# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section 1</th>
<th>INTRODUCTION</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.</td>
<td>Purpose and Scope</td>
<td>5</td>
</tr>
<tr>
<td>II.</td>
<td>Mission and Vision Statement</td>
<td>8</td>
</tr>
<tr>
<td>III.</td>
<td>Goals &amp; Objectives</td>
<td>8</td>
</tr>
<tr>
<td>IV.</td>
<td>Authority &amp; Responsibility</td>
<td>10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section 2</th>
<th>PROGRAM SCOPE and CONTENT</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I.</td>
<td>Organizational Structures</td>
<td>12</td>
</tr>
<tr>
<td>II.</td>
<td>Organizational Relationships</td>
<td>13</td>
</tr>
<tr>
<td>III.</td>
<td>Scope</td>
<td>13</td>
</tr>
<tr>
<td>IV.</td>
<td>Medical Management Interfaces</td>
<td>17</td>
</tr>
<tr>
<td>V.</td>
<td>Monitoring and Evaluation</td>
<td>17</td>
</tr>
<tr>
<td>VI.</td>
<td>Reporting and Documentation</td>
<td>19</td>
</tr>
<tr>
<td>VII.</td>
<td>Resources</td>
<td>20</td>
</tr>
<tr>
<td>VIII.</td>
<td>Delegation</td>
<td>20</td>
</tr>
<tr>
<td>IX.</td>
<td>Planning and Evaluation</td>
<td>21</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section 3</th>
<th>RISK MANAGEMENT</th>
<th>22</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.</td>
<td>Introduction</td>
<td></td>
</tr>
<tr>
<td>II.</td>
<td>Authority and Responsibility</td>
<td>22</td>
</tr>
<tr>
<td>III.</td>
<td>Purpose</td>
<td>23</td>
</tr>
<tr>
<td>IV.</td>
<td>Goal</td>
<td>23</td>
</tr>
<tr>
<td>V.</td>
<td>Objectives</td>
<td>23</td>
</tr>
<tr>
<td>VI.</td>
<td>Organization</td>
<td>24</td>
</tr>
<tr>
<td>VII.</td>
<td>Risk Management Process</td>
<td>26</td>
</tr>
<tr>
<td>VIII.</td>
<td>Claims Management</td>
<td>27</td>
</tr>
<tr>
<td>IX.</td>
<td>Operational Linkages</td>
<td>27</td>
</tr>
<tr>
<td>X.</td>
<td>Retention of Records</td>
<td>28</td>
</tr>
<tr>
<td>XI.</td>
<td>Reporting</td>
<td>28</td>
</tr>
<tr>
<td>XII.</td>
<td>Confidentiality</td>
<td>29</td>
</tr>
<tr>
<td>XIII.</td>
<td>Annual Appraisal</td>
<td>29</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section 4</th>
<th>PATIENT SAFETY</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I.</td>
<td>Purpose</td>
<td>29</td>
</tr>
<tr>
<td>II.</td>
<td>Philosophy</td>
<td>30</td>
</tr>
<tr>
<td>III.</td>
<td>Objectives</td>
<td>30</td>
</tr>
<tr>
<td>IV.</td>
<td>Organization</td>
<td>30</td>
</tr>
</tbody>
</table>
V. Communicating with Patients 33
VI. Patient Safety Education 34
VII. Patient Safety Improvement Activities 34
VIII. Reporting 34

Section 4 THE CARE EXPERIENCE PROGRAM

I. Introduction 36
II. Objectives 36
III. Scope 36
IV. Structures, Roles, Responsibilities & Resources 36
V. Subcommittees 37
VI. Key Management Practices 37
VII. Key Operational Processes 38
VIII. Communication Channels 38
IX. Quality Improvement Process 39

Section 5 BEHAVIORAL HEALTH CARE

I. Introduction 40
II. Purpose and Objectives 40
III. Authority and Responsibility 40
IV. Scope 41
V. Structure and Channels for Decision-Making 41
VI. Continuity and Coordination Between Medical and Behavioral Health Care 42
VII. Program Evaluation 42

Section 6 MEDICAL MANAGEMENT PROGRAM

I. Purpose and Scope 43
II. Goals and Objectives 43
III. Authority, Accountability, and Responsibility 44
IV. Committee Group Structure 45
V. Behavioral Health Care 46
VI. Delegation 48
VII. Methodology & Criteria 51
VIII. Appeals Process 58
IX. Provider & Member Satisfaction 63
X. Risk Management / Patient Safety 63
XI. Confidentiality 64
XII. Planning & Evaluation 64
XIII. New Technologies and Innovations 65
XIV. Medical Management Committee 65
XV. Medical Advisory Committee (MAC) 68
XVI. Medical Management Inter-Rater Reliability Testing 69
XVII Pharmaceutical Management 70
XVIII. Medical Management Reports 72
<table>
<thead>
<tr>
<th>ATTACHMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1  KP Ohio Strategic Framework</td>
</tr>
<tr>
<td>1.2  Executive Leadership Team Ohio - Organizational Chart</td>
</tr>
<tr>
<td>2.1  Quality Council Structure</td>
</tr>
<tr>
<td>2.1a Quality Council Purpose, Membership, and Meeting Schedule</td>
</tr>
<tr>
<td>2.2  Organization Chart – Quality and Service</td>
</tr>
<tr>
<td>2.3  Organization Chart – Population Care</td>
</tr>
<tr>
<td>3.1  Confidentiality and Participation Statement</td>
</tr>
<tr>
<td>3.2  Medical Management Committee Confidentiality Statement</td>
</tr>
<tr>
<td>3.3  Medical Management Focus Studies</td>
</tr>
<tr>
<td>3.4  UM Transition Scope / Change Matrix</td>
</tr>
</tbody>
</table>
SECTION 1: INTRODUCTION

I. KAISER PERMANENTE OHIO

PURPOSE AND SCOPE

Kaiser Foundation Health Plan of Ohio (KFHP) is a group model Health Maintenance Organization (HMO) serving 122,342 members in the Greater Cleveland and Akron / Canton areas and their surrounding communities, encompassing nine counties in all. Kaiser Permanente (The Plan) is jointly managed by KFHP and the Ohio Permanente Medical Group (OPMG) which directly serves approximately 79% of the member population.

Approximate Kaiser Permanente Ohio membership (Flash Membership Summary December 2010) consists of:

- **99,463** (81%) non-Medicare members
- **22,879** (18.7%) Medicare Cost and other Medicare members
- **76,415** (62.5%) Traditional members
- **19,658** (16%) Point of Service (POS) members
- **26,269** (21.4%) Deductible / Coinsurance and High Deductible members

Within Kaiser Permanente Ohio (KPO), seven affiliated care networks are in place to assist with health care delivery. The seven care networks serve approximately 25,087 (21%) members.

KPO offers a comprehensive health care delivery system, including:

- Ambulatory Medical Services including Primary Care, Specialty Care, Laboratory, Pharmacy, Radiology, Nuclear Medicine and Rehabilitation
- Preventive Services
- Self-Care Resources
- Advice Nurse Services (24 Hours / Day)
- Acute Inpatient Hospital Care
- Ambulatory Surgery
- Care (Disease) Management
  - Health Coaching – Commercial network members only
- Acute Inpatient Rehabilitation Services
- Skilled Nursing Care
- Durable Medical Equipment
- Home Health / Hospice Care
- Behavioral Health Care
- Dialysis Services
Transplant Services
Discharge Planning – OPMG only
Elder Care Services
Advanced Care Panels for those identified as Resource Intensive Members

KFHP contracts with OPMG to provide medical care to its members. OPMG extends its practitioner / provider network by contracting with community-based physicians to provide physician services in addition to OPMG services.

The Plan provides outpatient medical services in ten medical office locations to members throughout nine counties. KPO operates its own Home Care Agency. Additionally, KPO provides ambulatory surgery at the Parma Ambulatory Surgery Center as well as contracted hospitals. Emergency services are offered at the Parma Medical Office, the Cleveland Heights Medical Center and at contracted hospitals. OPMG contracts for selected specialty care with area specialists and facilities.

The Plan contracts with 34 area hospital / hospital systems (which include behavioral health care services) and 17 preferred skilled nursing facilities.

Scope: Ohio Counties Served (9):
- Cuyahoga
- Geauga
- Lake
- Lorain
- Medina
- Portage
- Stark
- Summit
- Wayne

Kaiser Permanente Facilities (10):
- Avon
- Bedford
- Chapel Hill
- Cleveland Heights
- Fairlawn
- Parma
- Rocky River
- Strongsville
- Twinsburg
- Willoughby

Affiliated Providers and Practitioners:

Contracted Hospitals (34):

- Cleveland Clinic Foundation – Main Campus (1)
- Summa Health System (5)
  - Akron City Hospital *
  - St. Thomas
  - Summa Western Reserve Hospital
  - Summa Barberton
  - Summa Wadsworth

- Cleveland Clinic Health System (10)
  - Fairview General (OB)
  - Lutheran Hospital

- Children’s Hospital Medical Center of Akron (1)
- Hillcrest Hospital
- Huron Hospital **
- South Pointe Hospital **
- Euclid Hospital
- Lakewood Hospital
- Marymount Hospital *
- Medina General Hospital
- Children’s Hospital for Rehabilitation

- MetroHealth System (1)
- Robinson Memorial Hospital (1)

- Lake Health System (2)
  - Lake West Medical Center
  - TriPoint Medical Center
- Parma Community General Hospital (1) *

- EMH Regional Medical Center (2)
  - Elyria Memorial Hospital
  - Amherst Hospital
- Mercy Medical Center (1)

- Belmont Pines (Child Psych)
  Trumbull County
- Windsor Laurelwood Hospital Center for Behavioral Medicine

- Crystal Clinic Orthopaedic Center (CCOC)
- Stella Maris (outpatient Behavioral Health)

- Edwin Shaw Hospital (Rehab Only)
- LTACH – Grace Hospital, Kindred Hospital, Select Specialty Hospital-Akron SHS, Inc., Select Specialty Hospital-Northeast Ohio, Inc.

* Primary OPMG Hospital
** OPMG Overflow

As of January 1, 2011

Primary Contracted Skilled Nursing Facilities (17):

- Parma Community General Hospital Skilled Nursing Center
- Aristocrat Berea
- *Broadview Multi-Care
- Edwin Shaw (SNF)
- Villa St. Joseph
- Life Care Center of Medina
- HCR Manor Care
- Harborside Healthcare
- Summit Health Care Management
- Wesleyan Village
- *Mentor Way Care Center Nursing and Rehabilitation Center
- *Wyant Woods Care Center
- *Avon Oaks Nursing Home
- MetroHealth Skilled Nursing Services
- MetroHealth Prentiss Center for Skilled
II. MISSION AND VISION STATEMENT

Our Mission:

Kaiser Permanente exists to provide high quality, affordable health care services and to promote and improve the health of our members and the communities we serve.

