2016 QUALITY PROGRAM DESCRIPTION
Hawaii Region

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Section I – Introduction

Overview

Kaiser Foundation Health Plan, Inc. (KFHP) Hawaii Region is a mixed model Health Maintenance Organization (HMO) serving 245,559 members on the islands of Oahu, Maui, Hawaii, Kauai, Molokai and Lanai. The Hawaii Region provides clinical care services in its own medical clinics on three islands: Hawaii (4); Maui (5), and Oahu (12), and opened a new clinic on the island of Kauai February 2016. On Molokai and Lanai, 326 members are cared for in private offices of a preferred provider network. The Region has one Kaiser Foundation Hospital (Moanalua Medical Center) on Oahu and is taking on the management of three community hospitals (Maui Memorial Medical Center and Kula Hospital on Maui, and Lanai Community Hospital on Lanai) in 2016. Additionally, the Hawaii Region contracts for care services with 26 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 Hawaii Region 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 Region members is provided by Hawaii Region 3,836 employees and 487 Practitioners of the HPMG.

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 Regional Quality Program Description serve to inform internal and external audiences about how the Hawaii Region is organized to support the organization’s commitment to assessing and improving performance on a continuous systematic and outcome-oriented basis.

The Hawaii Region 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 are aligned with the Kaiser Permanente (KP) National Strategy, guided by the Hawaii Region’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 Region 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.

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1 December 2015
2 Excludes call-in, year-to-date January 2016
The Kaiser Permanente Mission and Strategies

Kaiser Permanente exists to provide affordable, high-quality healthcare services and to improve the health status of our members and the communities we serve. To accomplish this, Kaiser Permanente has incorporated program-wide principles of continuous quality improvement that began with The Quality Agenda. Today, this commitment is described as the Kaiser Permanente Promise which provides the guiding principles and vision under which Kaiser Permanente operates and works to improve. Kaiser Permanente strives to deliver on the following four service commitments through people and systems:

- Quality you can trust
- Caring with a personal touch
- Convenient and easy care
- Affordable care

Strategic Priorities

The Hawaii Region’s Regional Executive Team (RET) comprised of executive leadership from the Medical Group, Health Plan and Hospital has articulated strategic priorities and goals through 2016.

The Hawaii Region’s strategic priorities focus on 1) Service; 2) Quality; 3) People; 4) Growth; 5) Finance; and 6) Community.

Specific measures have been determined as high priority to provide a focus for organizational improvement for 2016. These high-priority measures are included in the 2015 Quality Work Plan and represent clinical areas and member experience in which there is a significant gap to target or where the measure represents an area of care that the Region has particularly targeted for improvement. Other ongoing measurement and monitoring are reported into the Quality Committee and provide a broader view of organizational performance, which also includes measures required by accreditation, regulatory and governing bodies.

Quality Objectives:

The Hawaii Region’s Quality Program is designed to:

- Improve the health status of members;
- Increase value to the member by improving member satisfaction with clinical and service quality;
- Demonstrate value to purchasers through outcome-oriented Quality Improvement (QI) activities and efficient use of resources;
- Collect, measure, and analyze information on significant aspects of patient care;
- Improve quality, continuity of care, patient safety, and the effectiveness of QI efforts and outcomes through ongoing reporting to executive leadership, governing bodies, physicians, and other healthcare practitioners, enabling them to make appropriate changes in policies, practices, and processes;
- Prioritize quality activities and identify opportunities for improvement in health care delivery;
- Assess and improve activities in support of strategic quality initiatives and National quality goals;
- Collect, trend, and analyze information on significant events and “close calls”;
- Identify opportunities to manage risks and improve patient safety;
- Align and integrate risk, utilization, clinical and service quality management, and patient safety;
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- Assure protection of peer review and quality information in accordance with federal and state statutes; and
- Ensure practitioner credentialing and privileging.

Authority, Accountability, and Responsibility for Quality

The KFHP/H Board of Directors has the ultimately accountability and responsibility for overseeing the quality of care and service provided to Kaiser Health Plan members for the Hawaii Region and all KP regions across the country. To exercise this responsibility, a Board subcommittee, the Quality and Health Improvement Committee (QHIC) was established to oversee quality of care and service across all KP programs on its behalf. The QHIC meets at least four times each year and reports its decisions, actions and recommendations directly to the KFHP/H Board of Directors. The QHIC is accountable to:

- Provide strategic direction for quality assurance and improvement systems
- Provide oversight of systems designed to ensure that quality care and services are provided at a comparable level to all members and patients throughout the Program across the continuum of care
- Provide oversight of the Program’s quality assurance, health improvement systems and organizational accreditation and credentialing.

Annually, QHIC reviews and approves the Region’s quality program description, work plan and evaluation. The Region submits Quality Committee meeting minutes and other reports as requested to the QHIC. The KFHP/H Vice President of Quality, Safety and Resource Management sends written follow-up letters to the President and the Executive Medical Director that document specific QHIC requests and decisions for the Region. The QHIC communication to the Region is also used as reports to the KFHP Board on the Region’s follow-up actions from previous recommendations. The QHIC reviews and, as appropriate, provides direction in the following areas:

Quality Assurance

- Overseeing quality systems, including quality goals, objectives and performance measures
- Identifying and addressing deficiencies in quality
- Reviewing, and as appropriate approving, standards for the global member experience, including standards for quality assurance, quality of care, patient safety, service quality, utilization, and risk management
- Reviewing and addressing the results of internal and external system audits

Quality and Health Improvement

- Promoting progress in member health improvement including health policy direction, disease prevention activity, reduction of health disparities among population groups and the development and dissemination of evidence based medicine.
- Approving annual targets for health improvement, including Healthcare Effectiveness Data and Information Set (HEDIS) and improvement in members’ health that contributes to community well-being.
- Approving annual targets for service quality including access to services, the care experience and overall member, and purchaser satisfaction.
- Monitoring and assessing performance against targets of the care delivery system, including clinical performance and member care experience.
- Evaluating results of quality of improvement activities including recommended actions and follow-up.
Organizational Accreditation & Credentialing

- Reviewing accreditation and licensing processes and reports, such as those of the National Committee for Quality Assurance (NCQA), The Joint Commission (TJC), Accreditation Association for Ambulatory Health Care (AAAHC), the Centers for Medicare & Medicaid Services and state agencies.
- Reviewing the integrity of systems relating to the selection, credentialing and competence of physicians and other health care practitioners, including systems for granting or terminating privileges, peer review, proctoring and continuing education.

