFHP/H and HPMG Presidents assign day-to-day quality management activities to the HPMG AAMD for Quality and Safety and the KFHP Quality and Safety Oversight Senior Director as the designated Executive Quality Leaders for the Hawaii Market.

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The Executive Quality Leaders co-chair the Hawaii Market Quality Committee, which provides direction, oversight, coordination, and communication of the Hawaii Market Quality, Patient Safety and Service priorities, activities, and performance, and the Quality Information Team.

The Executive Quality Leaders assume ultimate responsibility and accountability for the direction, implementation, and success of the program.

The HPMG AAMD for Quality and Safety is the designated senior physician accountable for implementing an ongoing Quality Program including accountability for patient safety and clinical risk management. The AAMD for Quality and Safety assigns accountability for quality improvement to each operation medical group leader through planning, design, implementation and review.

### Quality Committee (QC)

The purpose of the Quality Committee (QC) is to provide direction, oversight, coordination, and communication of the Hawaii Market Quality, Patient Safety and Service priorities, activities, and performance. QC serves as the Market's Quality Oversight Committee as delegated by the Boards' Quality and Health Improvement Committee (QHIC). Goals of the QC are to:

- Improve the reliability and clinical effectiveness of care
- Improve patient satisfaction and create a WOW experience for the KP Hawaii members / patients
- Eliminate incidents of medical harm to KP Hawaii members / patients and never events

The Hawaii Market Quality Committee meets a minimum of eight times per year to provide direction, oversight, coordination and communication of the Hawaii Market Quality, Patient Safety, Clinical Risk Management and Service priorities, activities, and performance. The role of its members is to ensure quality objectives and work plan tasks are accomplished as well as to ensure that strategic quality goals are met. The QC, along with the Quality Information Team (QIT), sponsors local quality improvement initiatives. The membership term of the Quality Committee is indefinite.

Quality Committee deliberations, decisions, and actions are documented through contemporaneous minutes. In general, meeting minutes are reviewed and approved by members at the subsequent meeting. Unresolved issues are tracked through resolution with an issues tracking log. Agendas and meeting minutes are retained by the official recorder and signed off by the chair(s).

The Quality Committee serves as the Market's quality oversight committee and has the authority and responsibility to review and act on the following:

- Quality Assurance/Improvement
- Patient Safety
- Clinical Risk Management
- Care Experience and Service
- Utilization Management
- Member Grievances / Complaints / Appeals data
- Clinical Practice Guidelines
- Regulatory (State and Federal) and accreditation – monitors performance relating to legal, accreditation, licensing, and internal or external reporting requirements
- Practitioner Performance (including credentialing and privileging)
- Laboratory, Diagnostic Imaging and Pharmacy (inpatient/outpatient)
- Home Health
- Integrated Behavioral Health – Services/Access/Standards
- Contracted Care / Network Reports
- Free-standing Ambulatory Surgery Centers

Other oversight accountabilities for the Quality Committee include:

- Development and implementation of the Market's quality, patient safety and service performance improvement programs.
- Analyses and evaluation of results of quality, patient safety and service performance improvement activities, take needed actions and ensure follow-up, as appropriate
- Identification of opportunities to improve in clinical effectiveness / service / patient safety goals including significant events reports, internal and external surveys, accreditation reports, results of audits, service area self-assessments and initiatives
- Recommendation of policy decisions
- Ensuring practitioner participation in leading the Quality, Patient Safety and Service priorities
- Communication of results of clinical effectiveness / patient safety / service activities to leadership and other committees

Refer to Quality Structure and Quality Information Process Flow with delineated oversight accountability of the QC to the governing bodies.

### Quality Information Team (QIT)

The QIT is a working group of the Quality Committee. The team is accountable for monitoring and tracking quality, patient safety and service performance measures for the Quality Committee. The QIT is comprised of quality leaders that meet at least monthly and more often as needed to ensure Quality Committee oversight, monitoring and reporting processes are in place and carried out. QIT membership, like the QC, is based on roles and responsibilities, not individuals. Terms are indefinite.

The members of the QIT include the following:

- HPMG AAMD for Quality and Safety (Co-chair)
- KFHP Quality and Safety Oversight Senior Director (Co-chair)
- HPMG AAMD Professional Chief of Medical Staff
- HPMG AAMD Hospital Specialties
- HPMG VP of Care Delivery Administration
- Director for Hospital Quality, Clinical Risk Management and Patient Safety
- Manager of Pharmacy Quality and Medication Safety and Pharmacy Informatics
- Director of Health Plan Quality

### Medical Executive Committee (MEC)

The MEC provides oversight to the KFH's services, activities, and functions, and implements Professional Staff policies. It receives and acts upon minutes, reports, and recommendations of committees, services, and others providing patient care and service as defined by the Bylaws and Rules and Regulations of the Professional Staff.

The governance of the MEC is derived from the Bylaws and responsibilities include fulfilling all functions and oversight responsibilities as delineated in the Bylaws, receiving and acting upon periodic reports from clinical services, professional staff committees, and other appropriate groups performing services under the Bylaws of the Professional Staff. The MEC approves quarterly reports of hospital outcomes, and quarterly reports to the BOD/QHIC. Voting membership includes: KFH Chief of Staff, KFH Assistant Chief of Staff and clinical department chiefs. Ex-officio members include the Hospital Administrator (with voting rights) and the Chief Nurse Executive (without voting rights). Other members of the professional staff and ex-officio members may be appointed by the Chief of Staff with approval of the MEC. Membership term of the MEC is indefinite.

The Committee meets at least once a month during ten (10) months of the year and maintains a permanent record of its proceedings and actions. The term of office continues until resignation or change in job occurs.

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### Quality, Risk, Safety, and Service Committee (QRSS)

The Quality, Risk, Safety, and Service (QRSS) Committee serves as the committee to implement, monitor and enhance operational systems to ensure quality improvement, performance improvement and patient safety for the hospital. The Institute for Health Care Improvement (IHI) Model for Improvement as well as other performance improvement models (e.g., Plan-Do-Study-Act) and tools are utilized to organize efforts that improve the quality of health care delivered and the processes that support quality care.

The committee facilitates the preparation of reports related to the hospital's quality assurance, performance improvement, and patient safety activities to be submitted to the Board of Directors' QHIC through the Medical Executive Committee and/or the Quality Committee on an ongoing basis and as requested.

The QRSS Committee also strives to reduce risk, improve patient safety and quality outcomes in the delivery of health services across all settings of care. The QRSS Committee monitors the effectiveness of the corrective actions taken in response to an adverse or sentinel event to ensure that the risk reduction strategies achieve the expected results. The QRSS Committee supports the process for ongoing patient safety training for physicians, nurses and hospital staff. Training will be based on identified issues and opportunities for improvement. As appropriate, training will incorporate the hospital's commitment to a "Just Culture" and responsible reporting. The QRSS Committee shall submit reports related to patient safety and risk management priorities to the Medical Executive Committee and/or the Quality Committee regularly and as requested.

Committee members may include: HPMG Associate Medical Director for Quality and Safety; Quality and Safety Oversight Senior Director, Director of Hospital Quality, Risk Management, and Patient Safety; Credentials; Quality and Safety Improvement Senior Manager; Inpatient Director of Pharmaceutical Services; Director of Diagnostic Imaging; Director of Clinical Laboratories; Chief Nurse Executive; and professional staff from other departments and clinical services. QRSS meets a minimum of four times (4) per year and maintains a permanent record of its proceedings and actions. The term of office continues until resignation or change in job occurs.

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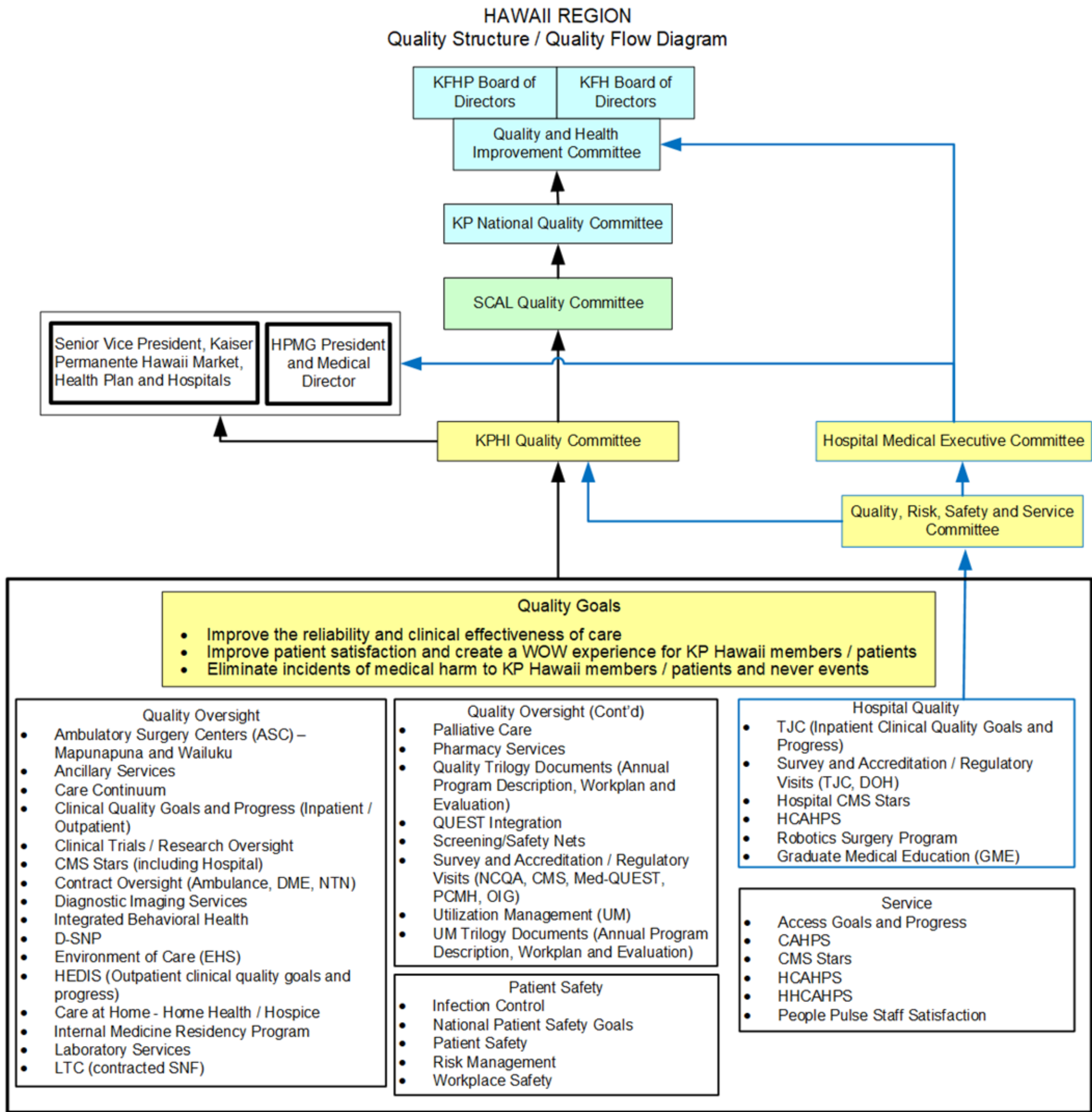