Our Vision:

As the health care organization of choice in Northeast Ohio, the people of Kaiser Permanente will:

- Deliver clinically superior care, promoting the health of the communities we serve
- Recognize the uniqueness of each member, earning loyalty through personalized care and service
- Practice resource stewardship, enabling care to be affordable
- Invite dialog and involvement, ensuring that we share in making decisions and taking actions
- Support each other’s development, resulting in a highly skilled, knowledgeable, and committed workforce

III. GOALS & OBJECTIVES

The Kaiser Permanente Quality Management Program is designed to improve the quality of clinical care and the quality of services provided to its members. To that end, the goals and objectives of the program are the following:

1. Prioritize quality activities to support the Strategic Plan (*Attachment 1.1-Strategic Framework*);

2. Provide resources in support of achieving the Quality Program Work Plan;
3. Incorporate the continuous quality improvement philosophy and methodologies, such as PDSA (Plan / Do / Study / Act) to facilitate change that supports the Strategic Plan;

4. Systematically collect, measure, and analyze information on significant aspects of care and service, evaluate provider performance, identify opportunities for improvement in the delivery of medical and behavioral health care services, patient safety, and clinical risk management which include significant event analysis and reporting; implement improvement initiatives and establish re-measurement schedules to assess improvements and success at holding gains;

5. Demonstrate value to our purchasers through outcomes-oriented quality improvement activities through interdepartmental collaboration including, but not limited to, Operations, Marketing, Claims, Customer Relations, etc.;

6. Communicate the results of the information collected about providers and practitioners to health plan administrators, enabling them to make changes in practice to improve the quality and safety of care and the appropriate management of resources;

7. Respect members’ rights and responsibilities; promote member satisfaction and retention, including assessing and monitoring member concerns regarding cultural, ethnic, racial and linguistic needs through an annual analysis of Consumer Assessment of Healthcare Providers and Systems (CAHPS) items regarding age, gender, ethnic and language results and the capture and analysis of complaint data;

8. Address the needs of a diverse population by collecting accurate and precise race, ethnicity, and primary language information from all of our members; link this information to KPO's overall quality improvement agenda so that patients benefit from how the data is used and support the design of innovative programs to eliminate health care disparities and provide care and services that are easily accessible, personalized, high quality, and affordable;

9. Protect the confidentiality of individual practitioners and members by restricting access to peer review and quality assurance / monitoring activities as delineated by state statute;

10. Effectively manage and optimize the use of ambulatory and inpatient resource stewardship by targeting high risk, high volume, and high cost aspects of care and service;

11. Implement and support the Clinical Risk / Patient Safety Program which focuses attention on standards and the prospective analysis of delivery systems for both the organization and health care professionals; the prevention of injuries to patients, visitors, and personnel, and the management of any adverse events in such a manner as to minimize negative consequences;
12. Provide oversight and monitoring of delegated activities including annual review of delegated credentialing activities, the delegated Medical Management (utilization management) activity of the American Specialty Health Network (ASHN) as well as ongoing quality oversight of contracted acute care and skilled nursing facilities which includes review of program descriptions, quarterly reports and annual evaluations by those entities;

13. Comply with applicable regulatory and accrediting body requirements.

IV. AUTHORITY AND RESPONSIBILITY

The Board of Directors of Kaiser Foundation Health Plan, Inc., (KFHP) in conjunction with the President of KFHP Inc. maintains ultimate responsibility for the oversight of the Quality Program in all regions, including the Ohio Region. The Board’s Quality and Health Improvement Committee (QHIC) acts as an oversight agent for the KFHP, Inc. Board of Directors. The QHIC holds the Ohio Regional President and Regional Medical Director and President of Ohio Permanente Medical Group accountable for the management of the Ohio Region’s program. The QHIC executes its responsibilities through the review of quarterly reports obtained from the Ohio region.

Beginning in 2011, the Medical Directors Quality Review (MDQR) site visit will be replaced with a leadership dialogue with QHIC based on data driven performance review and infrastructure assessment. Dialogue will delve into four areas:

a) gaps in current performance from internal goals or external benchmarks,
b) significant areas of risk,
c) key initiatives for improvement, and
d) description of regional infrastructure to support ongoing monitoring.

The QHIC has the responsibility to provide the Ohio Region with feedback and recommendations from their review and analysis of the quarterly reports as well as HPQO findings. Kaiser Foundation Health Plan of Ohio (KFHPO) responds to all inquiries and recommendations made by the QHIC.

Administrative oversight of the KFHPO Quality and Medical Management programs are the responsibility of the Vice President of Quality and Service, the Director of Accreditation and Resource Stewardship and the Vice President & Associate Medical Director for Medical Operations.

The Department Chiefs and Department Managers, working with Executive Leaders, implement the clinical and behavioral health aspects of the Quality program, ensuring that care and service standards are met and safe clinical practices are promoted. *(Attachment 1.2)*

The Medical Director assigns accountability for implementing the ongoing Behavioral Health Program, a component of the core health care delivery product, to the Chief of...
Behavioral Health Services (BHS), a member of OPMG. The Chief of BHS works with the BHS Department Manager to manage ongoing operations of all mental health and addiction medicine services within KP Ohio including staffing, access, quality review and service initiatives. See Section 5, Behavioral Health Program.

The Associate Medical Director of Quality Improvement, along with the Health Plan’s Vice President of Quality and Service co-chair the Senior Quality Council (SQC). The SQC provides oversight, coordination, and communication for all Ohio quality activities, including the functions of the quality councils as described in Attachment 2.1, all CQI initiatives, risk management / patient safety initiatives, OPMG medical group and network credentialing, member services, member satisfaction and complaint data, significant event reports, Pharmacy management, medical management, contracting, delegation activities, the OPMG Board of Directors and major health plan operational issues. The SQC also has the responsibility of reviewing and approving the Ohio Region’s Quality and Medical Management Program Description, Program Evaluations, and Work Plans.

The SQC directs, facilitates, and supports consistent and comprehensive reporting throughout the organization, establishes annual quality priorities, approves and evaluates progress and outcomes of the quality work plan, identifies major Ohio organizational quality initiatives, provides resources, evaluates progress and outcomes, reviews and recommends policy decisions, institutes needed actions and ensures follow-up. The Committee reviews reports and data analysis generated through audits, monitors studies and outcomes of care, performance improvement measurements and recommendations made by external and internal regulatory and accreditation reviews. In addition, the Committee ascertains that the region and service areas meet or exceed these recommendations.

KFHPO shares certain medical functions with the Board of Directors of the Ohio Permanente Medical Group (OPMG). OPMG contracts with all physicians and allied health care practitioners and completes performance evaluations. KFHPO provides support to these functions.

The Credentials Committee is a joint responsibility of Health Plan and OPMG. The Committee approves credentialing policies and procedures as well as reviews and makes decisions regarding the credentialing and re-credentialing of all OPMG, supplemental, contracted referral and network practitioners, including allied health professionals. The Credentials Committee also conducts the assessment and reassessment for organizational providers.

The Credentials Committee is comprised of nine physicians, one allied health professional, the Vice President and Regional Counsel, the Director of Network Development and Performance, all with voting privileges. This includes the Associate Medical Director of Quality Improvement, the Vice President of Quality and Service, and the Director of Risk Management and Population Care Management. The Credentials Committee meets on a monthly basis.
SECTION 2: PROGRAM SCOPE AND CONTENT

I. ORGANIZATIONAL STRUCTURES

The Quality Management Program encompasses the OPMG Clinical Departments including Behavioral Health, ancillary departments, affiliated practitioners and providers and oversight of delegated activities. It also provides a link to Medical Management, Risk Management / Patient Safety, Legal Counsel, Compliance, Accreditation, Customer Relations, Population Care Management and Prevention, the Medical Group and the Care Experience initiatives. This structure creates the appropriate nexus of Compliance, Risk and Quality to address referred issues. The Program defines the quality management aspects of the partnership between KFHPO and OPMG in the provision of optimal quality medical care and services and the appropriate use of resources.

Physicians and Health Plan representatives from the clinical departments present the results and analysis of their ongoing quality and resource management monitoring activities to the Care Delivery Council (CDC) as well as the regular review and reporting of quality of care, service, clinical risk, patient safety, pharmacy management and resource management issues. The CDC communicates significant findings and overarching issues to other appropriate quality councils as well as through quarterly reports to the SQC. Attachment 2.1 and 2.1a depict the organizational reporting structure and links.

The Clinical Department Chief is responsible for assuring that each clinical department has a functioning and effective quality and resource management oversight process. The specific functions may be delegated to a physician designee who will chair the Clinical Department Quality, Resource Management (QRM) Subcommittee. The QRM Subcommittee is responsible for performing departmental peer review for cases identified via the Peer Review Process. Review is conducted based upon quality initiatives including Health Effectiveness Data and Information Set (HEDIS), third party regulators, accrediting bodies such as the National Committee for Quality Assurance (NCQA), business initiatives, clinical risk management and patient safety initiatives and other indicators as determined by the department to meet critical member and / or department needs, and to incorporate member complaints regarding the clinical and service aspects of care into their ongoing review.

Reporting:

The Clinical Department QRM Subcommittees report all findings and recommendations for action as a result of the ongoing QM Program to their respective clinical departments for input and approval. The reports provide an aggregate of findings, trends, actions, and an assessment of the effectiveness of the departmental quality program.
II. ORGANIZATIONAL RELATIONSHIPS

PARTNERSHIP

Ohio’s Quality Program is based on a foundation of partnership between OPMG and KFHPO. To support the patient care delivery needs of the organization, KFHPO and Clinical Departments monitor high risk, high volume, problem prone and high cost aspects of care, including continuity of care, patient occurrences including significant events, proactive patient safety and clinical risk management aspects, access, quality control, resource management, member satisfaction and environmental safety concerns. KFHPO supports OPMG in the areas of data collection, information analysis, report generation and consultation regarding QRM activities and accreditation standards. OPMG then interprets the information and uses it to improve patient care processes, outcomes, patient safety and clinical risk management. OPMG performs this through peer review, performance review, and redesign of patient care processes under the auspices of the OPMG Board of Directors.