The QHIC receives documents and reports for oversight of the quality of care and services provided to members including:

- Quality Committee meeting minutes;
- Annual quality and resource stewardship program descriptions, work plans, annual evaluations, and credentialing and re-credentialing policies and procedures;
- Joint Commission core measures, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and internal quality inpatient indicators including falls, pressure ulcers, bundled care for acute myocardial Infarction
- Significant events and complaints
- National quality and population management results (e.g., HEDIS)
- Quarterly Ambulatory Surgery Center data

The QHIC and HPMG Board of Directors hold the Hawaii Region’s KFHP/H President and HPMG Medical Director accountable for the effectiveness of the Hawaii Region’s quality program. The President and Medical Director assign day-to-day quality management activities to the HPMG Associate Medical Director (AMD) of Quality and Safety and the KFHP Vice President (VP) of Quality, Safety and Patient Experience as the designated Senior Quality Leaders for the Hawaii Region. The Senior Quality Leaders co-chair the Regional Quality Committee and the Quality Information Team. The HPMG AMD of Quality and Safety and the KFHP VP of Quality, Safety and Patient Experience co-chair the Region’s governing Quality Committee, which provides direction, oversight, coordination, and communication of the Hawaii Region Quality, Patient Safety and Service priorities, activities, and performance.

KP National Quality Committee (NQC)

The Medical Directors of the Permanente Medical Groups, in partnership with KFHP/H senior leaders, established the National Quality Committee (NQC) to provide leadership, direction, and oversight of processes to improve continuously the quality of clinical care and services provided by the organizations that constitute the Kaiser Permanente Medical Care Program.

The NQC establishes the National Quality Strategy and monitors the continuous progress of each region by reviewing annual program descriptions, work plans, and evaluations, as well as quality reports and minutes from the Region. The Department of Care and Service Quality reviews and summarizes these documents for the NQC’s review prior to submission to the QHIC.

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.

Section II – Hawaii Region Quality Structure and Oversight

Hawaii Region Quality Structure

The Hawaii Region 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 AMD for Quality and Safety and the KFHP VP of Quality, Safety and Patient Experience.

The HPMG AMD for Quality and Safety and the KFHP VP of Quality, Safety and Patient Experience co-chair the Regional Quality Committee and the Quality Information Team and assume ultimate responsibility and accountability for the direction, implementation, and success of the program. Sharing accountability is the HPMG VP of Quality and Care Integration and the Senior Director of Quality, Accreditation, Licensing, Credentials and Peer Review, both formal members of the Quality Information Team and the Quality Committee.

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

Quality Committee (QC)

The Regional Quality Committee meets a minimum of eight times per year to provide direction, oversight, coordination and communication of the Hawaii Region 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, via the Quality Information Team (QIT), sponsors local QI 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 Region’s quality oversight committee has the authority and responsibility to review and act on the following:

- Quality Assurance/Improvement
- Patient Safety
- Clinical Risk Management
- Service
- Integrated Quality Management (Resource Stewardship and Utilization Management)
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- Member Care Experience\(^3\)
- 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)
- Nursing – Advice nursing and other
- 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 Regional 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

The Quality Committee is directly accountable to the Regional Executive Team (RET) with monthly reports on Committee actions and recommendations. Refer to Quality Structure and Quality Information Process Flow with delineated oversight accountability of the QIT and QC to the RET and governing bodies.

Quality Information Team (QIT)

The QIT is a sub-committee and working group of the Quality Committee. The QIT is comprised of quality leaders that meets 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 team is accountable for monitoring and tracking quality, patient safety and service performance measures for the Quality Committee.

The members of the QIT include the following:
- HPMG Associate Medical Director (AMD) for Quality and Safety (Co-chair)
- KFHP Vice President of Quality, Safety and Patient Experience (Co-chair)
- HPMG AMD Professional Chief of Staff
- HPMG VP of Quality and Care Delivery Integration
- Senior Director of Quality, Accreditation and Licensing, Credentials, and Peer Review
- HPMG Director of Quality and Patient Safety
- Regional Patient Safety Officer
- Quality Management Manager

\(^3\) Includes CAHPS, HCAHPS, Meteor, CFS, etc.
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. Membership includes: KFH Chief of Staff, KFH Professional Staff Vice Presidents, Chiefs of each clinical service, other members of the professional staff, Hospital Administrator and Clinical Nurse Executive. Ad Hoc non-voting members include Moanalua Clinic Manager, Clinical Risk Manager, Quality, Accreditation and Licensing, and others.

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.

Quality, Risk, Safety, and Service Committee (QRSS)
The Quality, Risk, Safety and Service Committee (QRSS) is responsible and accountable to MEC for hospital-wide quality, risk, service and safety management program and to Quality Committee for those processes determined as Regional QRSS develops, implements, and evaluates the annual KFH Performance Improvement Plan. The Committee links both hospital and regional quality objectives to strategic goals; analyzes aggregate data; monitors progress of quality / patient safety initiatives; coordinates quality and patient safety activities; integrates quality, patient safety, clinical risk, utilization management, and professional competency information; identifies problem areas; recommends quality/patient safety priorities and resources to the Medical Executive Committee (MEC) and communicates results of hospital quality/patient safety activities to leadership and other committees.