## C. Hawaii Market Quality Management Program Scope

The Market offers a comprehensive health care delivery system, including ambulatory care, preventive services, hospital care, behavioral health (mental health and substance abuse treatment), home health care, hospice services, rehabilitation, and skilled nursing services. Sole practitioner health care services by HPMG are offered at Kaiser Permanente owned and operated medical offices throughout Hawaii. In addition to these medical office buildings, the Market operates a general acute care hospital, a skilled nursing facility and two home health agencies.

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Majority of care and services covered by the KFHP insurance are provided directly by HPMG practitioners at Hawaii Market managed facilities. If medically indicated services are not available within HPMG or KFH, contracted community practitioners and/or contracted community providers (Contracted Providers) are used to ensure availability of medical care and service in accordance with the Health Plan benefit agreement.

The Hawaii Market Quality Program covers all care and service and ancillary services (including contracted services) provided to all members and patients across the continuum of care. The Quality Program encompasses Hawaii Market activities aimed at assessing and improving care and services. Although KFHP is ultimately accountable for the quality of care and service provided, quality management and oversight are a shared responsibility of KFHP, KFH and HPMG. These three entities collaborate in close partnership to provide and coordinate high quality and effective medical management for KFHP members, striving continuously to improve the care and service.

Hawaii Market Quality Program monitors and evaluates significant aspects of the clinical care, member services, and administrative services provided to members. The program integrates cross-functional activities through interdisciplinary teams when possible. The program emphasizes quality improvement activities in member care and service, including:

- Advice Nurse Services
- Ambulatory Surgery Center Services
- Ancillary Services
  - Diagnostic Imaging
  - Laboratory and Pathology
  - Pharmacy Services
- Clinical Services
- Dialysis Services
- Continuing Care Services
  - Home Health
  - Long Term Care
  - Utilization Management
  - Skilled Nursing Facility
- Health Information Management
- Hospital Services
- Integrated Behavioral Health Services
- Member Services
- Nursing
- Outside Services
  - Authorizations and Referral Management
  - Durable Medical Equipment
  - Medical Transportation and Ambulance Services
- Preventive Health Services, Health Education, Promotion and Outreach
- Research

The Quality Management Program links departments, functions, systems and processes to enable the Hawaii Market to provide optimal quality and continuity of medical care and service to its members. The Market President and Executive Medical Director through KFHP/KFH and HPMG corporate structures ensure resources are allocated to develop and maintain the Quality Program.

Physicians and operations managers throughout the Market are allocated time, office space, and support staff to perform specialized Quality Improvement Program roles and are members of committees, participate in special projects, and conduct studies on behalf of the Quality Management Program. In addition, each physician, manager, supervisor, nurse and front-line employee is responsible for contributing to performance targets for quality improvement initiatives.

The Hawaii Market believes in a data driven approach to implementing and maintaining quality improvement efforts. The Market has analysts that support utilization management, credentialing, clinical quality, disease management and service improvements. Additionally, analysts are staffed throughout clinical and health plan operations to support primary care, specialty care, clinical support services, continuing care services, mental health, hospital services, information technology, membership services,

and member relations. Information Technology (IT) and analytical resources support quality improvement initiatives including HEDIS reporting and data extracts for measurement and analysis. Involvement of IT resources also includes design, implementation and ongoing support of disease registry information and registries.

Monitoring activities are conducted and reported on a market, clinic, hospital, health care team, and individual practitioner level, whenever possible. Important aspects of care and service in monitoring and improvement activities include:

Appointment availability and accessibility of services
Appeals/denials monitors
Appropriateness and efficiency of ancillary services
Compliance and regulatory issues
Continuity and coordination of care
Contracted care/network
Credentialing and privileging activities
Cultural Competency
Environmental health and safety
Focused studies
High-volume and/or high-risk diagnoses and/or problem prone processes
Infection control practices
Internal customer needs and expectations
Medical record documentation
Medication safety
Member care experience/ Consumer Assessment of Healthcare Providers and Systems (CAHPS)/ METEOR
Member concerns and grievance process
Member disenrollment using voluntary termination surveys
Operative and invasive procedures that put patients at-risk
Over-utilization, misutilization and under-utilization
Oversight of delegated activities
Patient safety
Population based care/Panel support services
Potentially compensable events
Preventive care
Quality and risk occurrences (Unusual Occurrence Reporting)
Quality control monitoring
Sentinel Events

## D. Structural Relationships and Coordination of Quality with Other Management Functions

Structural linkages exist through collaboration and participation on various Hawaii Market committees. In addition, these functions have a reporting relationship to the QIT and Quality Committee. Participants on the QIT have management responsibilities for clinic and hospital operations, risk management, credentialing and re-credentialing of practitioners and providers.

Structural relationships and linkages between various management functions impact quality care and service. These functions are listed and described below:

### Moanalua Hospital

The Hospital is dedicated to continuously improving quality and recognizes its responsibility to support the Hawaii Market Quality Program. The Hospital Quality Program is a systematic, hospital-wide program of quality assessment and improvement activities and applies to all personnel in hospital and hospital-based services.

The goal of this Program is to monitor, evaluate, and improve the quality of care and service delivered to hospitalized patients and their families. The Program's objectives are aligned with

and in support of the Hawaii Market Mission and Strategic Priorities. Details can be found in the Hawaii Market Hospital Quality Program Description.

### Ambulatory Surgery Centers

The Mapunapuna and Wailuku Ambulatory Surgery Centers (ASCs) are freestanding surgical outpatient facilities, operated by Kaiser Foundation Health Plan, Inc. and are accredited by the Accreditation Association for Ambulatory Health Care (AAAHC). The ASCs are designed to provide quality care for eligible patients who are scheduled to undergo procedures which meet the criteria for ambulatory surgery. The ASCs are an integral part of the medical care delivery system as a vital link to promoting continuity of care with timely, appropriate and safe discharge planning from the ASC to patient home and referral of patients from the ambulatory care setting to the hospital if needed. Please refer to the ASC Quality Program Description that describe formal linkage to the Hawaii Market Quality Committee and the Governing Body.

### Outside Medical Services

The Outside Medical Services Steering Committee is responsible for reviewing and refining strategies and tactics to ensure that outside medical services are affordable and high quality for our members. It provides operational oversight, guidance, direction, monitoring and evaluation of outside services. Membership of the Outside Medical Services Steering Committee is comprised of the Director of Outside Medical Services Continuum, VP of Hospital Administrator and Continuum, KP Hawaii Market Chief Financial Officer, Finance Director Outside Medical Services, Outside Medical Financial Analysts, Director of Provider Contracting, Director of Strategic Engagement for National Claims Administration, HPMG AAMD Physician Business Services, HPMG Executive Director of Finance and Accounting, HPMG Finance Manager and HPMG Outside Medical Analyst. The Mission Statement of the Outside Medical Steering Committee is: In COLLABORATION with Clinical Leaders, Continuously drive towards industry BEST PRACTICES for utilization management and claims validation, Achieve STRONG & FAIR CONTRACTS with vendors that support KP's mission, Execute on STRATEGIC OPPORTUNITIES for internalization and collaboration with key external partners, OPTIMIZE USAGE of the internal care delivery system to minimize outside medical expense, All of which is supported by world-class ANALYTICS and VISUALIZATION, to provide AFFORDABLE, HIGH-QUALITY HEALTH CARE services to improve the health of our members and the communities we serve.

### Special Needs Plan

Kaiser Permanente (KP) offers a Special Needs Plan (D-SNP) called Senior Advantage Medicare and Med-Quest Plan, for its dual eligible members (D-SNP). Dually eligible persons tend to have complex, high cost, high medical and psychosocial needs. Members must have both Medicare and Med-Quest benefits with Medicare assigned to Kaiser Permanente.
The Centers for Medicare & Medicaid Services goal for all Special Needs Plans is to improve member health outcomes by ensuring: 1) Improved access to medical, mental health and social services; 2) Better coordination of care; 3) Adequate provider network; 4) Seamless transition of care through an identified point of contact; 5) Appropriate utilization of services; 6) Cost effective service delivery.