III. SCOPE

The KFHPO Quality Management Program monitors and evaluates significant aspects of the clinical care and administrative services provided to members. The program takes a broad based approach to monitoring and integrates cross functional activities through the use of multidisciplinary teams whenever possible. The program emphasizes quality improvement activities in member care and service that includes but is not limited to the following aspects:

- Acute Hospital Services
- OPMG Clinical Departments
- Operations
- Network Development and Performance
- Customer Relations
- Medical Management
- Practitioner and Provider Review and Oversight (PPRO)
- Clinical Risk Management / Patient Safety

Monitoring activities are performed using a number of different methods such as:

- Review of all Quality & Risk Reports (QRRs)
- Review of selected member complaints including information on special and cultural needs and preferences
- Monitoring of the grievance and appeals process
- Review of 180 day letters (pre-suit notification letters)
- Monitoring of referrals from Clinical Risk Management and Patient Safety as well as from the Medical Management Department
- Assessing adherence to preventive health guidelines
- Review of congruence with specific clinical practice guidelines
• Medical Record Reviews
• Monitoring referrals from claims and criteria based diagnosis or procedure focused studies to evaluate current practice against expected performance standards in order to identify opportunities for improvement
• Prospective analysis of service delivery systems to identify system redesigns that will improve patient safety and reduce or eliminate clinical risk
• Review of access and availability data, i.e. geo-access reports, CAHPS results related to access and availability
• Survey information
• Member and Practitioner Satisfaction Survey Results
• Significant Events and Situation Management issues
• Compliance with accreditation standards and activities

Rate based indicators such as readmission rates, are monitored to identify trends in quality of care, service, patient safety, and in medical management. Sentinel indicators such as delay in treatment, coordination of care, and inappropriate documentation are monitored to identify events requiring peer review and / or investigation. Member complaints and surveys are monitored to determine satisfaction levels of our members and to identify needed changes within the organization.

Significant events are monitored and analyzed to bring to the forefront those unexpected occurrences that result in, or present the risk of, the loss of life and bodily harm, disrupt operation, or threaten the assets and / or the reputation of KP Ohio. These occurrences are reviewed in such a fashion in order to prevent, detect, and correct errors and adverse variations in system performance. Any unexpected occurrences that suggest a breakdown in processes and systems are evaluated, communicated and analyzed to identify variation or deviation in system performance by performance improvement methods (Root Cause Analysis). These analyses are considered confidential and privileged quality / peer review documents. Systems and processes to prevent, detect, and correct errors or deviations are priorities that are then implemented and monitored. A brief summary of finding and actions taken, indicating that a thorough and credible review process occurred, are forwarded to Program Offices Department of Care and Service Quality.

The Network Development and Performance Department is linked to Practitioner and Provider Review and Oversight (PPRO) during contracting via information exchange and on-site reviews, if indicated. All contracts require full participation in quality management activities, access to members’ medical records, and a statement affirming that the practitioner is expected to communicate openly with the patient regarding appropriate treatment(s) without penalty. Contracting language has also been expanded to include language for the network providers which include a description of the processes used to inform practitioners, groups, and providers about the Quality Program, and language related to notifying Kaiser Permanente when a significant event occurs to a Health Plan member. Compliance issues are referred to the Regional Compliance Officer as appropriate. These contracts also incorporate patient safety and Leap Frog initiatives and language regarding Employee Retirement Income Security Act (ERISA) regulations. Periodic reports are specified in the contract including those
Guidance, direction, monitoring, and evaluation of affiliated care and service is provided through the departments of Network Development and Performance, Credentialing, Customer Relations, Risk Management / Patient Safety and Medical Management. Attachment 2.1 and 2.1a demonstrate the links between the committees for these various departments. Issues from the information and results of the review are taken to the appropriate committee and reported through resolution. In addition to regional contracting efforts, KFHPO uses some national contracts. The National Continuation Care Contracting Department in Oakland, California manages ambulance and DME. National Transplants and Contracting Services in Oakland, California manage the National Transplant Network (NTN). The NTN is guided by physician and other health care practitioners via a National Transplant Advisory Board and its quality activities are overseen by the Quality Improvement Committee of the NTN. There is a regional representative on the Quality Improvement Committee of the NTN. Each of the National Contracting Departments annually updates a Quality Program Description and Work Plan. These documents are then submitted to the Department of Care and Service Quality Program Offices for review.

Access and availability is formally evaluated annually, or when there is a significant increase or decrease in either enrollment or when service area expansion occurs, through the Access and Availability Subcommittee. The role of this subcommittee is to provide ongoing monitoring / evaluation of availability and access to Primary Care and Specialty Care including OB / GYN, Behavioral Health, and high volume specialties for both the core and affiliated networks. The subcommittee reviews performance on measures of access and availability such as GeoAccess reports, telephone metrics and relevant CAHPS survey results. The organization’s effectiveness at meeting the cultural, ethnic, racial and linguistic needs and preferences of members is evaluated annually via analysis of relevant CAHPS questions and complaints, census data, and translation services usage reports. The subcommittee makes recommendations regarding access and availability policy.

**Complex Case Management:** The Kaiser Permanente Ohio (KPO) Complex Case Management (CCM) program consists of focused, high intensity case management and care coordination services to positively affect the health outcomes of vulnerable, at risk and high utilization populations through the use of clinical systems, streamlined evidence based care pathways and processes. The program is designed to ensure that members at high risk for hospital re-admissions due to catastrophic events or select chronic conditions receive evidence based comprehensive assessments, detailed care plans and post-hospitalization follow-up. The goal is to quickly reconnect patients with primary, specialty and/or population management teams. This collaborative program integrates catastrophic case management, resource stewardship (utilization management) and chronic care coordination for service areas within KPO.

The CCM program is staffed by Registered Nurses (RNs) and Licensed Independent Social Workers (LISWs) that provide both admission and post hospital discharge case management/coordination. Case managers (from the catastrophic case management
team) continuously evaluate the quality of care provided as well as outcomes of treatments and services during and following acute admission as patients and their families require focused management and support. Case managers (from the chronic care coordination team) provide post hospital discharge care to members with newly diagnosed or complex HF and HIV diagnosis to facilitate transitions and ensure patients are able to self manage conditions. Both teams work together to ensure patients are successfully supported as they move across the care continuum.

As additional resources to support the program become available, the overall goal of the program will be to expand criteria to include other conditions that utilize the top 1% of all resources.

Objectives

- Assist patients in regaining an optimal health status;
- Improved functional status of chronic conditions;
- Proactively identify and capture patients for the program;
- Develop effective case management care plans that match the patients health needs with timely, evidence based care and services;
- Promote improved quality of life in a cost effective setting
- Provide timely access to service; and
- Provide case managers tools to positively impact the target population

Goals

- Decrease inpatient re-admission rates;
- Decrease emergency department and clinical decision unit admissions
- Promote member satisfaction across the program

The ACP Program strives to help select members by achieving the following goals:

- Improve care to a high-risk group of patients with multiple chronic illnesses
- Improve member satisfaction with the care
- Increase identification of terminal illness and provide End of Life Care
- Increase documentation of Advance Directives
- Increase proactive encounters with patients
- Identify and intervene on psycho-social needs
- Obtain accurate information about medications
- Improve patient self-management and care coordination
- Help patients remain in their homes safely
- Decrease use of the emergency department
- Reduce hospitalizations
- Decrease 30-day readmission rates

Population Care Management is responsible for disease management activities, as well as prevention screenings and health promotion activities. Disease Management (DM) includes data management of the health status of KPO members and identification of members eligible for disease management programs. This includes monitoring members’ conditions and their adherence to the program’s treatment plan,
consideration of other health conditions and lifestyle issues as indicated by practice guidelines. The Disease Management Program addresses the following chronic conditions: Diabetes, Heart Failure, Asthma, and Depression, and implementation of interventions to support improved clinical outcomes.

Disease management programs were developed by Kaiser Permanente Care Management Institute (CMI), a sister organization that includes representatives from all Kaiser Permanente regions. CMI develops and maintains evidence-based clinical practice guidelines, designs disease management programs and collaborates with Kaiser Permanente health plans in the development of appropriate indicators and provision of comparative data. CMI quickly responds to current research that may impact guidelines for chronic disease processes.

CMI annually evaluates member participation rates and satisfaction with the DM Program; results are sent to KP Ohio. Member complaints and inquiries are reviewed monthly and action taken as deemed necessary. Outreach and other interventions are designed and implemented to assist members and practitioners in managing chronic disease as well as preventive screenings. Health promotion includes group classes, member education materials, the Total Health Assessment questionnaire and oversight of wellness programs.

The KP Ohio Guideline Committee oversees the development and dissemination of acute and chronic medical care and behavioral health care Clinical Practice Guidelines (CPG) in Ohio. The Committee is committed to support clinical practice with systematically developing guidelines that clarify content of appropriate, high quality, measurable, cost effective care and effectively provide clinical decision making. The committee meets regularly to review submission of proposed guidelines, the adoption of nationally approved guidelines by the Care Management Institute guide the development of new guidelines and review and update existing guidelines. These guidelines are developed with full provider involvement, based on sound scientific evidence. CPG are reviewed and revised according to a formal timetable, (at least every two (2) years or sooner if needed), incorporating advances in scientific knowledge regarding clinical care. Clinical Guidelines are reviewed at regular department meetings. The guidelines are posted on the Ohio Intranet, Network Development Provider Website, emailed to Chiefs of Departments and followed by a Send-all to include all OPMG and KPHP employees.

IV. MEDICAL MANAGEMENT INTERFACES

The Medical Management Program interacts with the Quality Management Program in three ways:

1. Identification of specific clinical quality occurrences. The Medical Management staff is responsible for assisting in the identification of specific patient centered clinical quality occurrences that are encountered as a result of the medical management process.
2. Monitoring of continuity and coordination of care that members receive and the implementation of actions to ensure and improve continuity and coordination of care across transitions of care and upon terminations of practitioner contracts. Current monitoring and improvement activities are focused on transitions from acute care, extended skilled care and home care back to Primary Care and involve monitoring discharge summary information. Electronic tracking of member movement between acute, extended and emergency care has been developed. The Ohio region’s Transition of Care work focuses primarily on transitions from inpatient to home, with new work started in the Emergency Department (ED) setting in 2010, to be completed in 2011.

3. Identification of areas of improvement for populations. The Medical Management staff is responsible for assisting in the identification of trends within the membership and the processes of care encountered as a result of the medical management process, that would improve the quality of care provided to an aggregate population. For 2011, KP Ohio will continue to focus on: Diabetes and Hypertension / Coronary Artery Disease.