Members are appointed by the Chief of Staff and may include: HPMG Associate Medical Director for Quality and Safety; KFH Professional Staff Vice President of Quality; Senior Director, Patient Safety and Workplace Safety; Clinical Risk Manager; Credential; Senior Director of Quality, Accreditation, Licensing, Credentials and Peer Review; Quality Management Consultant; Inpatient Director of Pharmaceutical Services; Director of Diagnostic Imaging; Director of Clinical Laboratories; Chief Nursing Officer; 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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- Improve the reliability and clinical effectiveness of care
- Improve patient satisfaction and create a WOW experience for KP Hawaii members / patients
- Eliminate incidents of medical harm to KP Hawaii members / patients and never events
Hawaii Region Quality Management Program Scope

The Hawaii Region 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 Hawaii Region operates a general acute care hospital, a skilled nursing facility and two home health agencies.

Majority of care and services covered by the KFHP insurance are provided directly by HPMG practitioners at Hawaii Region 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 Region 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 Region 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 is 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 Region 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 the use of interdisciplinary teams whenever possible. The program emphasizes quality improvement activities in member care and service, including:

- Advice Nurse Services
- Ambulatory Surgery Center Services
- Dialysis Services
- Provider Contracting and Relations (contracted providers/services/network)
  - Authorizations and Referral Management
  - Durable Medical Equipment
  - Medical Transportation and Ambulance Services
- Continuing Care Services
  - Home Health
  - Long Term Care
  - Medical Social Services
  - Resource Stewardship (formerly UM)
  - Skilled Nursing Facility
- Diagnostic Imaging
- Health Information Management
- Clinical Departments:
  - Anesthesia
  - Integrated Behavioral Health Services
  - Diagnostic Imaging
  - Emergency/Urgent Care Services
  - Family Practice
  - Internal Medicine and its sub-specialties
  - Laboratory and Pathology
  - Neuroscience and its subspecialties
  - Obstetrics and Gynecology
Occupational Health
Pediatrics and its subspecialties
Surgery and its subspecialties
Health Education, Promotion and Outreach
Hospital Services
KP Online (internet-based services; www.kp.org)
Medical Clinics
Member Services
Nursing
Pharmacy Services
Preventive Health Services
Rehabilitation Services
TeleHealth

Monitoring activities are conducted and reported on a regional, 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
- 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, mis-utilization 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

There are national contracts for ground and air ambulance services, durable medical equipment (DME) and organ transplant services. The National Contracting Department in Oakland, California manages the ground and air ambulance and DME contracts. The National Transplant and Contracting Services in Oakland, California also manages the National Transplant Network (NTN). The NTN is guided by physician and other health care practitioners via a National Transplant Advisory Board and quality is overseen by the Quality Improvement Committee of the NTN. Each of these national contracting departments annually updates a Quality Program Description and Work Plan and submits these documents to the Department of Care and Service Quality (DCSQ), Program Offices for review.
Quality Program Description, Work Plan and Evaluation Annual Update

Annually, beginning in the fourth quarter of the year, and completed in the first quarter of the following year, the QIT leads an evaluation of the effectiveness of the prior year’s Quality Program Work Plan, reviews the Program Description, and develops a Work Plan for the coming year, all formally reported and approved by the Quality Committee. This annual evaluation informs Hawaii Region leadership about successes, opportunities, and gaps in meeting program implementation or established goals in the Regional QM Work Plan.

The formal evaluation process of the Quality Program includes assessment of the Region's Quality structure and processes. The Quality Committee, AMD for Quality and Safety, KFHP VP of Quality, Safety and Patient Experience and the QIT evaluate the performance of the Quality Program and revise the goals, initiatives, structure, or responsibilities to ensure an effective program. Quality initiatives are continuously assessed throughout the year. Quality issues are tracked and improvement efforts are documented. Improvement opportunities identified through the formal evaluation process and other assessment processes including NCQA, The Joint Commission, Med-QUEST, HPQO, CMS DOH reviews are considered for inclusion in the current or subsequent year’s Quality Work Plan.

The Quality Program Description and the Quality Work Plan are also reviewed, evaluated and amended annually. The Work Plan identifies the Region’s objectives and planned activities to improve quality and safety of clinical care, quality of service and member experience with target completion dates and responsible persons. This evaluation assesses the impact of clinical care and services delivered, achievement of goals or objectives, and informs improvements to the following year’s Quality Program. These three documents (QM Program Evaluation (prior year), QM Program Work Plan, and QM Program Description) are reviewed and approved by Quality Committee and submitted to the KFHP/KFH Boards’ Quality Health and Improvement Committee (QHIC) for further review and comment. In accordance with The Joint Commission requirements, Kaiser Foundation Hospital reviews, evaluates and revises the Hospital Performance Improvement Program and Plan annually. It is endorsed by QUIPSC, approved by MEC/HEC, and submitted to the Boards’ QHIC for further review and comment.

The Hawaii Region Quality Program Description and the annual Quality Evaluation documents are available to all practitioners, including affiliates (practitioners and providers), and employees of the Hawaii Region upon request, and an annually updated summary of the Quality program and accomplishments is made available to members.

Section III – Structural Relationships and Coordination of Quality with Other Management Functions

Structural linkages exist through collaboration and participation on various regional 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:
A. Ambulatory Surgery Centers
The Honolulu and Wailuku Ambulatory Surgery Centers (ASCs) are freestanding surgical outpatient facilities, operated by Kaiser Foundation Health Plan, Inc. and the Wailuku ASC is 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 Regional Quality Committee and the Governing Body.

B. Integrated Behavioral Health
The HPMG Integrated Behavioral Health Chief and the Integrated Behavioral Health Services (IBH) Regional Manager are members of the Regional Quality Committee. Processes are in place to ensure that IBH 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. 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 Regional Manager provide routine expertise and oversight of quality for the Hawaii Region. The Chief provides oversight for clinical decisions, staff training and development and case consultation. The IBH Chief and IBH Regional Manager are responsible for quality improvement, and core competencies for the professional staff. The IBH Chief’s relationship with the Regional 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 Call Center 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 regional Quality Improvement committees and other appropriate committees
- Peer Review and Interdisciplinary Team Review.
C. Clinical Risk Management

The Hawaii Region 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 Region’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.