The SNP Model of Care (MOC) Elements include:

1) Description of the SNP Population: The SNP MOC describes its population demographics and unique characteristics of the most vulnerable members, including but not limited to:
    - Age, gender and ethnicity
    - Socioeconomic status, living conditions and environmental factors
    - Barriers, such as language barriers and other significant barriers
    - Major diseases, co-morbidities, chronic conditions
    - Social, cognitive and functional limitations
2) Care Coordination: The SNP MOC details key roles and responsibilities of the care coordination process including a comprehensive assessment, referring and facilitating

health care and community-based services, development and implementation of a person-centered care plan, monitoring and follow up. Care coordination responsibilities for SNP care managers include, but are not limited to:

- Completing Health Risk Assessment (HRA): SNP care managers are required to conduct an HRA of the SNP member upon initial enrollment (within 90 days before or after a SNP member's current effective enrollment date), annually (within 365 days of last assessment), and when members experience a significant change in health. The HRA assesses the status of the member's medical, functional, mental health, cognitive, and psychosocial status, caregiver support (if applicable), and other needs.
- Development of an Individual Care Plans (ICP): Based on the HRA results, SNP care managers develop a care plan that includes goals, interventions and self-management. The care plans are routinely updated and routed to the member's PCP for review and follow up as appropriate.
- Collaboration of an Interdisciplinary Care Team (ICT): The ICT comprises of multiple disciplines that include the primary care physician (PCP), nursing, social services, medicine, pharmacy, and behavioral health and includes the engagement of the member and/or caregiver as needed. The ICT supports the PCP to better manage the health needs of the SNP member. SNP provides a face-to-face, including telehealth, encounter with each SNP member at least annually with a member of the ICT
- Seamless Care Transitions: SNP care managers serve as the point of contact to coordinate seamless transitions across healthcare settings. In collaboration with providers, SNP care managers ensure the members and/or caregivers understand the discharge instructions. To prevent avoidable readmission, a review of medications, future appointments are discussed, barriers are identified, referrals to appropriate community-based services are made, and the SNP ICP is updated.

### QUEST Integration

The Hawaii Market shall comply with all the Department of Human Services Med-QUEST Division (MQD) quality management requirements which serve to monitor and improve performance through established performance measures in non-clinical and clinical care areas. Performance measures are expected to have a favorable effect on health outcomes and member satisfaction. Performance activities shall include seeking input from members, providers, MQD (and its designees) and community agencies / resources toward improving the quality of care provision of services to members.

The Med-QUEST Division's requirement is to conduct two performance improvement plans (PIPs) as a part of the Quality Assessment Performance Improvement Program. Performance measures may be based on CMS core measures or initiatives, State priorities, or areas of concern that arise from previous measurements or current performance initiatives and that are designed to achieve results, through ongoing measurements and interventions resulting in significant improvement sustained over time. For the current cycle, three PIPs are required. The first PIP is on Behavioral Health Coordination. In partnership with the other QI health plans, Community Care Services (CCS), and DOH Behavioral Health Administration divisions, the goal is to develop an infrastructure to streamline communication, information sharing, continuity, and coordination of care across agencies that provide services for a population with severe persistent mental illness, developmental disabilities, and other chronic issues. The second PIP is on improving Plan All-Cause Readmission rates. The third topic is yet to be assigned by the MQD.

The status and results of each project and all data will be reported to the State and the External Quality Review Organization (EQRO) as necessary to enable validation of the performance including the status and results of each project.

As required by MQD, the Health Plan will submit performance measurement data as follows: 1) Measure and report to the State its performance, using standard measures required by the State including those that incorporate the requirements of 438. 204(c) and 438.240(a)(2); 2) Submit to

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the State, data specified by the State, which enables the State to measure the MCO's performance; or 3) Perform a combination of the activities described.

Also, as required by MQD and as described in the Identifying and Providing Case Management to Long Term Support & Service Members (LTSS) and Expanded and Special Health Care Needs Members (EHCN/SHCN), the Hawaii Market has mechanisms in place to properly assess the members and put the appropriate services in place based on the members' needs.

In the event that Health Plan elects to delegate QAPI Program activities and functions, the Health Plan will request approval from MQD within 90 days of the contract approval (as required by MQD). Upon DHS approval, the Health Plan will draft a written delegation agreement with the delegated organization describing the responsibilities of the delegation and the health plan, the health plan's policies and procedures for evaluating and monitoring the delegated organization's performance, and frequency of reports required from the delegated organization. Prior to execution of the delegation agreement, the Health Plan will conduct a site visit and evaluation of the delegated organization's ability to perform the delegated activities; and thereafter conduct an annual on-site visit and/or documentation/record reviews to monitor/evaluate the quality, content and frequency of reports of the delegated organization's assigned processes (unless the delegate is accredited by NCQA in which case, the annual on-site may be deemed).

## E. Organizational Performance Improvement and Assessment

Continuous Improvement Philosophy

Since 1990, Kaiser Permanente Hawaii Market has been committed to a philosophy of continuous quality improvement. Organizational Excellence in clinical care, service and patient safety is the mission with the following important themes: member needs determine the care delivery system (member-centered care); the key relationship for the member is with his or her physician; teams in the care delivery system enhance this relationship; responsibility and accountability is enhanced by effective information and multi-disciplinary problem-solving; data-driven, fear-free learning is important for continuous improvement ("Information for Improvement, Not for Judgment"); the goal is to find better ways to meet or exceed the member's needs or expectations; physician leadership, in all aspects of quality activities, is vital to success. Teams function effectively with precise information, leadership development, and technical process facilitation.

Leaders establish performance measures and collect data on priority processes and key outcomes related to patient care, safety, organizational functions, and care experience. The approach is planned, systematic and organization-wide. The activities are collaborative and interdisciplinary. The Market uses process and outcome data and information to prioritize, develop, and implement initiatives to improve patient care, safety and service across the continuum of care.

Performance Assessment

Well defined quantitative and qualitative performance measures are vital components of clinical and service improvement activities. Each improvement project defines desired performance indicators, for processes and outcomes. These measures allow monitoring of progress and assurance of accountability. Performance targets (e.g., national benchmarks, inter-market Kaiser Permanente "best in program" measures, etc.) are identified for comparison with current local Hawaii Market performance. Interventions are designed by teams with direct clinical and operational accountability to achieve targeted outcomes and systematic performance improvement.

Examples of sources for performance goals used in clinical and service improvement programs are:

- Core Measures mandated by The Joint Commission and hospital service quality (H-CAHPS).
- NCQA Quality Compass reports on clinical and service quality (HEDIS, CAHPS)
- Quality improvement initiatives focused on measurable improvement for select populations based on high quality evidence-based medicine (primary and secondary) prevention activities fostering prevention (immunizations), early diagnosis, behavioral changes promoting health, and reducing complications for specific populations like elder care or for chronic conditions like diabetes and coronary artery disease.

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- CMS Mandated improvement projects including a Quality Improvement Project (QIP) focused on Antidepressant Medication Management – acute phase and Quality Improvement Strategy (QIS) focused on Initiation of Alcohol and Other Drug Dependence Treatment.
- Incorporation of HPMG KP Promise goals and targets to improve clinical quality.

In general, the Quality Program targets improvement in processes and outcomes that affect high risk, high volume, high cost, complex patient populations, both in the hospital and ambulatory settings as guided by the Market's Quality goals and objectives.

Performance Improvement

Clinical quality and member service improvement projects are prioritized in the strategic planning and prioritization process. Systematic data is translated to information, and aligned with clinical and service goals, across the continuum. The following are examples of improvement activities:

### Clinical and Service Quality Improvement

The Market measures and monitors clinical and service quality improvements relating to clinical and service care its members receive through various processes including monitoring of HEDIS, CAHPS, H-CAHPS and TJC Measures on an ongoing basis. Some examples of focused Hawaii Market clinical and service quality improvement initiatives are diabetes care, cardiovascular health, cancer screening, mental health and wellness, health equity, and access to primary, specialty and behavioral health care.

### Clinical Practice Guidelines (CPG)/Evidenced Based Guidelines

KPHI Clinical Practice Guidelines (CPGs) are based on the best available clinical evidence on important health outcomes. Clinical Guidelines Committees review relevant evidence and advise the program on each CPG. KPHI adopts or adapts evidence-based guidelines developed by the National Guideline Program and operationalizes these guidelines considering the needs of KPHI's membership.

The KP National Guideline Program (NGP) provides evidence-based clinical recommendations to support care delivery and optimize the health of KP members. Based on a rigorous methodology, clinical practice recommendations are essential tools for improving quality of care; they support physicians, other health care professionals, and administrators in their quest to provide the highest quality of care through the consistent delivery of effective clinical practices. When implemented, these practices help to reduce unwarranted variation in care and improve clinical outcomes.

Guidelines are developed under the direction of the KP National Guideline Directors Group. In order to ensure that recommendations are of high quality, relevant, and reflect the body of the scientific evidence, the Guideline Development Teams abide by an evidence-based, systematic and transparent process. The Guideline Director will review and revise policies and procedures for the Guidelines Process at least every three (3) years. The CPG process includes review by physician and allied health experts, practitioners involved in the change, and ultimate authorization at the Quality Committee.