V. MONITORING AND EVALUATION

Objective, measurable indicators are developed to monitor identified important aspects of care and service within the delivery system. Clinical departments are responsible for establishing performance standards and / or identifying performance benchmarks in order to measure performance against a particular indicator or aspect of care or service. Each department analyzes its data and incorporating principles of continuous quality improvement (CQI), identifies opportunities for improvement and takes appropriate action based upon the analysis. Outcomes are evaluated to determine the effectiveness of actions taken for improvement. Important aspects of care and service monitoring activities include but are not limited to the following:

- Member Satisfaction including complaints, compliments, grievances, appeals and satisfaction surveys
- Practitioner satisfaction
- HEDIS data
- Panel management and patient outcomes derived from Permanente On-Line Interactive Network Tool (POINT), the electronic panel management system
- Member disenrollments using voluntary termination surveys
- Availability, accessibility and wait times
- High volume and / or high risk diagnoses / procedures
- Infection Control practices
- Documentation via medical record review for practitioners and allied health
- Practitioner and provider oversight activities
- Appropriateness and efficacy of ancillary services
- Quality and risk occurrences
- Continuity of care
- Quality Control
• Medical Management
• Review of affiliated care
• Potentially compensable events
• Patient Safety initiatives
• Clinical Risk Management initiatives
• Safety Alerts
• Environmental surveys
• Significant Events and Situation Management Issues
• Compliance issues
• Compliance with clinical practice guidelines

Continuity and coordination of medical care that members receive across the health care network is monitored at least annually. Coordination of care is measured between primary and specialty care practitioners / services, primary care and behavioral health practitioners / services, and primary care practitioners and provider services.

Action plans are developed when opportunities to improve coordination of medical care are identified.

Practitioners Who Terminate:

KP provides timely written notification to members who are affected by the termination of their regularly visited primary or specialty care physician / practitioner. KP complies with regulatory requirements to notify members at least 30 days prior to a practitioner leaving, changing locations, or reducing their practice, if this information is made known in a timely fashion. This includes contracts with specialty group practices. The process assists the member in selecting a suitable alternative practitioner.

Continued Access

Members who are undergoing active treatment for a chronic or acute medical condition are able to continue access to the practitioner for the condition for up to 30 calendar days or longer providing the practitioner agrees to conditions of information sharing, UM policies and procedures and payment; members in their second or third trimester of pregnancy can continue access to the practitioner through the postpartum period.

VI. REPORTING AND DOCUMENTATION

Quality improvement activities are documented and reported to the Care Delivery Council (CDC). The CDC receives quarterly reports from the departments or services reporting and participating in the Quality Program.

On a quarterly basis, a report of significant quality activities is reported to the KFHP Board of Directors’ Quality and Health Improvement Committee (QHIC) through the Senior Quality Council (SQC). Also, on a regular basis, quality, patient safety and risk management information and education is provided to the clinical departments and the organization through various publications and forums. These include, but are not
limited to individual clinical department newsletters, the OPMG newsletter, Quarterly Shareholders Report, postings on the Ohio Intranet and the KP Forum. Summary reports of survey readiness are provided to the SQC and Compliance Committees.

Quality profiles for OPMG practitioners are created at a minimum annually and also upon request. The quality profile consists of aggregated data from peer review, attributed practitioner complaints, message turnaround times, focused practice reviews and Art of Medicine scores (department and individual). Department Chiefs review the quality profile and legal claims for credentialing, re-credentialing and annual evaluations. Practitioners can request a copy of their quality profile at any time by contacting the Performance Improvement and Patient Safety Department.

On an annual basis, representatives on the designated quality councils participate in the review and updating of the Quality Management and the Medical Management Program Description, annual evaluation, and annual work plan.

- Program Evaluations serve to assess the effectiveness of quality improvement activities in the areas of clinical care and service and in the areas of medical management. The annual evaluations promote the implementation of more effective interventions, revision of the Quality Management & Medical Management Program Description, and drive the updates to the Quality Management and Medical Management Work Plans.

- Once completed, the documents are presented to the SQC for review and approval prior to submission to QHIC.

Information regarding member rights and responsibilities is provided to all practitioners and members. This policy states our commitment to treating members in a manner that respects their rights as well as expectations of member responsibilities along with addressing information concerning benefits and obtaining care. Articles regarding member rights and responsibilities are published annually in the Partners in Health newsletter and are also provided in subscriber information. New member marketing materials are evaluated for comprehension via telephone surveys.

VII. RESOURCES

The Ohio Region leadership has the responsibility for providing appropriate resources to support quality management activities including coordination and consultation to all departments within the organization in the performance of their quality management activities. The Quality Outcomes and Management Team provide analytic support to the region on strategic quality initiatives with an emphasis on the HEDIS measures. The Performance Improvement and Patient Safety Department leads and assists with performance improvement activities in the region as it relates to risk, quality and patient safety issues. The Population Care Management Department conducts outreach activities and coaching to our members on disease management and prevention as well as health education publications.
Quality management activities involve the partnering of Risk Management, Population Care Management, Patient Safety, Clinical Operations, the Accreditation Department, Market Research, Medical Management, Compliance and individual departments throughout the Ohio Region on quality improvement processes.

VIII. DELEGATION

Quality improvement activities are not delegated to any entity or organization. A delegated utilization (Medical Management) arrangement was implemented in 2002 with the American Specialty Health Network which provides chiropractic and complementary care to Federal employees.

Credentialing functions may be delegated in accord with the provisions of a contractual agreement and in compliance with the standards for delegation. Credentialing of contracted practitioners on staff at affiliated hospitals is delegated through a Memorandum of Understanding. OPMG monitors the results of the hospitals’ assessment and reassessment processes by conducting on-site reviews of policies, procedures, minutes and credentials files annually. Results of these reviews are reported to the Credentials Committee, the OPMG Board of Directors and to the hospitals, along with a time frame for correcting any variances from KFHP’s credentialing standards. The hospitals’ credentialing policies are reviewed as part of the delegation oversight process. Any findings or deficiencies are addressed by corrective action plans which are monitored by the Credentials Committee.

IX. PLANNING AND EVALUATION

KP Ohio is committed to providing quality care and performs ongoing assessment of the activities and projects designed to improve the quality of care and service rendered to members along with the review of the resources needed. The QM Program assesses its performance on quality initiatives continuously throughout the year, through review of quarterly data in the QuEST Report and the review and update of the Quality Work plan. Quality issues are tracked and improvement efforts are documented. Problem solving efforts are evaluated and re-measured to determine their effectiveness. An annual evaluation of the previous year is conducted and reported during the first 4 months of each year to aid in setting revised goals for the subsequent year’s Quality and Medical Management Work Plans.

The Ohio Quality & Medical Management Program Description is reviewed by SQC and revised at least annually and as needed. A copy of the Quality & Medical Management Program Description is available to members and practitioners upon request by contacting Customer Relations. The information on how to obtain a copy of this document is published annually and distributed in the Partners in Health newsletter, OPMG Update Newsletter and the Provider Connection newsletter.
On an annual basis, the SQC provides the final approval to the Quality and Medical Management Work Plans and helps to assure that they are aligned with strategic initiatives. This supports the quality priorities and organizational initiatives established for the year.
SECTION 3: RISK MANAGEMENT / PATIENT SAFETY

I. INTRODUCTION

The Kaiser Permanente Ohio Risk Management Program has been established to minimize adverse events, to learn from experience, to improve the system, to reduce risks, to prevent injury and support and assist the providers in resolving conflicts.

The Board of Directors of the Health Plan has granted overall authority and responsibility for the implementation of the Risk Management Program to the President and the Medical Director of the Ohio Region. The President and the Medical Director have further delegated the responsibility for the program to the Director, Accreditation and Resource Stewardship and the Associate Medical Director of Quality Improvement.

The Risk Management Program has been focused and will continue to focus on creating an infrastructure for a comprehensive and proactive risk management program.

The Legal Department along with Public and Professional Liability (PPL) Claims Practice Group supports the indemnification program in the Ohio service area for professional and general liability. The staff in this area works closely with Clinical Risk Management and Quality from the reporting of an event through the investigation and assessment of liability to eventual disposition.

II. AUTHORITY AND RESPONSIBILITY

The President of the Health Plan and the Medical Director of the Ohio Permanente Medical Group authorize all indemnification payments. Limited settlement authority is extended to Regional Counsel and the PPL Claims Manager. Additionally, Regional Counsel and the PPL Claims Manager have authorized signature authority for expenses related to professional liability claims and lawsuits. Settlement authority is addressed at monthly Liability Review Committee (LRC) meeting. Claims and lawsuits are presented to the Committee; the Presidents of both organizations make recommendations for resolutions. Resolution may include settlement or authority to defend a matter at trial.

The Patient Safety Program functions under the direction of and in collaboration with Risk Management. The Associate Medical Director of Quality Improvement and the Physician Director Risk Management and Patient Safety (OPMG) serve as the Medical Advisors for the Risk Management / Patient Safety Committee as well as for Risk Management and Patient Safety initiatives.
**RISK MANAGEMENT**

**III. PURPOSE**

To provide a safe environment for patients / members and staff by continuously evaluating the processes and outcomes of Kaiser Permanente activities.

**IV. GOAL**

Minimize the number of adverse patient / member, staff, visitor and property incidents, thereby decreasing loss and reducing risk. This is accomplished through identifying opportunities for improvement and employing Enterprise-wide Risk Management strategies that lead to improved patient / member outcomes and safety.

**V. OBJECTIVES**

The objectives of the Risk Management Program are:

1. Develop mechanisms for early identification and reporting of unexpected or unanticipated outcomes that have caused injury or have the potential to cause injury, this includes proactive risk assessments and ongoing education based on needs identified through various tracking and reporting systems

2. Orient new staff members to their responsibility of providing a safe environment for patients / members, visitors and other staff, as well as proper reporting of unusual incidents and future incident prevention

3. Integrate data received from Performance Improvement (PI) activities as they pertain to potential losses to the organization, staff and patients / members; make recommendations toward resolving issues causing losses

4. Investigate, categorize and analyze incidents, including patient / member / family complaints to establish patterns or trends involving individuals, locations or types of incidents, and to determine appropriate action to prevent recurrence

5. Provide / coordinate educational programs to Health Plan staff and OPMG practitioners related to Risk Management issues and concerns: the topics will stem from process issues identified by, but not limited to, critical incident reviews, incident reports and closed claims

6. Communicate findings of Risk Management activities to appropriate departments, committees or individuals

7. Maintain a safe environment for patients / members, visitors and staff

8. Comply with federal, state and local regulatory requirements, and MDQR standards pertaining to Risk Management
9. Implement and support a “Just Culture” to create an atmosphere where providers and staff readily report errors and / or potential risks to patient safety and are accountable to improve our systems and processes.