Clinical Risk Management utilizes the established committee structure and reporting relationships developed for the quality functions of the organization. The HPMG Physician-Chair (the AMD for Safety and AMD for Quality) 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 region 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 received directly in the department are reviewed for potential liability and entered into the National Risk Management database (aka NetSet).
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- 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,
  - Tends 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 insures 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 insures 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 regional AOC’s and other leaders on the SMT process; leads and guides SMT’s as needed at the time of the event
  - Risk/Legal Workgroup – Reviews newly opened legal claims; summarize the allegations of the claim and present to the Risk/Legal workgroup; then identifies any immediate risk 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 waiver 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 Region. 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.
    - Clinical Risk Management orient all newly hired providers to CRM processes, including review of Hawaii malpractice climate, risk management structure, communication and quality of service management guidelines. All newly hired personnel receive risk management orientation through the New Hire Orientation Program. Content include an introduction to Clinical Risk Management structure, objectives, and functions, criteria and process for reporting events,
    - Risk Management partners with HPMG’s Professional Development team for educational offerings on risk/legal matters to the medical group several times a year. These offerings include Art of Medicine/Communication Unanticipated Adverse Outcomes, and CME events for various departments.
D. **Concern Grievance Management**

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 the automated Customer Feedback System (CFS). CFS facilitates the monitoring, routing, tracking, reporting and resolution of concerns and grievances.

The Quality Metrics Department has on-line access to CFS. The monitoring process for all complaints that are generated in the CFS are reviewed by Quality Metrics RN Analysts for all product lines: Medicare, Medicaid, Commercial, and Exchange. A note is placed on the complaint indicating RN review. Once a CFS is identified as a potential “quality” case, the analyst will enter this information into QALine for peer review. The Clinical Risk Management Department is also on-line and reviews cases with potential risk implications, as well as those with confidentiality issues which are forwarded for review by the Regional Privacy Officer. Member Services distributes weekly tracking and trending reports to Executive Leadership, Clinic Manager and Supervisors, Department Chiefs and Physicians-In-Charge. Trended data is also presented to the Quality Committee on an annual basis and is used in the methodology to determine the Top Five Concerns on an annual basis. The QIT and QC provide oversight for the customer concern, grievance and appeals processes.

Information concerning benefits and obtaining care is provided to members included in various member communications including member handbooks and publications. The process to evaluate new member marketing materials includes surveying of members, patient satisfaction results, and feedback through the Customer Feedback System. Oversight is provided through oversight and monitoring reporting process to the QIT and Quality Committee.

E. **Credentialing, Privileging and Peer Review**

**Credentialing and Privileging**

The KFHP, Inc./KFH Boards of Directors have authorized HPMG and KFHP, Inc. and KFH to perform credentialing and privileging functions. The Quality Committee and Medical Executive Committee (MEC)/Wailuku Ambulatory Surgery Center (WAI ASC) MEC/Honolulu Ambulatory Surgery Center (HON ASC) MEC have been charged with overseeing the credentials and privileges function. They have appointed the Credentials and Privileges Committee (CPC) to implement the Hawaii Region’s Credentialing and Privileging policies and procedures.

HPMG, KFH, and KFHP, Inc. Hawaii Region jointly participate as members of the Hawaii Region CPC for the purpose of fulfilling the credentialing and privileging responsibilities for the Region. Term of the membership of the CPC is indefinite. The CPC has a membership of at least five with representation from the departments of Anesthesiology, General Surgery, OB/GYN, Medicine, Family Practice, Diagnostic Imaging, Emergency Medicine, Pediatrics specialty, Health Plan (Legal), and Compliance. The Committee meets monthly and more frequently as needed. The CPC reports annually to the Quality Committee and to the MEC/WAI ASC EC/HON ASC EC and the KFHP, Inc./KFH Boards on a monthly basis or when necessary. The CPC oversees credentialing/recredentialing process for Licensed Independent Practitioner’s (LIPs) and Allied Health Professionals (AHPs).

Credentialing and recredentialing of all LIPs and AHPs are governed by the CPC policies and procedures. LIPs include doctors of medicine or osteopathy, dentists, podiatrists,
optometrists, clinical psychologists, social workers, chiropractors, physician assistants, advanced practice nurses, physical therapists, occupational therapists, and speech therapists practicing on behalf of the Kaiser Permanente Medical Care Program. The CPC makes credentialing decisions regarding affiliated community and Kaiser practitioners without hospital privileges. The CPC recommends approval to the MEC of all LIPs and AHPs requesting KFH (Moanalua) privileges with final approval by the KFH Board of Directors and the Ambulatory Surgery Center (ASC) Medical Executive Committee (MEC) of all LIPs and AHPs requesting ASC privileges with final approval by the KFH, Inc. Board of Directors. Recredentialing is required every two years. Site visits are conducted, if applicable, for both credentialing and recredentialing.

Credentialing and recredentialing of Organizational Providers (including QUEST Integration) is managed by the Credentials Department and through the same approval processes for LIPs. All recommendations are formally recorded in the meeting minutes of the Quality Committee and Medical Executive Committee and ASC MEC.

Site visits are conducted based on complaint and for providers whose organization is not accredited by a recognized accrediting body, if applicable, for both credentialing and recredentialing. Credentialing and recredentialing is delegated to American Specialty Health Group, Inc. (ASH Group), which is an NCQA-certified organization, for chiropractic care, acupuncture and massage therapy. Virtual Radiologic (vRad) is also delegated for radiologic services.

Peer Review
Clinical departments perform peer review based on their own clinical indicators and established standards. Peer review findings are reported through the following oversight process, as needed: departmental peer review, department chiefs and special session of MEC / ASC MEC as needed. The Practitioner Performance Oversight Group is a committee that oversees the process of practitioner clinical and non-clinical performance. Additionally, information from other internal sources, including reports from automated data sources which may be supported by focused studies is used in the practitioner evaluation step of the credentialing and privileges process. Focused studies, providing greater detail and empirical support regarding a particular area of practice or practitioner’s performance, may lead to the development of standards of practice. These standards of practice may be used to improve practitioner performance as well as evaluate clinical competence.