### Continuity and Coordination of Care

The Market recognizes that effective communication and collaboration is essential to ensure continuity of care for members. Electronic documentation shared across the continuum of care is critical. KP HealthConnect is accessible in every service delivery area through multi-level "need to know" security codes. Health Care Teams, clinical pharmacists, nurse and physician advice lines, same day access, integrated mailings, electronic messaging, integrated ancillary systems (lab, diagnostic imaging, pharmacy, etc.) form a complex support network to support patients at any location, including Home Care.

To ensure continuity and coordination of care, the Market makes a good faith effort to provide timely notification to Health Plan members affected by the termination of a practitioner and has

processes in place to facilitate the selection of a new practitioner. The process includes notification to members under certain circumstances to continue seeing the terminating practitioner if discontinuity could cause a recurrence or worsening condition under treatment and/or interference with anticipated outcomes.

#### Knowledge Management

All clinical care is documented and delivered using an integrated electronic medical record (KP HealthConnect). This system interfaces with pharmacy, laboratory, and diagnostic imaging systems to provide real-time data for all patients. To support population-based primary and secondary preventive care, the Market also has developed a patient-based chronic disease decision-support system. This tool allows the physician to be able to see how members with chronic diseases are doing in meeting specified quality goals related to monitoring and management. Similar population management tools have and are being planned for other specialties. With KPHC providing a comprehensive patient-centered medical record, and equipped with population care registries, password protected for licensed providers and HIPAA compliant, appropriate caregivers have complete clinical information and a personal health history for every patient at every encounter in all care settings. This allows for well-informed case management, behavioral support, clarity and safety around diagnostic testing, monitoring and treatment (medications, allergies, etc.) and enhanced collaborative clinical care with each member, on their terms. In addition, Kaiser Permanente continues to make it easier for members to use web based and mobile platforms to access care. Each Kaiser member is able to sign up via the member web site (www.kp.org) or mobile app to use secured messaging with their health care providers; view most lab and diagnostic imaging results, outpatient and inpatient notes and summaries, medications, allergies, and current health conditions; refill prescriptions; request and/or cancel appointments on-line; utilize e-visits to get help with medical concerns; chat with a nurse, pharmacist or member services representative. Text messaging notifications are available for appointment reminders and pharmacy refills. Members can utilize telemedicine options for virtual urgent care with a provider using Get Care Now and scheduled video visits with primary care and specialty providers. The newest feature for Kaiser members is Get Care Now. Through the member web site or mobile app, members with urgent concerns can request virtual urgent care with a provider via video or telephone.

#### Unusual Occurrence Reporting (UOR) System

The Market has an online incident reporting system that is available to all staff and physicians for reporting adverse events such as medical errors, significant events, close calls, hazardous conditions, events that disrupt normal facility operations, and other clinical concerns. Data collection, aggregation and analysis of unusual occurrence reports have been utilized to identify potential and actual Sentinel events for investigation; identify and report patterns and trends; and recommend improvements in processes and systems to reduce risks and prevent recurrences.

Failure Modes Effects Analysis (FMEA) is completed on a routine bases no less than 18 months apart to proactively address patterns / trends that are identified as high risk or problem prone. Revisions and improvements in the system and the quality processes remain ongoing.

Oversight of the UOR process and maintenance of the system is the responsibility of the Clinical Risk Management Department. Improvement activities are initiated through both Quality Management and Clinical Risk Management programs.

### F. Annual Work Plan and Evaluation

The Hawaii Market Quality Program includes yearly planned Quality Improvement (QI) activities and objectives for performance improvement including but not limited to quality and safety of clinical care, quality of service. The Annual Work Plan includes timeframes for each activity’s completion; staff members responsible for each activity; monitoring of previously identified issues; and evaluation of the quality program. The Annual Work Plan is a dynamic document which is used for reporting, analysis, and edited as required to address organizational priorities. KFHP assesses and documents the activities, accomplishments, and barriers from the previous year in the Annual Work Plan Evaluation.

The effectiveness of the Quality Program and Work Plan and achievement of goals and objectives are reviewed at least annually. The Program Description, Work Plan and Evaluation are distributed to regulatory and accreditation bodies after final approval by the Hawaii Market Quality Committee.

# V. Confidentiality and Non-Discrimination

## Confidentiality statement

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

## Non-discrimination Statement

KFHP does not discriminate based on race, ethnicity, national origin, color, ancestry, religion, sex (including gender, gender identity, or gender related appearance/behavior whether or not stereotypically associated with the person's assigned sex at birth), language (including members with limited English proficiency), marital status, veteran's status, sexual orientation, age, genetic information, medical history, medical conditions, claims experience, evidence of insurability (including conditions arising out of acts of domestic violence), source of payment or geographic location within the service area, All organizations that provide Medicare Advantage plans, including KFHP must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

# VI. Health Plan Delegation Oversight

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

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

KFHP written delegation agreements clearly outline all delegated activities and the responsibilities for KFHP and the delegated entity, which are mutually agreed upon. These agreements are kept in a central, easily accessible location. KFHP conducts annual reviews to ensure the delegate's continuing ability to meet requirements and expectations. Additionally, there is at least semiannual review of reporting requirements and performance through submitted documents and activity reports, according to the reporting submission requirements.

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

Kaiser Permanente Hawaii Market is accountable for the quality of clinical care and service provided to its members. At this time, the Hawaii Market delegates credentialing and utilization management functions to the American Specialty Health Group (ASHG) for supplemental riders for chiropractic, acupuncture and massage therapy and as a base benefit for Medicare subluxation.

ASHG maintains their NCQA certification which includes utilization management and credentialing functions. The NCQA designation for ASHG will be used in lieu of defined oversight requirements for the Hawaii Market.

The Utilization Management Committee provide the primary oversight of the utilization management function and the Credentials and Privileges Committee provides oversight for credentialing functions for the Hawaii Market.

The Hawaii Market delegates credentialing functions to the following NCQA certified organizations for tele-behavioral health:

- AbleTo
- NOCD
- PATH

The NCQA Certs in credentialing for these organizations will be used in lieu of defined oversight requirements for the Hawaii Market.

The Hawaii Market delegates credentialing functions to Ginger.io for select tele-behavioral health practitioners. The Credentials department monitors Ginger's performance on an ongoing basis.

The Credentials and Privileges Committee provides oversight of credentialing functions for all organizations to whom credentialing is delegated within the Hawaii Market.

## Visiting Member Program

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

KFHP has credentialing, quality improvement and utilization management processes and policies, in compliance with regulatory and accreditation requirements, to protect members when they are seeking services outside of their home region. Collective Representatives from National and Regional Quality, Credentialing and Utilization Management Departments perform delegation oversight in all regions as it pertains to the Visiting Member Program.

## Health Plan Oversight of New or Changed Clinical Services

The Health Plan reviews and approves the provision of new services or a change in the manner in which services are provided. Any new or changed service must be approved by the KFHP Board of Directors prior to its implementation.

The Kaiser Permanente (KP) Hawaii New Equipment, Products, Procedures, and Services (NEPPS) Committee oversees, reviews and approves new services, product and equipment assessed by the NEPPS Workgroup to identify and mitigate potential risk involved with their implementation. This is accomplished by thorough examination using FMEA and/or risk assessment methodologies, to include but not limited to: incorporating the needs of patients, staff, and others; incorporating results of performance improvement activities; incorporating information about potential risks to patients; incorporating evidence-based information in the decision-making process; and incorporating information about sentinel events.

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Requests for change in services are reviewed and approved by Regulatory Accreditation and Licensing, Hawaii Market Compliance.

### Contract Evaluation and Oversight

At least annually the health plan assesses the quality performance of the agencies, organizations and individuals with which it contracts for the provision of care, treatment, and services provided to the health plan's members.

Where applicable and appropriate, HPMG, health plan and hospital leaders will select the best methods to oversee the quality and safety of services provided through contractual agreement. Examples of sources of information that may be used for evaluating contracted services include the following:

- Review of information about the contractor's nationally recognized accreditation or certification status
- Review of information about the contractor's licensing or certification status:
- Direct observation of the provision of care
- Audit of documentation, including medical records
- Review of incident reports
- Review of periodic reports submitted by the agencies, organizations or individual providing services under contractual agreement
- Collection of data that address the efficacy of the contracted service
- Review of performance reports based on indicators required in the contractual agreement
- Input from staff and patients
- Review of patient satisfaction studies
- Review of results of risk management activities

The individual assigned responsibility for each contract is accountable to review the contract expectations and establish appropriate quality and operational indicators and monitoring frequencies, and to report performance through the established quality structure. In the event that contracted services do not meet expectations, leaders take steps to improve care, treatment, and services.

## VII. Practitioner Participation and Credentialing

### Authority

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

### Roles and Responsibilities

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

The credentialing function is carried out through the Credentials and Privileges Committee established jointly by the Kaiser Foundation Health Plan, Kaiser Foundation Hospitals and the Hawaii Permanente

Medical Group. The Credentialing and Privileges Committee reports to the Quality Committee. The Credentialing and Privileges Committee is a peer review body with members from the range of practitioners participating in the network. The Credentialing and Privileges Committee implements and oversees credentialing policies and processes, and assures compliance with applicable legal, regulatory and accreditation requirements. The Credentialing and Privileges Committee makes a final credentialing decision for those practitioners within its scope of authority, including, but not limited to, the approval, denial, suspension, termination, limitation and revocation of credentialing of practitioners, subject to any retained or otherwise delegated authority by the Board of Directors.