10. Create and support a Learning Culture where we learn from near misses and errors and improve performance as a result.

Annual goals and objectives will be developed to operationalize the Risk Management Plan.

VI. ORGANIZATION

1. Leadership

The leadership supports the maintenance of the Risk Management Program through allocation of resources necessary to fulfill the plan’s requirements. Leadership will support the establishment and maintenance of linkages between Operations and Risk Management. The Assistant Director of Risk Management and Population Care Management is responsible for directing risk management activities in the absence of the Director of Risk Management and Population Care Management.

2. OPMG

OPMG participates in Risk Management activities related to the clinical aspects of patient / member care; provides clinical expertise necessary, including development of criteria for identifying adverse patient / member incidents; reviews variances to identify deviations from the standard of medical care; and utilizes Risk Management information in the credentialing / reappraisal process. The Physician Director, Risk Management and Patient Safety Co-Chairs the Risk Management / Patient Safety Committee.

3. Health Plan Staff

All Health Plan staff members support and participate in activities of the Risk Management Program; conduct operations in accord with organizational policies and procedures, NCQA standards, and state and federal requirements; report injuries, adverse incidents and unusual incidents with or without injury to the Director of Risk Management and Population Care Management and / or the Clinical Risk Manager per the facilities incident reporting policy; and participate in Risk Management educational programs as needed or at minimum, annually.

4. Environmental Health and Safety Officer

The Environmental Health and Safety Officer ensures that standards are in place to measure staff performance in managing and improving the environment of care. Management of the environment of care includes processes and activities related to reduction and control of environmental risks and hazards, prevention of accidents and injuries and maintenance of safe conditions for patients / members, visitors and staff.
5. **Clinical Risk Manager**

The Clinical Risk Manager is responsible for implementing and monitoring the Risk Management work plan. In addition, the Clinical Risk Manager investigates critical incidents / sentinel events, takes corrective action to eliminate incident causes; and initiate peer review for any patient / member case that presents a possible quality of care concern. Provides education and consultation on risk management to providers and Health Plan staff. Collaborates with Operations to identify trends, investigate incidents and improve systems and processes.

6. **Regional Patient Safety Lead**

The Regional Patient Safety Lead (RPSL) identifies areas for quality improvement in the clinical area by reviewing near misses, conducting Patient Safety Walk Arounds and JCAHO (Joint Commission on Accreditation of Healthcare Organizations) sentinel alerts, and collaborating with Risk Management. The Regional Patient Safety Lead will collaborate with Operations to conduct PI activities to improve the processes identified.

7. **Quality Consultants**

The Quality Consultants will collaborate with Risk Management to identify system / process issues and conduct quality reviews on appropriate cases. In addition, they will collaborate with Operations to conduct performance improvement (PI) projects based on the system / process issues identified.

8. **Customer Relations Department**

The Customer Relations Department will collaborate with the Director of Risk Management and Population Care Management to identify potential quality of care and systems issues through the patient / member complaint process. Customer Relations tracks and trends customer issues to identify areas for PI. Customer complaints related to compliance issues, including but not limited to Health Insurance Portability and Accountability Act (HIPAA), Privacy / Security and Fraud, Waste and Abuse, will be referred to the Regional Compliance Office for investigation and follow-up.

9. **Claims Manager**

The Claims Manager collaborates with the Director of Risk Management and Population Care Management and / or the Clinical Risk Manager to identify high risk areas and potential systems issues. This information will lead to PI and loss prevention. Lessons learned from closed cases are shared with Risk Management at the Lessons Learned Committee and improvements are made in collaboration with Operations and OPMG.

10. **Compliance**

The Director of Risk Management and Population Care Management assures that issues identified in the Risk Management process associated with compliance issues are appropriately referred to the Regional Compliance Office. This includes, but is not limited to, scope of practice, HIPAA, Fraud, Waste and Abuse, and other issues identified as compliance related by the National Compliance Office and the Office of
Inspector General (OIG). The Director of Risk Management and Population Care Management collaborates with the Regional and National Compliance to respond to hotline calls pertaining to quality of care and risk issues.

To maintain an appropriate and ongoing nexus between Quality, Risk and Compliance as directed by the OIG, Risk / Quality will participate in designated Compliance committees, and Compliance will participate in designated Risk / Quality committees.

11. **Human Resources**

The Human Resources Department will collaborate with Risk Management to ensure a “Just Culture” is employed when evaluating incidents.

12. **Director of Risk Management and Population Care Management**

The Director of Risk Management and Population Care Management is responsible for the overall Risk Management Program development and implementation. This includes collaboration with the Regional Patient Safety Lead, Customer Relations Department, Quality Consultants, Claims Manager and Compliance as outlined above.

In the absence of the Director of Risk Management and Population Care Management, the Physician Director, Risk Management and Patient Safety and / or the Clinical Risk Manager will perform these duties.

**VII. RISK MANAGEMENT PROCESS**

Risk Identification — collection of information about patient/member incidents and other situations representing a potential loss to Kaiser Permanente by the following:

- a. Proactive risk assessments
- b. Incident Reports and data analysis
- c. Patient / member complaints
- d. Customer satisfaction surveys
- e. Sentinel events / critical incidents
- f. Chart reviews stemming from referrals, customer complaints, incident reports
- g. Chart requests from attorneys
- h. Physician peer review
- i. Practitioner reporting
- j. Patient / member safety rounds
- k. Legal complaints and suits
- l. Random chart audits
- m. Departmental policy and procedure reviews
- n. Pharmacy data
- o. Informal reporting by staff
- p. Recommendations by external review agencies
- q. Physician Risk Profiles
- r. Security Incident Reports
- s. Tracking and trending incidents
The Risk Management Program establishes and maintains a “Just Culture” reporting system through the development and implementation of systemized procedures for detecting, reporting, collating, analyzing and summarizing incidents. Incidents should be reported within 24 hours of the incident or discovery of an incident to Risk Management in Peminic (incident reporting database). However, any sentinel event should be reported immediately to the Director of Risk Management and Population Care Management or the Clinical Risk Manager.

**Risk Control — Includes, but is not limited to, the following:**

a. Provide education to staff and physicians on identified risk issues  
b. Develop / revise policies and procedures based on current guidelines and standards  
c. Forward new standards and guidelines to appropriate departments / practitioners to maintain standard of care  
d. Conduct case reviews with staff that result in action plans to improve processes  
e. Collaborate with operations to ensure staff are trained on new equipment / procedures  
f. Review staffing effectiveness in high risk areas  
g. Recommend the purchase of new equipment as necessary  
h. Respond promptly to and follow up on patient / member complaints  
i. Collaborate with Situation Management Team to review sentinel events / critical incidents  
j. Collaborate with Operations to resolve process / systems issues identified per closed claims, incident reports, quality or patient safety  
k. Implement recommendations by external review agencies related to risk management and patient / member safety  
l. Use outcome measures to evaluate quality improvement activities  
m. Create a culture of safety  
n. Deploy Safety Action Teams to improve systems and process issues identified through risk, patient safety and quality

**VIII. CLAIMS MANAGEMENT**

See policies for Legal Department.

**IX. OPERATIONAL LINKAGES**

The operational linkage between the Risk Management, Patient Safety and Quality is accomplished through the following mechanisms:

1. Referrals from concurrent review are made to the appropriate department and / or committee
2. Any identified incidents related to the clinical aspects of patient / member care and safety are referred to the appropriate committee or department for investigation, analysis and action

3. Sentinel events and / or identified trends are referred to the appropriate committee for evaluation and action

4. If an opportunity to improve care is identified, the appropriate staff / department / committee are notified and an appropriate action is developed, initiated and monitored for effectiveness

5. Patient / member complaints are tracked and analyzed to identify opportunities to improve performance: areas identified are referred to the appropriate department / committee for evaluation and action

6. Results from patient / member satisfaction surveys are reviewed for risk and quality issues and referred to the appropriate committee / department for evaluation and action

7. Quality Consultant identifies outcome measures to evaluate action plans formulated by the various committees / departments as a result of the aforementioned events

8. Regional Patient Safety Lead will proactively identify potential safety issues and collaborate with Operations to develop action plans for PI

9. High risk multi-disciplinary risk / patient safety / quality issues are referred to Risk Management Patient Safety Committee for review and potential formation of a Safety Action Team to improve the processes / systems involved

X. RETENTION OF RECORDS

Applicable federal, state and local laws are followed pertaining to record retention. Please refer to the Business Records Retention Policy.

XI. REPORTING

Pertinent findings from Risk Management activities will be reported to Senior Quality Council as often as necessary, but not less than annually. Serious issues will be reported as they are identified.

Examples of reporting include, but are not limited to:
1. Incident report summaries
2. High-risk patient safety issues
3. Class I product recalls
4. Claims and litigation summary reported by Claims Management to the Senior Quality Council
5. Variances from generic screening and adverse patient / member outcomes reported to the appropriate departments / committees for quality improvement as they occur
6. Equipment / supply / device related incidents reported in compliance with Safe Medical Devices Act
7. Sentinel Events and Never Events
8. Major Unusual Incidents reported per state regulations by the Manager of Behavioral Health Services

XII. CONFIDENTIALITY

Any and all documents and records that are part of the internal risk management program, as well as the proceedings and reports from any OPMG or Health Plan review committee, shall be confidential and not subject to subpoena or discovery or introduced into evidence in any judicial or administrative proceeding. All such documents and records will be maintained in accordance with the applicable legal privileges.

Committee members recognize that any and all data reviewed by them shall be held in strict confidence. Any breach of this confidence may result in disciplinary action including termination.

All requests and / or subpoenas from attorneys and regulatory agencies for information pertaining to Risk Management or PI activities will be reviewed by the Director of Risk Management and Population Care Management / Claims Manager prior to release.

XIII. ANNUAL APPRAISAL

The Risk Management Plan will be evaluated annually to determine its effectiveness and to assure that problems that impacted patient / member care and safety were identified and resolved. This Risk Management Plan is formally adopted by the Senior Quality Council.

PATIENT SAFETY

I. PURPOSE

The Regional Patient Safety Plan (‘the Plan’) is designed to reduce medical errors and hazardous conditions by utilizing a systematic, coordinated and continuous approach to the improvement of patient safety through the establishment of mechanisms that support effective responses to actual occurrences and hazardous conditions; ongoing proactive reduction in medical / health care errors; and integration of patient safety priorities in the design and redesign of all relevant organizational processes, functions and services.
II. PHILOSOPHY

We believe that:

• Patient safety comes first
• Patient safety is every patient’s right
• Patient safety is every employee’s responsibility

We have an ongoing commitment to build safe systems that will prevent accidental injury to our patients.