Peer Review is designed to assure credentialed practitioner oversight and management of care and improvement by focusing on adverse patient occurrences. A framework of review, analysis, education presentations, and oversight assures responsible quality improvement participation by HPMG physicians and affiliated practitioners. Physician chiefs are responsible for Quality oversight in the Practitioner Performance Oversight Committee.

F. Moanalua Hospital
The Hospital is dedicated to continuously improving quality and recognizes its responsibility to support the Regional 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 objectives of the Program are aligned with and in support of the Hawaii Region Mission and Strategic Priorities.
The objectives of the Program are to:

1. Establish a consistent, organized approach to quality assessment and improvement throughout the organization
   1.1 Promote a philosophy of continuous quality improvement
   1.2 Conduct quality activities using performance improvement methodologies and tools
   1.3 Prioritize quality initiatives to support the mission and strategic priorities
   1.4 Support staff in the use of quality management methodologies and tools
   1.5 Decrease variation in key functions and processes to improve outcomes
   1.6 Integrate data collection and analysis on important functions, processes, outcomes, and initiatives
   1.7 Identify opportunities for improvement
   1.8 Develop and implement action plans
   1.9 Measure and report results
2. Communicate information about quality activities and results throughout the organization
   2.1 Report on progress toward goals and results to staff, management, physicians, members, and Program Office on a regular basis
   2.2 Document quality activities
3. Support collaboration on quality goals across services and across the continuum
   3.1 Utilize an interdisciplinary process for problem identification and improvement activities
   3.2 Engage physician partners in all aspects of quality and patient safety activities
   3.3 Involve all levels of staff in quality and patient safety activities
4. Ensure that quality control, quality assurance, and quality improvement activities are included in the Program
5. Utilize resources efficiently to promote high quality through integration of quality and utilization initiatives
6. Reduce risk events, adverse patient occurrences, and claims through integration of quality, patient safety, and clinical risk initiatives
7. Maintain high quality, safe care to patients through integration of quality, patient safety, clinical risk, and credentialing
8. Comply with laws, rules and regulations, regulatory, and accrediting agency requirements related to quality

The KFH Professional Staff Vice President of Quality and Patient Safety and the Senior Director of Quality, Accreditation, and Licensing, Credentials and Peer Review oversee the hospital day-to-day quality activities and act as the hospital quality liaisons to the MEC and QC, and represent the hospital for quality reviews and surveys. Other areas supporting hospital quality include:

- Service chief/medical director and manager/supervisor are responsible for the development, implementation, and evaluation of the local quality activities supporting the Patient Care and Services Plan.
- Situation Management Team (SMT) – group of staff and physicians with specialized training and authority to advise, coach, facilitate, and coordinate the organizational response to a sentinel or reportable event, and coordinate communication to patient/family when an unanticipated adverse outcome occurs.

The hospital establishes performance measures and collects data on key initiatives, processes, and outcomes related to patient safety, quality care, service, and organizational functions. A balance of process and outcome measures is selected by hospital leaders - outcomes to understand the result and processes to understand what
has been done to cause the results. Measures are identified and developed with input from interdisciplinary teams, expert staff, current literature, regulatory or accreditation agencies, and professional organizations. Leaders utilize priority-based criteria in the selection of measures. Criteria based on high risk, high volume, problem-prone, or high visibility processes include:

1. Expected impact on performance such as cost, quality, service, safety, infection
2. Relationship to regional strategies, and hospital goals and priorities
3. Relationship of potential improvement to requirements of regulatory or accrediting agencies
4. Patient needs and expectations
5. Risk management or patient safety concerns

Measurement priorities are reviewed annually and revised as necessary.

When a Sentinel Event (an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof, or an event which otherwise adversely affects the quality of care and service, operations, assets, or reputation of Kaiser Permanente) occurs, procedures are developed and implemented in accordance with Kaiser Permanente Program and hospital policies, including root cause analysis, development and implementation of a plan of correction, ongoing monitoring of selected measures, communication to senior leaders, and reporting to the MEC and the BOD-QHIC.

Performance of new or modified processes, targeted areas for study, or processes that involve risks or may result in sentinel events are monitored through a systematic, data collection process.

The hospital uses statistical process control tools and techniques to display and analyze data appropriate to the specific data reviewed. Intensive assessment is initiated when statistical analysis and comparison show that performance varies significantly from the expected, from other organizations, or from recognized standards. In addition, intense analysis is initiated when a sentinel event occurs.

Analysis may show a system/process problem, performance problem, or knowledge deficit. The best strategy for solving systems/process problems is a collaborative and interdisciplinary team approach using continuous improvement process methodology. When the focus is on individual performance, the hospital provides education if there is a knowledge deficit or provides the individual with a sufficient opportunity to improve if a performance problem is identified. If performance does not improve, corrective actions are pursued.

The Joint Commission (TJC) – ORYX - Core Measures - a national Performance Measurement System and six Core Measure Sets selected by KFH to comply with standards established by TJC support the strategic and quality goals of the Kaiser Program. Data is analyzed and assessed on a quarterly basis by QRSS and communicated to the appropriate committees and workgroups to identify improvement opportunities, develop actions, and ensure follow-up. TJC publicly reports the results of each hospital’s performance on their web site. The publication provides state and national comparisons.

Hospital Patient Satisfaction Survey - Satisfaction data and information from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey is monitored, analyzed and reported to the MEC and Hospital Executive Committee (HEC). HEC integrates the information with other quality findings, analyzes it to identify trends or significant occurrences, and initiates appropriate action. Aggregate patient satisfaction
data from the hospital is included in regional satisfaction data reported regularly to the QIT and QC. Results are included in the annual quality program evaluation.

CMS - Hospital Quality Alliance - KFH submits data on Perinatal Care – 01, Immunization, Stroke, VTE measure sets and beginning January 1, 2015 will include the entire Perinatal Care and Tobacco measure sets. Results are reported with the Joint Commission core measures on a quarterly basis to QRSS.

American Heart Association (AHA) - Get With The Guidelines (GWTG) - Results are reported regularly to the QRSS.