The Chairperson of the Credentialing Committee is directly responsible for oversight of credentialing processes. The chairperson is the Physician Leader for Credentialing. The chairperson's accountabilities include, but are not limited to, chairing the Credentialing Committee meetings, answering questions related to adherence to policies and procedures, qualifications of practitioners, quality of care concerns, proctoring, peer review and practice reviews.

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

### Peer Review/Practitioner Oversight

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

## VIII. Care Experience

Every Moment Matters is a KP national consumer experience initiative to ensure members, patients, and customers experience KP's best at every location at every time, by putting them first and collaborating as one team. The goal is to provide a superior experience every time anyone interacts with the organization. Every Moment Matters leads to developing solutions that improve end-to-end experiences and increase consistency at every member touch point, resulting in reduced variation and consistent delivery of services.

The KP Hawaii consumer experience initiative focuses on key drivers of consumer experience - access to care and the care experience. Access initiatives ensure KPHI members have access to care when they need it, where they need it, and how they need to receive care. Care experience can be articulated through a set of principles based on what members and patients expect and deserve when they interact with the organization. These principles are organized under a framework of *Caring for Hawaii's People like Family* that invokes the member's collective voice: treat me with kindness and caring (ALOHA); take care of me and do the right thing (MALAMA PONO); treat me like family (OHANA); and come with a heart of gratitude (MAHALO). The principles define how members and patients should feel when they interact with Kaiser Permanente Hawaii, everywhere, every time because every moment matters

KFHP assures member satisfaction across the continuum of care (including satisfaction with network adequacy and timely access to care) and service delivery and member due process with the functional areas of complaints, grievances, and appeals. KFHP assures compliance with regulatory and accreditation requirements/standards related to member service functions such as pharmacy benefit

information, claims processing, quality review processes and accuracy of information, web and telephonic personalized Health Plan services, and proposed member information innovations. KPHP also assures that member materials and information provide clear, concise, accurate, and unambiguous information about: 1) member rights and responsibilities; 2) benefits and coverage, and 3) access and availability of care and service delivery.

Member concerns and grievances are received from a variety of sources such as letters, in person, e-mail, "Let Us Hear From You" Feedback Card, and patient surveys and documented in an automated system that facilitates the monitoring, routing, tracking, reporting and resolution of concerns and grievances.

Documented complaints for all product lines (Medicare, Medicaid, Commercial and Exchange) with a potential Quality of Care concern are reviewed by Quality Resource Management RN Analysts and complaints identified as potential “quality of care” cases are entered into the Peer Review System. The Clinical Risk Management Department also reviews cases with potential risk implications, as well as those with confidentiality issues which are forwarded for review by the Hawaii Market Privacy Officer.

Member Relations provides ongoing and trending reports to Executive Leadership, Clinic Manager and Supervisors, Department Chiefs and Physicians-In-Charge. Trended data is also presented to the appropriate committees on an annual basis for oversight of the customer concern and grievance and appeals processes.

## Care Experience Assessment

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

- Consumer Assessment of Healthcare Providers and Systems (CAHPS), Hospital CAHPS (HCAHPS), child HCAHPS and Home Health CAHPS (HHCAHPS)
- Complaint, grievance, and appeal data
- Member Experience Tracking Evaluation and Opinion Research (METEOR) Survey
- Home health survey
- Skilled nursing facility survey
- Hospice patient and family satisfaction survey
- Outpatient Pharmacy Hawaii Market Surveys
- Patient Satisfaction Survey (PSAT) now called MAPPS/ASQ
- Ambulatory Surgery Center / Ambulatory Surgery Unit (ASC/ASU) Care Experience Surveys also known as OASCAHPS
- Brand Strength Monitoring Reports
- NRC Real-Time Feedback Survey (Inpatient)
- Consumer Feedback Management Platform/CFMP (Ambulatory)
- Google Reviews

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

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# IX. Access to Care

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

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

The Market has adopted specific standards to ensure accessibility to members for primary care, specialty care practitioners and behavioral health practitioners as defined in the Accessibility of Services policy: The Quality Committee approves the standards and reviews performance at least annually.

# X. Equity, Inclusion and Diversity

## Membership and Membership Diversity

KFHP's Hawaii Market serves members under several commercial and government product lines. As of Q4 2023 KFHP, Hawaii covers 271,035 lives.

KFHP Hawaii also serves a diverse cultural and linguistic membership. Of the members*:

- 34.67% identify as Asian
- 24.58% identify as Caucasian/White
- 20.59% Native Hawaiian or Other Pacific Islander
- 18.45% identify as Multiracial/Unknown/Other
- 3.62% identify as Hispanic/Latino
- 1.30% identify as African American/Black
- .41% identify as American Indian or Alaska Native

*Data Source is KP HealthConnect (as of July 2023)

## Equity, Inclusion & Diversity (EID)

Kaiser Permanente is committed to Equity, Inclusion and Diversity (EID) as a key business strategy essential to maintain high-quality and affordable healthcare, best-in-class service, and our status as the best place to work and leverages its rich diversity of people and enduring commitment to inclusion in order to remain a leader in providing high quality care that is affordable, improves total health, and is designed to ensure that all medically necessary covered services are available and accessible to all members as referenced in the Nondiscrimination section. Southern California and Hawaii’s EID Department ensures that all covered services are provided in a culturally and linguistically appropriate manner.

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It is the policy of KFHP to require that its provider network of facilities and services be accessible to individuals with mental or physical disabilities in compliance with the Americans with Disabilities Act of 1990 (“ADA”) and Section 504 of the Rehabilitation Act of 1973 (“Section 504”) and other applicable federal and state laws and regulations that prohibit discrimination on the basis of disability.

KFHP requires culturally and linguistically appropriate services for members. SCAL and HI Equity, Inclusion and Diversity (EID) will help to transform care delivery across the spectrum of care with the goal of reducing or eliminating disparities. EID provides assistance to care delivery by:

- Setting quality standards, building the continuously improving infrastructure, and monitoring practices that can reduce and address barriers to culturally competent care, such as the provision of language interpretation, translation and disability-related auxiliary aids and services
- Advancing KP’s ability to provide equitable care by supporting innovative efforts to reduce health care disparities, and by spreading best practices.
- Collaborating with human resources to enhance the ability of our workforce to consistently deliver high quality patient care and services experience to our members.
- Providing expert consultation on cultural and linguistic services to KP marketing, sales, and member services functions, to improve members’ and potential members’ KP experience.
- Facilitating organizational compliance in the areas of cultural and linguistic services and supports the infrastructure responsible for driving regional strategic diversity initiatives.

# XI. Population Health

## Patient-Centered Medical Home (PCMH)

KFHP supports the PCMH model. The PCMH model develops relationships between primary care providers, their patients and their patients’ families. In the PCMH model, primary care promotes cohesive coordinated care by integrating the diverse, collaborative services a member may need. This integrative approach allows primary care providers to work with their patients in making healthcare decisions. These decisions are based on the fullest understanding of information in the context of a patient’s values and preferences. The medical home team which may consist of nurses, pharmacists, nurse practitioners, physicians, physician assistants, medical assistants, educators, behavioral health therapists, social workers, care coordinators, and others will take the lead in working with the patient to define their needs, develop a plan of care, and update a plan of care as needed.

Care coordination includes the following activities:

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

## Population Care Management

At Kaiser Permanente Hawaii (KPHI), the Integrated Population Health Management (IPHM) Program incorporates the methods and functionalities of utilization management, case management, disease management, and wellness programs as well as medical, economic, and psychosocial expertise to address the needs of the whole person. This approach allows members to easily move through appropriate levels of care, optimizing outcomes and improving access to care.

The IPHM Program contributes to service, quality, and affordability along KPHI's care continuum from caring for healthy members, to those at risk, or those who have chronic and/or complex conditions, providing prevention, disease management and complex care to members of all lines of business including Commercial, Marketplace / Exchange, Medicare, and Medicaid.

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Principles, Priorities, Goals and Objectives
The different departments that make up the Integrated Population Health Management Program (IPHM) provide market oversight as well as operational management over the programs designed to keep members healthy, provide recommended screenings, manage chronic conditions, and support members at advanced stages of illness. The program defines measurable goals to support the market's population health program strategy.

Core principles:

- Help members achieve health, prevent disease and complications of disease, manage chronic conditions.
- Help members take care of themselves by addressing root causes of chronic conditions through self-management and lifestyle change.
- Assist Primary Care Physicians to help members in their care.
- Harness a variety of population health techniques to achieve goals and meet members where they are.
- Take advantage of the skill set of the team to achieve goals.

The IPHM's strategy is designed to develop and foster innovative relationships between the team and the member. In addition, these relationships are explicitly designed to augment and support the key relationships between the primary care physician, other members of the care team, and the members.

IPHM is a model for population care, which utilizes the special skills of advance practice registered nurses, chronic disease registered nurses, clinical pharmacists, registered dietitians, social workers, and clerical staff to help reach defined quality goals and assist with market priorities through an evidence-based, whole member care approach to improve the health status of members and to support the primary care physician across the care continuum.

The Patient Support Services (PSS) team is an integral part of the IPHM program. PSS manages members with chronic conditions including diabetes, hypertension and cardiovascular disease, gout, osteoporosis, and depression among others. The team utilizes several tools including How Are We Doing (HAWD), and Mana ku. These tools extract data from KP HealthConnect (electronic medical record) to provide real time data on targeted populations for feedback, monitoring, and management of the quality of care being delivered as measured against market clinical standards.
There are various ways that members are identified and enrolled in IPHM programs. For example, members may be referred to IPHM programs by their Primary Care Physicians, they may self-refer, or they may be invited to participate if they meet program criteria (i.e., member outreach). The method of member identification and program enrollment varies by program.