III. OBJECTIVES

The objectives of the Plan are to:

• Encourage organizational learning about medical / health care errors
• Incorporate recognition of patient safety as an integral job responsibility
• Incorporate patient safety education into job competencies
• Implement corrective, preventative and general medical error reduction educational programs to reduce the possibility of patient injury
• Encourage recognition and reporting of medical / health care errors and risks to patient safety by establishing and supporting a “Just Culture” for reporting
• Involve patients in decisions about their health care and promote open communication about medical errors / consequences which occur
• Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate actions
• Review and investigate serious outcomes where a patient injury has occurred or patient safety has been impaired in collaboration with risk management
• Review and evaluate actual and potential risk of patient safety in collaboration with risk management
• Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk
• Initiate patient safety programs recommended by National Patient Safety to reduce harm to patients
• Support sharing of knowledge to effect behavioral changes within the Region by providing feedback on a regular basis to staff, practitioners and various committees

IV. ORGANIZATION

The Kaiser Foundation Health Plan of Ohio (KFHPO) has global responsibility for assisting in the delivery of effective and efficient medical care in keeping with professionally recognized standards and available resources. Within that scope, the KFHPO delegates the responsibility for the implementation and oversight of the Plan to the Director of Accreditation and Resource Stewardship and the Department of Performance Improvement and Patient Safety.
The Risk Management / Patient Safety Committee (Co-Chaired by the Physician Director of Risk Management and Patient Safety and the Director of Risk Management and Population Care Management)

The Risk Management / Patient Safety Committee provides a multidisciplinary forum for analysis of risk to patient safety and the dissemination of information on identified risk for the purposes of improving patient care and reducing morbidity and mortality within the Region. It shall review reports on occurrences typically ranging from “no harm” frequently occurring “near misses” to sentinel events with serious adverse outcomes, claims and identified risks, which are gathered in accordance with this plan. It shall review, analyze and disseminate the information it receives, as appropriate, to the Senior Quality Council, chairmen of clinical departments, and appropriate administrative personnel. It prioritizes patient safety / risk issues and develops workgroups to analyze processes / systems and develop action plans for improvement. The Senior Quality Council provides oversight of the Committee’s activities and plans. (See Risk Management / Patient Safety Committee Charter)

Regional Patient Safety Lead (RPSL)

Under general supervision, develops implements and monitors the Regional Patient Safety Program and work plan. Develops and monitors performance indicators / metrics for patient safety. Collaborates with appropriate departments to collect, analyze and trend data from multiple reporting systems / sources to identify opportunities to improve patient safety and decrease clinical risk. Develops and coordinates workgroups and task forces to address priority issues identified. Acts as a resource throughout the Region for issues related to patient safety. Participates on the Risk Management Patient Safety Committee and other committees impacting patient safety. Ensures organization’s compliance with accreditation and licensing standards, laws and regulations, and internal requirements related to patient safety. Assesses need for educational programs, as well as, developing and implementing proactive patient safety programs to promote patient safety. Acts as a liaison with Kaiser Permanente’s National Patient Safety program.

Director of Risk Management and Population Care Management

Provides supervision to the RPSL and has overall responsibility for patient safety. Develops the Regional Patient Safety Plan and annual work plan in collaboration with the RPSL. Co-chairs the Risk Management / Patient Safety Committee. Supports a “Just Culture” for reporting of incidents and near-misses.

Physician Director of Risk Management and Patient Safety

Leadership

Leadership assumes a role in establishing a culture of safety that minimizes hazards and patient harm by focusing on processes of care. The leaders of the organization are responsible for fostering an environment through their personal example; emphasizing patient safety as an organizational priority; providing education to practitioners and Health Plan staff regarding the commitment to reduction of medical errors; supporting proactive reduction in medical / health care errors; and integrating patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

Regional Compliance Officer

The Regional Compliance Officer reports patient safety issues to the RPSL. Participates on the Risk Management / Patient Safety Committee. The RPSL reports any compliance issues to the Regional Compliance Officer.

Clinical Risk Manager

Identifies patient safety issues from various reporting mechanisms and notifies the RPSL. Investigates any patient safety issues involving patient injury in collaboration with the RPSL. Participates on the Risk Management / Patient Safety Committee. Supports a “Just Culture” for reporting of incidents and near-misses. Develops and implements the Regional Risk Management work plan.

Claims Manager

Identifies patient safety / risk issues discovered during the investigation and analysis of potential / actual claims and reports them to the Risk Management / Patient Safety Committee and to the offices of Risk Management and Patient Safety. Participates on the Risk Management / Patient Safety Committee.

Quality Consultants

The Quality Consultants shall share with the Risk Management / Patient Safety Committee potential sources of patient injury. Likewise, the Committee shall, to the extent possible and in a manner consistent with the protection of confidentiality of patient safety data, share with the quality improvement program, aggregate closed professional liability claims data, open claims and incident report data. The Quality Consultants will lead performance improvement activities as assigned by the RMPS Committee. Patient, family, and staff opinions, needs, perceptions of risks to patients, suggestions for improving patient safety, and staff willingness to report medical / health care error will be monitored for performance improvement.

Environmental Health and Safety Officer

The Environmental Health and Safety Officer ensures that standards are in place to measure staff performance in managing and improving the environment of care.
Management of the environment of care includes processes and activities related to reduction and control of environmental risks and hazards, prevention of accidents and injuries and maintenance of safe conditions for patients, visitors and staff.

**OPMG**

Each member of OPMG shall participate in the Regional incident reporting system (See Quality and Risk Reporting Process Policy and Significant Event Reporting Policy) and in the preparation and implementation of corrective action activities in the event of identified risk. Each clinical department shall implement the requirements of the plan, in accordance with patient safety standards and established criteria for patient care and safety, by developing appropriate policies and procedures, identifying cases of potential risk areas and correcting identified safety concerns. In conjunction with its participation in departmental and Regional quality improvement programs, each clinical department shall coordinate and incorporate patient safety indicators into its medical staff monitoring and evaluation systems for the purpose of monitoring and evaluating high-risk activities.

**Health Plan Staff**

Individual staff members are responsible for learning and following jobs and task-specific procedures for safe operations. Staff will participate in the regional incident reporting system.

Each department, which provides or affects patient care, shall implement the requirements of the plan by identifying potential risks in patient care and safety by developing appropriate policies and procedures, identifying potential risk areas and correcting identified safety concerns. Each department shall assure the participation of its members in the Regional incident reporting system and in the preparation and implementation of corrective action plans.

Department Heads / Managers are responsible for orientation of new staff members to the department and, as appropriate, to job and task-specific safety procedures. When necessary, the RPSL will provide department heads with assistance in developing safety programs or policies.

**Patients**

Patients will be asked to participate on performance improvement projects to provide insight, suggestions, and comments on patient safety issues.

**V. COMMUNICATING WITH PATIENTS**

Patients are educated on their diagnosis and treatment options by the practitioner and are included in all aspects of their care and treatment. No decisions are made for the patient without including the patient and / or family as appropriate.
Patients and their families are informed about the outcomes of care, including unanticipated outcomes. The responsible licensed independent practitioner or his / her designee clearly explains the outcome of any treatments or procedures to the patient and, when appropriate, the family, whenever those outcomes differ significantly from the anticipated outcomes.

VI. PATIENT SAFETY EDUCATION

The orientation process emphasizes medical error reduction and specific job-related aspects of patient safety. Ongoing in-service and other education and training programs emphasize specific job-related aspects of patient safety. As appropriate, this training incorporates methods of team training to foster an interdisciplinary, collaborative approach to the delivery of patient care, and reinforces the need and way(s) to report medical / health care errors.

The Regional Patient Safety Lead shall plan and conduct educational activities in coordination with other educational efforts undertaken in the Region. In addition, the RPSL will communicate issues of importance that will be sent to clinical areas on a regular basis or when an issue is identified.

The safety of the health care delivery system is enhanced by the involvement of the patient, as appropriate to his / her condition, as a partner in the health care process. The comment card and patient satisfaction survey encourage the patient’s participation and suggestions for changes in the facilities. Specific attention is directed at educating patients and families about their role in helping to facilitate the safe delivery of care.

Safety information for patients is available on the Kaiser Permanente website, in brochures at each facility and in other various Kaiser Permanente publications that are distributed to patients. In addition, safety information related to the patient’s care and treatment is reviewed at each office visit as appropriate.

VII. PATIENT SAFETY IMPROVEMENT ACTIVITIES

Patient Safety Improvement Activities are developed annually in the Regional Patient Safety Work Plan. Other initiatives and activities are based on trends, events, claims and new patient safety guidelines or information as they become available. The new initiatives are reviewed and prioritized by the Risk Management / Patient Safety Committee prior to implementation.

VIII. REPORTING

The Patient Safety Work Plan is evaluated at a minimum annually by the Risk Management / Patient Safety Committee and reported to the Senior Quality Council.

The RPSL reports on all patient safety activities and identified risks to patient safety to the Risk Management / Patient Safety Committee monthly.
The Risk Management Team reports patient safety / risk issues to the Risk Management / Patient Safety Committee monthly.

A quarterly report is sent to the Senior Quality Council on the activities of the Risk Management / Patient Safety Committee.

Reports are sent to the Health Plan staff and practitioners regarding patient safety initiatives, activities, and outcomes on a regular basis.
SECTION 4: THE CARE EXPERIENCE PROGRAM

I. INTRODUCTION

The Care Experience Program is designed to meet and ultimately exceed the member's expectation for superior service and medical care. The Clinical Delivery Council (CDC) assigns accountabilities to support an operational program that is designed to provide service quality. Ultimately the program is designed to assess leadership and management practices, the work environment which includes people and systems, access and availability and service quality.

II. OBJECTIVES

The Care Experience Program’s objectives and outcomes include:

- Developing common sets of standards for performance in key areas of service
- Developing common sets of measures
- Monitoring performance and taking actions to improve the organization's performance against the standards, including sharing results with practitioners and providers
- Reviewing and approving policies related to access and availability
- Oversight of complaint data

III. SCOPE

The Care Experience Program scope encompasses both the Core and Affiliated Networks for practitioners and members.

IV. STRUCTURE, ROLES, RESPONSIBILITIES & RESOURCES

The Health Plan President and Regional Medical Director hold the Vice President of Medical Operations and the Vice President and Associate Medical Director of Clinical Affairs accountable for the day-to-day management of the care experience. The clinical department managers and chiefs are responsible for ensuring care is provided in accordance with KPO policies and current treatment standards. Operational managers with assistance from clinical staff as required are responsible for ensuring service is provided within standards and issues are addressed on a timely basis.