American College of Surgeons – National Surgical Quality Improvement Program (ACS NSQIP) - Results are available bi-annually and are reported regularly to the QRSS.

G. The Integrated Quality Management (IQM) Outside Medical Meeting
Membership of the IQM Outside Medical Team is comprised of the Vice President of Clinical Operations Contracting and Community Benefit, the Associate Medical Director of Outside Services and Network Management, the Associate Medical Director of Hospital Specialties, and the Director of Provider Contracting and Relations.

The IQM Outside Medical Team is responsible for operational oversight, guidance, direction, monitoring and evaluation of affiliated care services. The Director of Provider Contracting and Relations has management responsibility to ensure that appropriate actions are taken on findings through process linkages between Contract Management, Credentialing, Claims, Member Services, Quality Management, Clinical Risk Management and Resource Stewardship.

Kaiser Permanente physicians and managers collaborate with affiliated care practitioners to continually improve the quality of care and service to Hawaii Region members. Contract language specifies that affiliated practitioners and providers, including those who make utilization management decisions, cooperate with Kaiser Permanente Hawaii Region’s quality program and activities as well as foster open communication. Kaiser Permanente Provider Contracting and Relations staff act as a liaison with community providers to identify issues of concern, and, when necessary, communicate with appropriate quality program leaders and/or referring physicians.

H. Patient Safety
The 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 our 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 4 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 patient safety structure is integrated into the quality structure and links entities, departments and committees to achieve goals. The HPMG Assistant AMD for Patient Safety and Clinical Risk and the Regional Patient Safety Director 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.

Assessment for potential high-risk patient safety concerns is performed on an ongoing basis by review of the following:

- Performance measures that pose potential risk during patient care, including but not limited to monitoring of the TJC National Patient Safety Goals, HEDIS measures, CAHPS and HCAHPS scores.
- Unusual Occurrence Reports (UOR): voluntary reports from staff on events that are considered non-routine unintended, undesirable, and/or unexpected.
- Significant Reportable Event Alerts: reports distributed by TJC on patient care processes that have caused injury to patients. The alerts include recommended strategies to prevent these medical / process errors.
- Survey findings: from staff and patients on perceptions related to systems and processes that impact patient safety
- Root cause analysis findings from significant reportable events
- Other patient safety, quality, clinical risk, compliance, member services, utilization, infection control or environmental safety data and information

I. Pharmaceutical Management

Pharmaceutical Services Department has a reporting accountability to the QIT and Quality Committee. The Pharmaceutical Services 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 Region. 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 include medical group representation from all major medical specialties, nursing representation, pharmacy representation, and allied health professional health representation.

The Kaiser Permanente Hawaii Drug Formulary is intended to promote appropriate drug utilization and ensure drugs available to patients/members meet established quality standards for safe and effective use, as well as limiting the availability of drugs that are unsafe, less than effective, ineffective 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 the drug. Clinical efficacy and the appropriate use of the drug 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 and updated pharmaceutical management procedures are published at least monthly and as changes are implemented and are available to practitioners on the Pharmacy Hawaii Web page. An annual summary on pharmaceutical management 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.

J. Prevention & Health Education
The Permanente Prevention Committee provides regional oversight for the development of clinical guidelines for the prevention and early detection of illness and disease. The committee meets monthly and consists of primary care physicians in Internal Medicine, Family Medicine, Pediatrics, and OB-GYN. The physician lead for Evidence Based Medicine, the immunization project coordinator and physician lead, as well as from our pharmacy and health education departments are also on the committee. Preventive care guidelines are developed under physician direction and are based on sound scientific evidence. Current membership information and regional quality priorities are also used to set priorities for guideline development and preventive care initiatives.

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 our physicians.

The Prevention & Health Education Department offers a wide variety of classes and educational service for members and the community. Members are encouraged to use the health promotion, health education and preventive health services available to them including the many interactive self-care tools located in Health and Wellness Centers around the Region and at kp.org.

K. Resource Stewardship
The Hawaii Region integrates quality and utilization disciplines into a balanced Resource Stewardship and Utilization Management Program, known as the Integrated Quality Management Program. Refer to the 2015 Hawaii Region Integrated Quality Management
Program Description for details regarding resource stewardship activities including objectives and strategies.

L. Service and Care Experience Strategy

Member and customer perceptions, experiences and requests drive service quality improvement initiatives. This is accomplished through delivery system processes designed to provide service quality and a satisfying care experience as well as to monitor and improve key aspects of service such as: leadership and management practices and the work environment through the People Pulse survey; access and availability of services, transitions in care across the continuum, and perception of member/patient service quality through various survey processes.

The KFHP Hawaii Regional President and Hawaii Permanente Medical Group President and Executive Medical Director assume responsibility and accountability for care experience activities. They in turn assign accountability to the Associate Medical Director of Professional Development and Service, the KFHP VP of Quality, Safety, and Patient Experience, and VP of Health Plan Services and Administration, as well as clinic and hospital operations and physician leaders. Member and patient satisfaction results and other sources of information and data are analyzed and reviewed at all levels of the organization on care experience and used to prioritize improvement initiatives.

Surveys and focus groups are used in the Hawaii Region to elicit feedback and information from health plan members, employer groups, employees and physicians. Surveys include:

- Concern summaries of formal concerns documented in the Customer Feedback System
- Employee Quality of Work Life Survey (People Pulse)
- Employer Satisfaction Survey
- HPMG Practitioner Surveys
- METEOR Survey
- NCQA Member Satisfaction Survey (CAHPS)
- Hospital Member Satisfaction Survey (H-CAHPS, Child HCAHPS, Home Health CAHPS)
- Outpatient Pharmacy Regional Surveys
- Patient Satisfaction Survey (PSAT)
- ASC/ASU Care Experience Surveys
- Brand Strength Monitoring Reports
- Practitioner surveys on experience with Utilization Management processes

The Hospital implemented the HCAHPS Survey in June 2006. The same vendor, National Research Corporation, is being used by all KP hospitals. Analysis is ongoing as results are compared to KP hospitals, the vendor database of hospitals and eventually, the CMS national and state results. CMS began public reporting of HCAHPS results in 2008.
Section IV- Organizational Performance Improvement and Assessment

Continuous Improvement Philosophy
Since 1990, Kaiser Permanente Hawaii Region 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 Hawaii Region 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.