Once enrolled, the approach to providing service to members with complex health needs involves an assessment of the member's condition, determining available benefits and resources, and developing a case management plan for monitoring and follow-up. Conditions require treatment and services across a variety of domains of care to ensure the best possible outcome.

On an annual basis, KPHI will conduct a comprehensive analysis of the impact of its IPHM Program's strategies to include quantitative results for relevant clinical, cost/utilization and experience measures; comparison of results with a benchmark or goal; and interpretation of the results.

## Prevention & Health Education

The Permanente Prevention Committee provides market oversight for the development of clinical guidelines for the prevention and early detection of illness and chronic conditions. The committee meets bi-monthly and consists of a variety of primary care and specialty providers working in conjunction with specialists in evidence-based medicine, immunization and health promotion. Preventive care guidelines are developed under physician direction and are based on sound scientific evidence. The Committee works with a variety of departments to implement guideline changes.

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Preventive care guidelines are published annually in the Members Handbook (member publication) and provided to all subscriber households. Members can also access kp.org to review the preventive care guidelines. A variety of venues also make the guidelines available to physicians.

The Center for Healthy Living offers lifestyle medicine resources to prevent and treat chronic disease for members and the community. Members are encouraged to use the many interactive self-care tools on kp.org.

# XII. Mental Health and Wellness

KFHP strives to create and enhance access to evidence-based care for mental health and wellness. The approach to providing high quality behavioral health services mirrors that of other clinical services and is based on providing care that is safe, timely, convenient, evidence-based, equitable, and of high quality. Mental Health and Wellness encompasses an array of services — from emotional wellness and prevention to specialized care for conditions and addictions. The approach to providing high quality behavioral health services mirrors that of other clinical services. It is based on providing care that is safe, timely, convenient, evidence-based, equitable, and of high quality.

KP is creating and providing more evidence-based care for mental health and wellness and providing better access to mental health care. KP's knowledge of population health combined with data drawn from the electronic health records, guides evidence-based care. KP also encourages emotional wellness and prevention of more serious conditions by giving members and their families the tools and support they need to improve their physical and mental health. KP has formed partnerships with community partners and advocacy organizations and use technology to accelerate work around mental health and wellness.

## Integrated Behavioral Health

Processes are in place to ensure that the Market's Integrated Behavioral Health (IBH) Services provide quality care and service including monitoring of behavioral health availability and accessibility standards, patient care experience, and continuity and coordination of care between medical care and IBH. The HPMG Integrated Behavioral Health Chief, psychiatrist Board-certified in Child and Adolescent Psychiatry and General Psychiatry and the Integrated Behavioral Health Services Market Manager are involved in the behavioral health care aspects of the Quality Improvement Program and annually reports to the Hawaii Market Quality Committee and advises the Committee on behavioral health matters. In addition, designated behavioral health practitioners serve on other committees including the Pharmacy and Therapeutics Committee and the Practitioner Performance Review and Oversight (PPRO) Committee. A centralized triage and referral center was established in 2000 and employs staff with appropriate qualifications under oversight of the Integrated Behavioral Health Chief. IBH improvement activities include integration of IBH into primary care and improving accessibility and availability of services and practitioners. The IBH Management Team, chaired by the IBH Chief and IBH Manager oversees all aspects of care and service.

The Behavioral Health Quality Improvement Program seeks to assure high quality, evidence-based and appropriate care across all settings of care. The Integrated Behavioral Health Chief and Integrated Behavioral Health Manager provide routine expertise and oversight of quality for the Hawaii Market. The Chief provides oversight for clinical decisions, staff training and development and case consultation. The IBH Chief and IBH Manager are responsible for quality improvement, and core competencies for the professional staff. The IBH Chief's relationship with the Manager is a collaborative partnership. The Chief along with the Manager chairs the Management Team which consists of supervisors for the Children's Team, Adult Teams, Support Staff Team, CD Team, Mental Health Integration Team and the Crisis and Triage Team.

The program seeks to improve the quality of behavioral health care and meet accreditation standards through the following activities:

- Monitoring appointment access against department standards
- Ensuring there is continuity and coordination of care between general medical care and behavioral

health care
- Protecting member confidentiality
- Participation in the development and revision to behavioral health policies and procedures
- Monitoring referral and triage protocols
- Planning and monitoring of Quality Improvement Activities and other activities specifically pertaining to behavioral health care
- Assuring that there is Integrated Behavioral Health participation in Hawaii Market Quality Improvement committees and other appropriate committees
- Peer Review and Interdisciplinary Team Review.

# XIII. Utilization Management (UM)

KP members and providers partner to optimize the health of members, organization, and communities as measured by patient, employee, and community satisfaction. Resource Stewardship/UM is the process of responsibly managing resources while improving the quality and safety of health care. It encompasses activities such as:
- Ensuring the right care is provided in the right place at the right time
- Eliminating waste, inefficiency, and unnecessary variation
- Providing quality care the first time, eliminating rework
- Ensuring the practice of evidence-based medicine
- Ensuring the care being provided is covered by a members' benefit package

Utilization Management staff are responsible for the Hawaii Market UM Program that includes the Moanalua Hospital, Hospitals and Nursing Facilities (Oahu and Neighbor Islands), Integrated Behavioral Health Services, Government Programs (i.e., QUEST Integration), Authorizations and Referrals, and Appeals. The program assures members receive their care in the most appropriate setting. This includes coordinating with utilization/resource management, quality management, clinical risk management and others when the quality of patient’s care is adversely affected.

Refer to the 2024 Hawaii Market Utilization Management Program Description for details regarding resource stewardship/UM activities including objectives and strategies.

# XIV. Pharmacy Quality

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

KFHP excels at the effective use and management of medications, resulting in high-quality at a lower cost. To reduce waste and ensure members receive the right medication, KFHP uses technologies to improve visibility into how medications are prescribed, dispensed, and inventory is managed. Member experience is supported by reducing variation among pharmacy sites while also focusing on affordability through strategic purchasing, formulary alignment, and evidence-based prescribing and management of specialty drugs.

As specialty drugs with limited clinical-effectiveness data and high prices enter the market, KFHP’s Emerging Therapeutics Strategy program provides standardized guidance for the appropriate use of new therapies and medications with consultative panels of inter-market physician specialists that review specialty drugs and provide recommendations.

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The Pharmacy Department has a reporting accountability to the Quality Committee. The Pharmacy Department supports the Pharmacy and Therapeutics Committee responsible for the development and surveillance of medication therapy and pharmaceutical management utilization policies and practices in the Hawaii Market. The Committee's charter is to promote excellence in medication therapy outcomes and clinical results, while minimizing the potential for adverse events. The Pharmacy and Therapeutics Committee meets at least quarterly and has overall responsibility for all medication use processes, including developing, maintaining, and approving drugs included in the Kaiser Permanente Hawaii Drug Formulary. Committee membership includes representatives from the medical group from all major medical specialties, nursing, and pharmacy.

The Kaiser Permanente Hawaii Drug Formulary is intended to promote appropriate drug utilization and ensure drugs are available to patients/members and meet established quality standards for safe and effective use, as well as limiting the availability of drugs that are unsafe, less than effective, or have a high potential for toxicity or abuse.

Formulary decisions are based on sound clinical evidence that supports the safe, appropriate, and cost-effective use of drugs. Clinical efficacy and the appropriate use of drugs which ensures safety precede and are paramount to all other decision factors, which include cost considerations, drug availability, operational procedures, electronic medical record functionality, and utilization.

Formulary decisions are published monthly and updated pharmaceutical management procedures are published at least bimonthly and are available to practitioners on the Pharmacy Hawaii SharePoint. An annual summary of formulary decisions is reviewed by the Pharmacy and Therapeutics Committee and current updates are distributed electronically to all physicians and staff, including network healthcare practitioners. Hard copies are distributed to those network healthcare practitioners who have no access to electronic distribution sources.

# XV. Patient Safety and Risk Management Programs

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

## Patient Safety

Kaiser Permanente Hawaii is committed to remaining a national leader in patient safety and becoming the safest place to give and receive care in Hawaii, the nation, or the world. As an integral part of the organization's Quality Program, patient safety requires providing patient centered care that is reliable, effective, consistent, 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. It is an ongoing and relentless commitment to build safer systems, using performance improvement methodology, and prevent the preventable.

The values that guide patient safety planning, implementation, and decision-making at Kaiser Permanente are patient-centeredness, reliability, and transparency.

The principles that promote excellent performance in the safe and effective delivery of health care are awareness, accountability, ability, and action. Activities aligned with these principles are implemented and aimed at ongoing achievement of the following objectives:

1. Promote a just culture that supports an environment of self-assessment and accountability and encourages reporting of near misses and errors to improve the system processes rather than individual blame.
2. Promote a strong and unified patient safety culture and environment embraced as a shared value where members and staff are safe.

3. Promote ongoing identification, sharing, and appropriate implementation of successful practices from other parts of the organization, other healthcare organizations, and organizations outside of healthcare.
4. Promote the Core Value of Patient Family Centered Care (PFCC), where the four cornerstones of PFCC: Respect and Dignity, Information Sharing, Partnership and Collaboration, assure safety and reliability in all aspects of care delivery.
5. Promote a “Speak Up” culture to “Stop the Line” whenever risk is perceived.
6. Developing new knowledge and understanding of patient and workplace safety in the delivery system.
7. Identifying, assessing, prioritizing, and addressing the most appropriate indicators and measures of safety.
8. Using performance improvement methodology as the method to improve identified patient safety issues.