The directors, managers, and chiefs are supported by key individuals in ensuring that care and service is monitored and improved. CDC is the primary provider of this support. Other departments contributing time and resources to either the Care Experience Program or its subcommittees include organizational Culture of Excellence, Organizational Development, Customer Relations, Market Research, Medical

V. SUBCOMMITTEES

The functions of the Care Experience Program speak to the development and dissemination of actionable information and interventions. The Care Experience Program is conducted within CDC. Operations’ leaders use this information to improve member satisfaction with service quality.

Specific subcommittees support CDC in overseeing the Care Experience Program. These committees include:

The Access and Availability Subcommittee:

- Assures that the organization’s policies and procedures comply with all accrediting body requirements
- Recommends standards for number and/or geographic distribution of and types of providers and practitioners (Primary Care Provider (PCP) and Specialty Care Provider (SCP)), including Behavioral Health practitioners
- Assesses the cultural, ethnic, racial and linguistic needs of members
- Establishes mechanisms to assure the accessibility of primary care services, behavioral health services and member services, including telephone access standards
- Assists in the evaluation of services
- Recommends interventions to improve performance

Primary Care Access Team and Specialty Performance Accountability Team:

- Hold regular meetings to review and assess access levels (appointment and telephone messaging) for Primary and Specialty Care teams and institute appropriate interventions as indicated

Survey Readiness Committee:

- Provides gap analysis of voluntary standards and identifies quality improvement initiatives to SQC
- Presents improvement initiatives to CDC

Annual reports are submitted by each clinical and ancillary department to CDC with significant issues which may be raised to SQC as required.

VI. KEY MANAGEMENT PRACTICES

Committees, managers and directors are charged with the systemic review and analysis of data and alignment of activities and resources with the strategic business planning process. The clinical departments hold regular meetings to discuss processes, issues,
barriers, interventions, and progress toward established goals. Data, e.g. continuous monitors and project outcomes, are collected both within the clinical and ancillary departments and from outside departments such as Customer Relations. Decisions related to interventions may be made at the manager, department / UBT, or the committee level as appropriate. Decisions related to resource allocation are made at these levels with consideration of workload as well as organizational goals and priorities.

VII. KEY OPERATIONAL PROCESSES

Key operational processes that are reviewed, assessed and monitored regularly include member satisfaction and complaints, access to services, wait times, telephone access, which includes Behavioral Health Services and communication with physicians and teams.

Operational processes include: preparation for implementation of a health risk appraisal and interactive consumer health tool availability and accessibility; functionality, accuracy and updating of pharmacy benefits, information on health plan services and a health information line; availability of innovative technology to improve member services and a health information line that assists members with wellness and prevention.

Specifically, member satisfaction data is collected in the form of complaints through Customer Relations as well as regular and focused surveys of members and patients i.e., Patient Satisfaction Surveys (PSS), CAHPS Surveys, Member Experience: Tracking, Evaluation and Opinion Research (METEOR) Surveys, etc. This data is reviewed at SQC. Access to services is monitored by measures including the ability to choose a PCP, having a PCP and the ability to see the PCP / care team. Satisfaction with wait times is monitored for appointment access as well as the wait time in waiting rooms and exam rooms.

Appointment access graphs are provided monthly to the department chiefs and managers and to their managers. Reviews regarding access are conducted quarterly with the department chiefs and managers on a quarterly basis.

Telephone service standards are approved by CDC. Telephone access is monitored monthly through service levels (the percentage of calls answered in specific time frames), abandonment rate, time on phone to make an appointment and complaints. Communication with PCP / team is measured through the complaint process as well as the tracking of messages from the call center to the primary care team and back.

The department collecting the data provides analysis of all data. For instance, the Member Service Center analyzes and reports telephone access information, including complaints, and reports in the quarterly report.

VIII. COMMUNICATION CHANNELS

Communication of decisions made at the top levels of the organization is provided through the committee structure as well as through managers at department and team
meetings. Routine communications of progress toward goals and member satisfaction survey results are presented through the Employee Communications e-mails or regularly scheduled functions like the KP Forum. Moreover, UBTs receive monthly updates of their performance metrics, which are aligned with regional / strategic goals.

Decisions made at the committee level are communicated through representatives of the committee. Decisions made at the department level are communicated by the managers to the staff and to the rest of the organization through reports at CDC.

**IX. QUALITY IMPROVEMENT PROCESS**

Issues are identified through routine monitoring at the UBT, department, facility and organization levels and through gap analysis. Issues which involve organizational resources or are multi-departmental are taken to CDC for review, prioritization and recommendation. CDC forwards final recommendations to SQC. During the process of formalizing an issue into a project, measures are identified and goals established. Initiatives within a department, or that are similar in scope, may be undertaken by the department as deemed by resources and objectives.

Quality improvement projects are measured through respective department and committee channels with analysis, implementation issues, barrier analysis and re-measurement taken to the appropriate department and / or CDC. Interventions are determined by those responsible for the project, e.g. the department manager. Ongoing communication of results is provided through appropriate reporting channels and presentations to groups such as managers or executive staff.
SECTION 5: BEHAVIORAL HEALTH PROGRAM

I. INTRODUCTION

Kaiser Permanente’s Behavioral Health Services (BHS) Department is an integral part of Kaiser Permanente’s healthcare network that provides a continuum of services including mental health, alcohol/chemical dependency, and wellness promotion. The department has a tradition of leadership in providing quality services in an organization that supports behavioral health service and is well positioned to succeed in a changing managed care organization.

The Behavioral Health Service Department’s mission is to provide quality behavioral health care that is readily accessible to members. The department strives for compassion, honesty, trustworthiness, mutual respect and tolerance in the provision of services with the goal to optimize function. The department strives to function as a cohesive team in supporting innovation and creativity and encouraging the use of individual talents to serve organizational goals.

The department’s vision is to expand joint programs with Primary Care and other Specialty Departments. These programs have a holistic focus with the intent to integrate physical, social and psychosocial aspects of care.

II. PURPOSE AND OBJECTIVE

The objectives for BHS are as follows:

1. Achievement of 90th percentiles on all BHS specific related HEDIS measures
2. Collaborate with Primary Care to achieve 90th percentile BHS related HEDIS measures and integrate NCQA standards
3. Superior Service exemplified by achieving a competitive performance level in service
4. A committed, engaged, aligned, and capable workforce by building and supporting leadership capacity and personal accountability

III. AUTHORITY AND RESPONSIBILITY

As stated in Section 1, the Board of Directors of Kaiser Foundation Health Plan, Inc. (KFHP) in conjunction with the President of KFHP Inc. maintains ultimate responsibility for the oversight of the Quality Program in all regions, including the Ohio Region. The Board’s Quality and Health Improvement Committee (QHIC) acts as an oversight agent for the KFHP, Inc. Board of Directors. The QHIC holds the Ohio Regional President and the Regional Medical Director and President of the Ohio Permanente Medical Group accountable for the management of the Ohio Region’s Program.
The Medical Director assigns accountability for implementing the ongoing Behavioral Health Program, which is a component of the core health care delivery product, to the designated behavioral health practitioner who is the Chief of Behavioral Health Service (BHS). The Chief of BHS is a member of OPMG. The Chief of BHS works with the BHS Department Manager to manage ongoing operations of all mental health and addiction medicine services within KP Ohio including staffing, access, quality review and service initiatives. The Chief of BHS participates in and issues policy decisions regarding Behavioral Health Services.

IV. SCOPE

The Behavioral Health Services (BHS) Department offers mental health, alcohol / chemical dependency and triage services. Mental health services include assessment and treatment via individual, couple, and group psychotherapy in addition to medication management, case management and psychological testing.

The Alcohol / Chemical Dependency (ACD) services include assessment, case management, as well as, individual intensive outpatient, day treatment, smoking cessation and aftercare therapy.

V. STRUCTURE AND CHANNELS FOR DECISION-MAKING

The Department Chief and the Department Manager co-chair a bi-monthly Quality / Leadership Committee meeting with representation from the various disciplines within the department, including Addiction Medicine, to address specific departmental issues. Information is then shared with BHS staff via monthly Administrative team meetings and monthly department unit based team meetings. BHS reports to the Clinical Operations Leadership Team (COLT) via the designated BHS health practitioner (the BHS Chief) and / or the BHS Department Manager. The BHS Department Manager and the BHS Chief are members of the Medical Management Committee. The Department Manager may represent the BHS Chief on matters considered within the Medical Management Committee.

ACCESS

Kaiser Permanente monitors access to care available for members seeking behavioral health services. BHS collects and performs an analysis of data to measure achievement of behavioral health standards including telephones answered by a non-recorded voice within 30 seconds at a minimum of 90% goal threshold.

REFERRAL PROCESS

KP Members may self refer to any Ohio Permanente Medical Group (OPMG) or contracted Kaiser Permanente provider for Behavioral Health and Alcohol / Chemical Dependency services.
Utilization Management is utilized to define appropriate level of care for mental health and alcohol / chemically dependent needs. Behavioral Health Milliman criteria are applied for determining the appropriate level of care. Only a qualified BHS provider (Chief or Assistant Chief) may deny services to a member based on strict criteria.

BHS refers various services externally. Inpatient mental health admissions are authorized to be admitted at our contracted hospitals.

The ACD Program refers externally for adult and adolescent residential services and adolescent intensive outpatient services. The Kaiser ACD Program operates an Adult Intensive Outpatient Program Track.

Inpatient detoxification services are provided at state licensed contracted free standing and hospital based facilities.

VI. CONTINUITY AND COORDINATION BETWEEN MEDICAL AND BEHAVIORAL HEALTH CARE

Behavioral Health / Primary Care integration activities foster collaboration between Primary Care and Behavioral Health specialists by monitoring and improving coordination between medical and behavioral health care and data regarding communication between Primary Care and Behavioral Health providers is tracked. Behavioral Health offers individual, group and onsite expertise, and treatment in disease related care environments.

VII. PROGRAM EVALUATION

The BHS program reviews multiple indicators on a quarterly basis. Those indicators fall into the categories of quality, service, access, patient satisfaction and utilization.
I. PURPOSE AND SCOPE

KPO’s Medical Management (MM) Program is designed to monitor, analyze, evaluate, and manage the efficiency and quality of healthcare services delivered to all members of the OPMG and affiliated networks. MM is a collaborative effort between KFHP and OPMG. These two entities work in partnership to demonstrate resource stewardship by providing high quality, optimally safe, fair, and effective medical care for Health Plan members while striving continuously to achieve appropriate and efficient clinical management of resources. KFHP subcontracts with KePRO Acquisitions, Inc. to provide specific Utilization Management services. The scope of these services is outlined in the attached document (Attachment 3.4). Criteria used for referrals management, inpatient and outpatient care by the MM Program are used as a resource in conjunction with the application of medical judgment which considers the individual’s care needs. All adverse determinations for medical necessity are made by an appropriate board-certified physician. In the instance of a behavioral health adverse determination, the decision is made by the appropriate licensed discipline (psychiatrist, doctoral-level clinical psychologist, or certified addiction medicine specialist).