A. 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 us to monitor progress and assure accountability. Performance targets (e.g. national benchmarks, interregional Kaiser Permanente “best in program” measures, etc.) are identified for comparison with current local Hawaii Region 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.
- CMS Mandated improvement projects including a Chronic Care Improvement Project (CCIP) with focus on reducing cardiovascular disease and stroke and a Quality Improvement Project (QIP) focused on the reduction of readmissions.
- 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 Region’s Quality goals and objectives.

B. 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 Practice Guidelines (CPG)/Evidenced Based Guidelines**
  A rigorous process for physician-led CPG development and oversight is managed by the KP Care Management Institute (CMI) and Hawaii Region Quality Management Program with oversight by the Regional Guideline Director. The KP National and Hawaii Region CPGs, distinguished as high-grade, evidence-based clinical recommendations, include performance feedback for continued improvement. CPGs are evaluated every two years at the KP National Care Management Institute and at the KP Hawaii Region level, or more often as clinically indicated. CPGs are developed and adopted based on relevance to the Hawaii Region’s membership, encompassing acute, chronic and behavioral health services. The CPG process includes review by physician and allied health experts, practitioners involved in the change, and ultimate authorization at the Quality Committee.

- **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 Hawaii Region also has developed a chronic disease and patient-based decision-support system. This tool allows the primary care physician to be able to see how all his/her chronic disease members 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 ready-to-hand complete clinical information and personal history for every patient at every encounter in all care settings. This allows for well-informed case management, behavioral support, and clarity and safety around diagnostic testing, monitoring and treatment (medications, allergies, etc.) to enhance collaborative clinical care with each member, on their terms. In addition, each Kaiser member is able to sign up via the member web site (www.kp.org) to use secured messaging with their health care providers; view select lab and diagnostic imaging results, office visit summaries, medications, allergies, and current health conditions; refill prescriptions; and request and/or cancel appointments on-line. To encourage members to take an active role in their own health, they are now able to take an on-line total health assessment, are provided information on healthy lifestyle programs, and have access to a number of validated sources for health and wellness education.

- **Population Care Management**
  The Patient Support Service (PSS) is a model for population care which utilizes the special skills of clinical pharmacists, pharmacy technicians, advance practice RNs, registered nurses, medical assistants and clerical staff to help reach defined quality goals and assist with regional priorities through an evidence-based, whole member
care approach to improve the health status of patients with chronic illnesses and to support the primary care physician.

The PSS team currently helps manage patients with chronic conditions including diabetes, hypertension and cardiovascular disease, gout, osteoporosis, among others. The team utilizes several tools including the Care Management Tracking System (CMTS), How Are We Doing (HAWD), and Mana ku (formerly the Panel Support Tool) to provide real time data on targeted populations for feedback, monitoring, and management of the quality of care being delivered as measured against regional clinical standards. On an annual basis, the PSS will solicit member feedback on care and services received relating to their condition. Member concerns and clinical processes are also analyzed for continuous improvement in meeting member needs.

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.

At a minimum on annual basis, the Hawaii Region reviews its disease management programs and revises as necessary based on new treatments and innovations in the standard of care, and notifies HPMG and affiliate practitioners of program information in the annual Quality Summary document.

**Continuity and Coordination of Care**

The Hawaii Region 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 and SNF/ICF facilities staffed by clinicians. On an annual basis, the Utilization Management (UM) Program conducts the Practitioner Satisfaction Survey, an internally developed survey to measure practitioner satisfaction with Utilization Management processes. This survey assesses practitioner satisfaction with communication between practitioners and UM to ensure continuity and coordination of care to members when members transition from one level of care to another. The Utilization Management Program monitors the results of the Practitioner Satisfaction Survey annually and reports findings to the –Integrated Quality Management Committee. Results that fall below established thresholds are identified and opportunities for process improvement are developed and implemented.

**Continued Access/Member Notification Upon Practitioner Termination**

The Hawaii Region’s policies and procedures comply with all regulatory and accreditation requirements. To ensure continuity and coordination of care, the Region 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.
- **Unusual Occurrence Reporting (UOR) System**
  The Hawaii Region 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.

- **Clinical and Service Quality Improvement**
  The Hawaii Region 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 Region clinical and service quality improvement initiatives are colorectal cancer screening, smoking cessation and flu vaccination.

- **Complex Health Needs**
  The Hawaii Region coordinates services across the continuum of care between all settings (hospital to care home to clinic) for members with complex health needs. The Hawaii Region has programs or initiatives in place to serve populations that may have complex health needs including obesity prevention and treatment, integrated behavioral health/pain management, cancer, palliative care, QUEST Integration and Medicare Advantage Dual Special Needs Plan as well as populations that have multiple chronic conditions, including cardiovascular disease, diabetes and hypertension. High-level objectives for serving members with complex health needs include: 1) identification of eligible members through various data sources including encounter data, hospital discharge data, pharmacy data, and cost and utilization data; 2) ensuring evidence-based complex case management systems and programs are in place; and 3) ensuring the effectiveness of such programs through defined goals. Description of programs and initiative can be found in separate documents.

- **Dual Special Needs Plan**
  The Hawaii Region will offer a Dual Eligible Special Needs Plan (D-SNP) on Oahu and Maui for eligible Medicare beneficiaries who have full benefit Medicaid status effective January 1, 2016. A 2016 quality improvement plan has been developed that will address measureable goals and health outcomes, methods to assess and track goals, actions if goals not met, ongoing performance improvement evaluation and dissemination of SNP quality performance in a separate document.