The Moanalua Medical Center will conduct bi-annual surveys to assess its Culture of Safety. The survey measures overall safety and includes the following Patient Safety Index topics: Improve Patient Safety, Safe as Patient, Speak-Up, Teamwork, Learn from Errors, Accountability, Open and Honest, Performance Feedback and Workload. Kaiser Permanente utilizes the Glint research survey that measures the Patient Safety Index to improve patient safety. The results of the survey will be used to enhance the Patient Safety Program at the Moanalua Medical Center.

The patient safety structure is integrated into the quality structure and links entities, departments and committees to achieve goals. The HPMG Assistant Chief of Hospital Medicine, Assistant Chief of Medical Staff, Director of Clinician Patient Communication and the Hawaii Market Patient Safety Officer participate in Situation Management Teams (SMT) as needed. An SMT is comprised of staff and physicians with specialized training and authority, who can advise, coach, facilitate and coordinate the organizational response to a Significant Reportable Event, reportable event, close call, etc. and/or coordinate the communication to a patient/family when an unanticipated adverse outcome occurs.

## Clinical Risk Management

The Hawaii Market is committed to providing high quality patient services, ensuring the safety of patients, visitors and staff as well as preserving its financial integrity to continue its mission. The Clinical Risk Management Program (CRM) was established to support this mission. The CRM Program, in partnership with the Market’s Quality Management (QM) Program, incorporates an interdisciplinary and organization-wide process that 1) identifies, evaluates and prioritizes issues that may create a risk of harm to its members and/or staff, coordinates the development of strategies to eliminate or minimize those risks, and educates its members, staff and organizational leaders about those risks and strategies; 2) identifies and minimizes events/occurrences that may present a risk of legal liability to staff and/or the organization; and 3) serves as a resource for staff. The fundamentals of the CRM Program Description are as follows:

- Analyzing individual events as well as cumulative data to identify opportunities to improve quality of patient care and reduce liability exposure
- Identifying significant problems that otherwise may go undetected and establish priorities for assessment and resolution
- Ensuring identified problems are resolved
- Developing and presenting risk management education programs that stress risk reduction/prevention strategies
- Ensuring viable risk management education programs that stress risk reduction/prevention strategies
- Instituting mechanisms to improve provider-patient communication
- Ensuring that relevant information is communicated to appropriate individuals/committees, including senior leaders, in order to implement and or modify practices to meet Quality and Clinical Risk Management objectives
- Improving quality of medical performance by identifying and recommending appropriate actions for identified risk management trends
- Evaluation of interventions through the review of data/trends
- Documenting appropriate actions in committee minutes and tracking the effective actions

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Clinical Risk Management utilizes the established committee structure and reporting relationships developed for the quality functions of the organization. The HPMG Physician Chair or AAMD for Quality and Safety / designee oversee the coordination of all risk management activities and reports CRM activities to the Hawaii Permanente Medical Group (HPMG Board), Quality Committee (QC), to Senior Leadership; and assists in the implementation and coordination of CRM actions/recommendations with these entities as needed.

The Clinical Risk Management Program contains the following major components:

- Risk Identification – information on situations, policies, and practices that could result in the adverse occurrences and/or financial loss to the institution is obtained from various clinical and operational departments in the market utilizing the following data collection and monitoring tools:
    - Unusual Occurrence/Report—used to identify any event that is not consistent with routine operations, which resulted in or could have resulted in injury or loss. Incidents appropriate for reporting include, but are not limited to, injury/illness (i.e., fall), medication error, drug reaction, equipment problems and inappropriate patient or staff behavior.
    - Clinical Risk Management Event reporting – All verbal or written reports of Sentinel Events received directly in the department are reviewed for potential liability and entered into the National Risk Management database (aka NetSet).
- Risk Analysis – determines the severity of potential loss associated with an event and implements a plan of action to eliminate or modify the severity of loss.
- Risk Mitigation – involves efforts to minimize the financial impact and improve patient, visitor, and employee safety.
- Risk Prevention –
    - Collects and monitors data concerning the type and number of unusual occurrences/adverse occurrences,
    - Trends and analyzes this data on a monthly basis to identify issues that pose potential risk of harm to the members and staff, and/or create potential legal risk for Kaiser Permanente and,
    - Coordinates with patient safety and quality experts to develop action steps. As a result of this process, the RM program ensures that programs and systems are in place to proactively ensure patient/staff safety and reduce or prevent potential adverse events.

  As a result of this process, the RM program ensures that programs and systems are in place to proactively ensure patient/staff safety and reduce or prevent potential adverse events.
- Event Management:
    - Situation Management Team – Provides guidance and education to the market AOC's and other leaders on the SMT process; leads and guides SMT's as needed at the time of the event
    - Risk and Patient Safety Huddle regularly reviews risk, quality, and patient safety cases and identifies any immediate mitigation steps that should be taken
    - Legal Claims Management - learnings from closed legal claims (managed exclusively through the Legal Claims Department) are shared with Clinical Risk Management for identification and prioritization of clinical performance issues that may be appropriate for monitoring and measuring, and can be used to help clinicians minimize risk, improve their clinical practice and patient safety
    - Early Resolution/Service Recovery - the Risk Manager is notified when an adverse event may need to be managed with wavier of co-payments, reimbursements or other financial offerings that might aid in managing the event at the time it occurs and works closely with the Director of Legal Claims for handling of these expenses. The efficacy of this program is evaluated annually
- Education & Orientation - Identifying and managing risk, in conjunction with awareness and education regarding risk reduction activities, is the responsibility of each manager, provider and employee in the Hawaii Market. When a potential risk or adverse occurrence is identified, systems addressing prevention and/ or minimization of the concern are reviewed and evaluated. If a system is not already in place, Clinical Risk Management, in collaboration with the department/s involved, develops a plan and systematic training across the continuum. If a system is already in place, Clinical Risk Management and the department involved will review and evaluate the need for staff re-education or review.

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# MINUTES OF THE KAISER PERMANENTE HAWAII MARKET QUALITY COMMITTEE

**(Date/Time/Location)**

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ATTENDANCE:
GUESTS: RECORDER:

| TOPIC | KEY DISCUSSION POINTS | CONCLUSION/ACTION | FOLLOW-UP STATUS |
|---|---|---|---|
| CALL TO ORDER | Meeting called to order by chairperson | Meeting called to order. | Closed. |
| SAFETY FIRST | One minute focus on Hawaii Market Patient Safety efforts. | Informational | Closed. |
| CONSENT AGENDA ITEMS<br>Meeting Minutes | Consent agenda items are distributed prior to the meeting for Committee's review. The Committee is asked if there are any concerns, changes, additions or deletions to the consent agenda items for discussion.<br>Meeting minutes are presented for formal approval as circulated. | Approval. | Closed. |
| Policy Approvals | A summary of policy changes for formal approval as circulated | Approval. | Closed. |
| Clinical Practice Guidelines | New Clinical Practice Guidelines are presented for adoption. | Adoption Approval. | Closed. |
| *Monitored Initiatives* | Annual reports or meeting minutes are distributed as part of quality oversight monitoring: | Annual monitoring. | Closed. |
| *Quality Committee Review Items* | Review items are distributed to the Committee for information:<br>• QHIC Reports<br>• Electronically approved policies | Informational. | Closed. |
| *Annual Quality Documents* | Present Annual Quality Management, Utilization Management, Hospital and ASC Trilogy Documents | Approval. | Closed. |
| *Outstanding Issues* | Present and discuss status of follow-up issues based on previous Quality Committee discussions. | Monitor issues until closed. | Closed. |
| *New Business* | | | |
| ANNOUNCEMENTS | | Informational. | Closed. |
| ADJOURNMENT | Meeting adjourned by chairperson. | Meeting adjourned. | Closed. |

Appendix B

# HAWAII MARKET QUALITY STRUCTURE

(Additional committees supporting Quality: Purpose, Role and Function, Meeting Schedule)

The Quality Management Program links departments, functions, systems and processes to enable the Hawaii Market to provide optimal quality and continuity of medical care and service to its members.

| COMMITTEE | ROLE AND FUNCTION | MEETING SCHEDULE |
|---|---|---|
| **Credentials and Privileges Committee** | The Credentials and Privileges (C&P) Committee is a peer review committee that performs oversight and provides support to the peer review process for credentialing and privileging of practitioners and providers in Kaiser Permanente Hawaii program.<br>Roles and responsibilities of the C&P Committee include:<br>• Recommend/approve LIPs, AHP and Organizations Providers for the Hawaii program.<br>• Recommend/approve privilege and proctoring processes.<br>• Review and approval of delegated credentialing and revisions as appropriate.<br>• Annual review and recommendation for revision of C&P policies and procedures.<br>• Oversight of implementation of C&P policies and procedures.<br>• Oversight and management of C&P database.<br>• Communication and review of local C&P Committee processes.<br>• Ongoing monitoring of sanctioned activity.<br>• Recommendation and oversight of quality indicator reporting process.<br>• Oversight of Medical Board/National Practitioner Data Bank reporting.<br>• Establish linkage between contracting/claims for purposes of ensuring that practitioners and providers are credentialed to see members.<br>• Oversight of survey results and corrective action taken within scope.<br>• Analyze reports as submitted from the monthly oversight reviews.<br>• Develop and implement effective processes for correcting.<br>• Ensure coordination of the program.<br>Membership term of the C&P Committee is indefinite. | At least ten times in a year either in person, electronically or by tele-conference |