- **Quest Integration**
  The Hawaii Region shall comply with all the Department of Human Services Med-QUEST Division (DHS) quality management requirements to improve the performance of established DHS performance measures, in clinical care and non-clinical care areas
that are expected to have a favorable effect on health outcomes and member satisfaction, including seeking input from and working with members, providers, Med-QUEST Division staff and its designees and community resources and agencies to actively improve the quality of care provided to members.

Med-QUEST Division 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, significant improvement, sustained over time, The PIPs will be on reducing readmissions and Diabetes. The Diabetes Performance Improvement plan will focus on member education, self-management and disease management.

The status and results of each project and all data will be reported to the State and the EQRO as necessary to enable validation of the performance including the status and results of each project.

As required by the Department of Human Services Med-QUEST Division, the Health Plan will submit performance measurement HEDIS 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 the State, data specified by the State, that enables the State to measure the MCO’s performance; or 3) Perform a combination of the activities described] and 2 above.

Also, as required by the Department of Human Services Med-QUEST Division and as described in the Identifying and Providing Case Management to Special Health Care Needs Members (SHCNs) Policy No. 6547-02-19, the Hawaii Region has mechanisms in place to assess the quality and appropriateness of care furnished to members with SHCNs.

In the event that the Health Plan elects to delegate QAPI Program activities and functions, the Health Plan will request approval from DHS within 90 days of the contract approval as required by the Department of Human Services (DHS) QUEST Integration Division. 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).

- **Cultural Diversity**

  The Hawaii Region has a Cultural Competency Strategic Plan which is reviewed annually with oversight provided by the Hawaii Diversity Council. The Council provides oversight to ensure that all members receive care that is culturally sensitive and provided within the context of the individual or cultural group. The Plan aligns diversity accomplishments and goals with the 14 15 National CLAS (Culturally and Linguistically Appropriate Services) Standards developed by the Office of Minority
Health. The CLAS Standards help the Council to assess current programs, identify programs and data needs and set priorities for the Region’s Diversity Program. The Council provides guidance to managers in program planning, evaluation, and compliance issues. The Council also oversees the workplan, which focuses on the following areas:

1. **CARE:** Provide the best care and service for all populations to eliminate disparities and create equity in our communities.
2. **WORKFORCE:** Optimize diversity at every level and create inclusive environments.
3. **MARKETPLACE:** Provide the most compelling value for our diverse populations and communities.
4. **SUPPLIER DIVERSITY / COMMUNITY:** Build equity through businesses and jobs and promote diverse and thriving communities.
5. **Compliance**

### C. Member Access and Availability of Services

The Hawaii Region has adopted specific standards to ensure accessibility to members for primary care, specialty care practitioners and behavioral health practitioners. The Region also has telephone standards for appointment access, member services and behavioral health services. The Quality Committee approves the standards and reviews performance at least annually. Telephone access results are available on a monthly basis. Measures are conducted and results reported on a regional, clinic, and individual practitioner basis whenever possible. Geographic availability is measured annually by Geo Access software.

### Section V – Program Oversight

#### Confidentiality and Non-restrictive Communication

Chapter 624-25.25 of the Hawaii Revised Statutes protects proceedings and records of peer review committees and quality assurance committees. Such records are limited to “recordings, transcripts, minutes, summaries, and reports of committee meetings and conclusions contained therein.” Protected information does not include “incident reports, occurrence reports, or similar reports which state facts concerning a specific situation, or records made in the regular course of business by a hospital or other provider of health care.” All quality management information is maintained in the Director of Professional Competency’s office or other designated locations within departments that have specific quality management responsibilities. Departments will maintain only quality management information relative to their respective departments and work that is in progress. Files regarding quality of care issues are not separately maintained in personnel files.

Contracts with individual practitioners and providers include a statement that specifies that practitioners cooperate with quality improvement activities. Contract language also specifies access to the practitioner’s medical record to the extent permitted by law and that Kaiser Hawaii Region allows open practitioner-patient communication regarding appropriate treatment options deemed medically appropriate without penalties, financial or otherwise.
Conflict of Interest

No individual has the ultimate responsibility for the review of the quality of patient care or appropriate utilization of resources for a patient with whom the individual is involved personally or professionally.

Resources

The Regional President and Medical Director through KFHP/KFH and HPMG corporate structures allocate resources to develop and maintain the Quality Management Program.

Physicians and operations managers throughout the Region are allocated time, office space, and support staff to perform specialized Quality Management Program roles. In addition, physicians and operations managers 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 management initiatives. Information Technology (I.T.) resources support quality improvement initiatives including HEDIS reporting and data extracts for measurement and analysis. Involvement of I.T. resources also includes design, implementation and ongoing support of disease registry information and registries.

Information about the Quality Management Program is available to members on kp.org and upon request. A notification on the availability process is sent to members on an annual basis. A statement is also included in the new member handbook to inform new members. Practitioners have access to quality management information from the on-line practitioner manual. In addition, an annual quality summary is sent to all internal and external physicians and providers.

Delegation

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

In 2015, the ASH renewed their NCQA certification which includes utilization management and credentialing functions. The NCQA designation for ASH will be used in lieu of defined oversight requirements for the Hawaii Region.

Oversight mechanisms are in place which include annual review and approval of ASH’s Clinical Services Program/UM program and at a minimum, semi-annual reporting for delegated credentialing and utilization management functions. The Integrated Quality 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 Region.

Care coordination for all members is delegated to the Kaiser Permanente Hawaii Region Patient Centered Medical Home (PCMH). KP Hawaii’s PCMH overall approach and model of care is designed to improve the quality, appropriateness and efficiency of care coordination for all members. The overall performance goal is to improve the quality and efficiency of health care for members with chronic and complex conditions. To achieve this goal, it is the expectation of all PCMH practice sites to manage these members. The health plan is responsible for identifying
patients who qualify for its disease management and complex case management programs, notifying the PCMH about the identification, and maintaining a tracking mechanism that includes these members. Notification to the PCMH is conducted for each patient when they are identified as being qualified for the disease management or complex case management programs from information via KP Hawaii’s electronic health record (KP HealthConnect) with the expectation of feedback from the practice on whether they intend to engage the patients on the list.