<table>
<tr><th>COMMITTEE</th><th>ROLE AND FUNCTION</th><th>MEETING SCHEDULE</th></tr>
<tr><td>Hawaii Market Medication Safety Committee (MSC)</td><td>The Kaiser Permanente Hawaii Medication Safety Committee (MSC) is a multi-disciplinary team of health care professionals who are directly or indirectly involved in the medication use system. The function of the MSC is to work with the hospital and medical office buildings and clinics across the market to eliminate medication errors and preventable adverse drug events that cause harm or potential harm to patients.<br><br>The MSC is under the direction of the Quality Committee (QC) and will report the functions and results of the MSC meetings to Hawaii Market QC on a regular basis.<br><br>Responsibilities<br>• Each member of the MSC represents and serves as an interface between the different areas represented for the purposes of establishing system-wide improvements in the medication use process.<br>• Ensure collaboration and agreement between stakeholders, removing barriers to effectiveness and success.<br>• Review high severity medication incidents (i.e., preventable adverse drug events), errors and close calls for opportunities to improve and develop safety actions and strategies to decrease future occurrences, which includes medication identified as “High Alert Medications.”<br>• Review, collaborate and approve market medication safety policies (i.e., High Alert Medication Policy)<br>• Identify, share and spread successful medication safety practices.<br>• Identify and notify of internal and external events that have a high potential for reoccurrence.<br>• Ensure that reliable processes, decreasing variation and defects to achieve better outcomes, using evidence to ensure the Market meets accreditation and regulatory standards as it relates to the medication use process.<br>• Membership term of the MSC is indefinite.</td><td>Quarterly, at a minimum</td></tr>
<tr><td>Patient Family Centered Care (PFCC) Advisory Council</td><td>The purpose of the PFCC advisory councils which exist on Oahu and Maui, are to promote sensitive, comprehensive, compassionate, and family-centered services. The PFCC Advisory Councils are committed to having patients and families become partners with KP in making their healthcare decisions. The PFCC Advisory Councils are guided by the four Core Concepts of Patient and Family Centered Care:<br>• Respect and dignity<br>• Information sharing<br>• Participation<br>• Collaboration</td><td>Monthly</td></tr>
</table>

| COMMITTEE | ROLE AND FUNCTION | MEETING SCHEDULE |
|---|---|---|
| **PFCC Advisory Council (Cont'd)** | The responsibility of the PFCC Advisory Council is:<br>• Giving feedback and reviewing existing programs and helping plan new programs.<br>• Creating systems and processes that strengthen communication between Kaiser Permanente staff and patients and families.<br>• Implementing changes that are aligned with the Mission and Vision.<br>• Participating as members of committees, process improvement teams and UBTs (unit-based improvement teams), as needed.<br>• Providing information to leaders and staff about patients' needs and concerns. | |
| **Permanente Prevention Committee (PPC)** | The PPC is an advisory committee to the Quality Committee and is responsible for evaluating and recommending suitable preventive screening and treatment based upon current evidence. The primary charge of the PPC is to reduce the burden of disease amongst members, by utilization of evidence-based practices with emphasis on prevention of disease, early detection, and timely treatment, and prevention of disease.<br>Responsibilities of the PPC include:<br>• Establish a clear and consistent pathway from evidence-based guidelines to the development of clinical recommendations.<br>• Provide a forum to discuss and decide prevention guidelines from perspectives of:<br>  • Strength of evidence for preventive measures<br>  • Health Plan and Benefits<br>  • Clinic operations<br>  • Implementation strategies<br>  • Ownership of market recommendations for preventive care measures to health care providers/affiliates of the Hawaii Permanente Medical Group.<br>• Membership of the PPC is indefinite. | Bi-monthly or at the discretion of the PPC Chair/Co-chairs |
| **Pharmacy and Therapeutics Committee** | The Pharmacy and Therapeutics (P&T) Committee is responsible for the development and surveillance of medication therapy and utilization policies and practices in the Market. The Committee promotes excellence in medication therapy outcomes and clinical results, while minimizing the potential for adverse events.<br>Responsibilities of the P&T Committee include:<br>• Reviewing, evaluating, and maintaining a formulary of medications and biologicals, based on evidence. | Quarterly at a minimum. |

| COMMITTEE | ROLE AND FUNCTION | MEETING SCHEDULE |
|---|---|---|
| **P&T Committee (Cont'd)** | • Reviewing a product for which new FDA indications have been approved within 90 days and a decision within 180 days of its FDA approval. Clinical justification is provided if this timeframe is not met.<br>• Reviewing a new FDA approved drug product within 90 days and a decision within 180 days of its release onto the market. Clinical justification is provided if this timeframe is not met<br>• Reviewing the Kaiser Permanente Hawaii Drug Formulary and regulatory requirements related to formulary management at least annually.<br>• Measuring performance related to the use of medications, biologicals, and diagnostic testing materials, including the processes for; 1) procurement, storage, and handling, 2) prescribing and ordering, 3) preparation and dispensing, 4) medication administration, and 5) monitoring of medications.<br>• Reviewing and approving evidence-based procedures, preprinted orders and forms with medications, medication guidelines and protocols, and practices that promote the safe, effective and medically necessary use of medications.<br>• Reviewing and recommending policies for Hawaii Permanente Medical Group, Hospital Executive Committee and Quality Committee approval.<br>• Reviewing and approving any applied traditional prior authorization, step therapy, or procedures.<br>• Reviewing reports of adverse medication events including medication errors and adverse drug reactions and making recommendations to improve medication use processes to prevent and avoid adverse events.<br>• Evaluating and communicating clinical data concerning new medications and their therapeutic uses.<br>• Developing and coordinating medication use evaluation activities.<br>• Establishing standards and approving protocols concerning the use and control of investigational medications and of research in the use of approved medications.<br>• Advising and making recommendations to the Benefits Committee on benefit coverage issues involving medications and biologicals.<br>• Advising and educating the Professional Staff on matters pertaining to the selection of available medication therapy.<br>• Coordinating and aligning its quality and performance improvement activities with the Hawaii Market Quality Management Program.<br>Membership term of the P&T Committee is indefinite. | |

<table>
<tr><th>COMMITTEE</th><th>ROLE AND FUNCTION</th><th>MEETING SCHEDULE</th></tr>
<tr><td>Hawaii Market Service and Care Experience Council</td><td>The Hawaii Market Service and Care Experience Council is responsible for development and oversight of an integrated market service strategy that focuses on the quality of members', patients', and families' service experience.<br>The responsibility of the Hawaii Market Service and Care Experience Council is to:<ul><li>Ensure Council activities are aligned with national service and care experience strategy, vision, values, and principles. Provide leadership to influence market service plans and monitor progress.</li><li>Review service-related metrics and results including:<ul><li>HCAHPS – Hospital Consumer Assessment of Healthcare Providers and Systems</li><li>CAHPS – Consumer Assessment of Health Healthcare Providers and Systems and METEOR</li></ul></li><li>MAPPS/ASQ</li><li>Customer Feedback System Reports</li><li>Complaints and Grievances Reports</li><li>Brand Strength Monitoring</li><li>Outpatient Pharmacy Hawaii Market Surveys</li><li>Employee and HPMG Practitioner Satisfaction Surveys</li></ul></td><td>Quarterly</td></tr>
<tr><td>Utilization Management Committee</td><td>The Utilization Management (UM) Committee provides oversight of utilization performance across the ambulatory, acute and post-acute settings and for day-to-day operational issues pertaining to successful UM practices, utilization targets and/or barriers to successes across the care continuum, serves as the review and approval body for utilization / resource management policies, procedures, utilization targets, UM guidelines and criteria, goals and improvement activities, across the continuum of care, including behavioral health in KPHI. It ensures regulatory compliance with all external and internal regulatory bodies and agencies, monitors performance for areas of potential over and underutilization and monitors utilization performance at the medical center level.<br>This committee provides oversight of UM activities and performance across the continuum of care at KPHI. The objectives include:<ul><li>To ensure that the KPHI UM programs, initiatives and strategies are aligned with the Program's quality agenda.</li><li>To address utilization issues, monitor utilization performance (Average Length of Stay (ALOS), Utilization Rates, Discharge Rates), follow-up on utilization performance improvement opportunities across the continuum of care.</li><li>To provide linkage with Hawaii Quality Committee (QC) to ensure that quality and utilization goal and activities are aligned in KPHI.</li></ul></td><td>Meet bi-annually</td></tr>
</table>

| COMMITTEE | ROLE AND FUNCTION | MEETING SCHEDULE |
|---|---|---|
| **UM Committee (Cont'd)** | • To request and review service area utilization management initiatives, action plans and outcomes.<br>• To develop and approve annual utilization goals / targets.<br>• To sponsor utilization projects and initiatives across the continuum of care that also improves quality of care and clinical outcomes.<br>• To review and approve policy decisions related to utilization management.<br>• To address regulatory / accreditation issues related to utilization management.<br>• To provide leadership and support for Kaiser Permanente Hawaii while striving for improved quality and appropriate utilization.<br>• To ensure the integration of quality, utilization management and finance to better understand the costs and benefits of any utilization initiative, while maintaining or improving the quality of care delivered to KPHI members.<br>• To monitor for potential areas of over- and under-utilization and initiate appropriate actions as indicated.<br>• To ensure that the needs of the individual member and available hospital and community resources are taken into consideration during all processes related to the medical plan of care and utilization management efforts.<br><br>Membership term of the UM Committee is indefinite. | |