II. GOALS and OBJECTIVES OF MEDICAL MANAGEMENT PROGRAM

The Medical Management Program goals and objectives are put forward to ensure access to the most appropriate and efficient healthcare services. The goals and objectives include:

1. Ensuring continuity and equitable access of quality medical care and effective resource stewardship for services provided to our members
2. Ensure that our members’ rights are recognized and protected
3. Ensure that our members’ safety is maintained across the entire continuum of care
4. Ensure that medically necessary services are covered under the members’ health plan benefits
5. Develop systems to evaluate and determine that services are consistent with accepted standards of medical practice
6. Perform peer review in conjunction with the Quality Management Program as is necessary
7. Coordinate thorough and timely investigations and responses to Member and Provider appeals
8. Initiate necessary procedural revisions to prevent problematic utilization issues from reoccurring
9. Ensure that the services delivered are medically necessary and are consistent with the patient’s diagnosis and level of care required
10. Keep Facilitate communication and develop positive relationships among members, physicians, and KFHP by providing education related to appropriate utilization
11. Keep Monitor, evaluate and analyze healthcare services provided by OPMG and contracted providers by tracking and trending data
12. Monitor, analyze and facilitate continuity and coordination of care
13. Enhance the delivery of care by fostering market-wide sharing of Medical Management practices and strategies
14. Support effective health promotion programs that will improve and maintain one’s quality of life
15. Use Medical Management data in the process of re-credentialing providers
16. Promote physician leadership within Medical Management
17. Promote member satisfaction and include member feedback for continuous program improvements
18. Promote provider satisfaction and include provider feedback for continuous program improvement

III. AUTHORITY, ACCOUNTABILITY AND RESPONSIBILITY

KPO’s Medical Management Joint Accountability Structure reflects the Medical Management staff and reporting structures. Staff positions and committee descriptions explain associated responsibilities and duties. Reporting relationships are clearly defined. Performance objectives are included in the staff evaluations. Interdepartmental coordination of managed care utilization of services is clearly delineated in the description of each department.

The QHIC holds the Regional President and the President and Medical Director of OPMG accountable for the program. They, in turn, entrust responsibility for the management of the program to the Assistant Medical Director for Clinical Resource Management and the Director of Accreditation and Resource Stewardship. The Medical Management Program reports to SQC.

President, KFHPO
Delegates responsibility for overseeing the organization and management of the Medical Management Program to the Director of Accreditation and Resource Stewardship with a focus on the program’s resource stewardship.

President and Medical Director, OPMG
Delegates responsibilities for the development and maintenance of the Medical Management Program to the Assistant Medical Director for Clinical Resource Management. Additionally, the responsibility for creating and implementing the MM Program’s infrastructure is delegated to the Medical Management Committee, co-chaired by the Assistant Medical Director for Clinical Resource Management and the Director of Accreditation and Resource Stewardship.

Assistant Medical Director for Clinical Resource Management
Responsibilities include the development and implementation of the Medical Management Program.

**Director of Accreditation and Resource Stewardship**

Responsibilities include the development and implementation of the Medical Management Program.

The Director of Accreditation and Resource Stewardship and the board certified physicians participating in the medical management process will collaborate and carry out the activities of the Medical Management Program. The Director of Accreditation and Resource Stewardship is responsible for managing the MM staff, which may include the following positions:

- Manager, Referrals Management and Clinical Review Services (including Referrals Management, retro review, pre-certification, targeted reviews, and durable medical equipment)
- Manager, Accreditation

**Chief of Behavioral Health Care Services (Senior Level Professional of BHS)**

The Chief of Behavioral Health Care Services (BHS) is the designated senior physician involved in the implementation of the behavioral health care aspects of the Medical Management Program. Additional responsibilities include:

- Designing and providing oversight of the use of clinically appropriate review criteria
- Involving BHS in the integration of care along the continuum
- Ensuring the triage of appropriate BH admissions to acute care facilities
- Ensuring the appropriateness and timeliness of BH care in the ambulatory environment

**IV. COMMITTEE GROUP STRUCTURE**

The Medical Management committee structure reflects the committee reporting structures across the Continuum of Care. (Appendix B)

1. **Senior Quality Council (SQC)**

   a. The SQC oversees all Medical Management Program activities. The MM Committee reports to the SQC on at least a quarterly basis.

   b. All policy, procedure, and program changes require the SQC’s approval.

   c. SQC may delegate additional responsibilities to the Medical Management Committee, as it deems necessary.

2. **Medical Management (MM) Committee**

The Medical Management Committee oversees the implementation of comprehensive, systematic, continuous processes of the Medical Management Program. The MM
Committee meets its program objectives in part by overseeing processes related to pre-service reviews, concurrent reviews, discharge planning, and post-service reviews of services performed for inpatient hospitalizations, emergency care, outpatient surgery, rehabilitation, home and hospice care. Selected services from outpatient, pharmacy, ancillary, and physician offices also are reviewed. The MM Committee monitors quality, continuity, and coordination of care. The Senior Quality Committee and Medical Management Committees work together on overlapping issues.

The MM Committee assumes accountability for resource stewardship on behalf of the members assuring services are well managed by making the most appropriate use of available healthcare resources. Sound utilization plans are defined, developed and executed by the MM Committee. The MM Committee oversees and monitors all delegated Medical Management activities.

The MM Committee establishes and maintains avenues of communication and networking among providers, staff, facility and health plan staff, and members.

Additionally, the MM Committee may review pharmaceutical service statistics, which are illustrated in cost and utilization analysis reports.

V. BEHAVIORAL HEALTH CARE

The Behavioral Health Department’s Utilization Management policies and procedures define appropriate use of outpatient and inpatient Behavioral Health Services. These procedures address triage criteria, admission criteria, discharge criteria, ongoing care as well as evaluation of sites of service and levels of care for Behavioral Health Services. Inpatient and Intensive Outpatient Services are reviewed by the BH Chief.

Appropriate clinicians are used for final determinations for all medical appropriateness decisions (psychiatrist, doctoral-level clinical psychologist, or certified addiction medicine specialist). Both the admitting physician and the BH consulting practitioner will coordinate care along the inpatient continuum.

Triage is performed by experienced clinicians with at least a master’s level degree in a mental health care discipline. Behavioral Health Services policy and procedure describes the standards for the triage process.

Mental Health

OPMG:

a. Members have direct access / self refer or can be referred by a physician for outpatient mental health services.

b. Once the mental health physician / provider determine an admission is necessary, the mental health admission is called to the KP HUB who collaborates with the BH Chief in applying appropriate admission criteria. The
KP HUB assigns the authorization number. The UM decision, patient demographics, and authorization number are entered into the KePRO UM system. KePRO staff then collaborate with the KP hospital-based teams to follow the patient for concurrent review and discharge planning.

c. The OPMG Mental Health hospital-based team rounds daily at our high volume hospital, Marymount Hospital, to provide ongoing case review and discharge planning. Inpatient Care Coordinators (IPCC’s), follow patients at our other contracted hospitals, providing ongoing case review and discharge planning.

**Affiliated Care Network:**

a. Members have direct access / self refer or can be referred by a provider for outpatient mental health services.

b. Once the mental health physician / provider determine an admission is necessary, the mental health admission is called to the KP HUB who collaborates with the BH Chief in applying appropriate admission criteria. The KP HUB assigns the authorization number. The UM decision, patient demographics, and authorization number are entered into the KePRO UM system. KePRO staff then collaborate with the KP hospital-based teams to follow the patient for concurrent review and discharge planning. Any specific clinical questions are addressed by the Chief of Behavioral Health. The Behavioral Health Case Managers perform ongoing review for these admissions using the Chief of Behavioral Health or Designee as a resource and final decision maker for medical appropriateness.

**Alcohol / Chemical Dependency (ACD)**

**OPMG:**

a. For outpatient services, members have direct access / self refer or have to be referred by a physician / provider, family member or Employee Assistance Program (EAP).

b. For inpatient services, once the mental health physician / provider determines an admission is necessary, the mental health admission is called to the KP HUB who collaborates with the BH Chief in applying appropriate admission criteria. The KP HUB assigns the authorization number. The UM decision, patient demographics, and authorization number are entered into the KePRO UM system. KePRO staff then collaborate with the KP hospital-based teams to follow the patient for concurrent review and discharge planning. Any specific unresolved clinical questions are addressed by the Director of ACD.

c. Extensions of stays are determined in consultation with the Director of ACD or designee
**Affiliated Care Network:**

a. For outpatient services, members have direct access / self refer or have to be referred by a physician / provider, family member or Employee Assistance Program (EAP).

b. Once the affiliated ACD physicians determine that an admission is necessary, the mental health admission is called to the KP HUB who collaborates with the BH Chief in applying appropriate admission criteria. The KP HUB assigns the authorization number. The UM decision, patient demographics, and authorization number are entered into the KePRO UM system. KePRO staff then collaborates with the KP hospital-based teams to follow the patient for concurrent review and discharge planning. Any specific unresolved clinical questions are addressed by the Director of ACD.

c. Extensions of stays are determined in consultation with the Director of ACD or designee.

**VI. DELEGATION**

When MM activities are delegated to contractors, the Health Plan maintains a documented evaluation of these activities. The letter of agreement for delegation of medical management activities includes:

1. The MM activities which are delegated, the responsibilities of the Health Plan, and the responsibilities of the delegated entity
2. The reporting requirements of the contractor to the Health Plan
3. The reporting requirements of the Health Plan to the contractor
4. The Health Plan’s evaluation process of the contractor’s responsibilities
5. The Health Plan’s approval of the delegated contractor’s MM program
6. The Health Plan’s mechanism for evaluating the contractor’s program reports
7. The Health Plan’s revocation and termination rights

The Health Plan performs a pre-delegation assessment to ensure the efficacy of pre-delegated UM functions. If an entity is found to be deficient in any functional UM area (pre-service, concurrent, post-service reviews, case management or discharge planning), the Health Plan will make a decision if it will partially delegate some UM functions versus completely delegate or not delegate to the entity. The final letter of agreement will stipulate those specific UM functions that are to be delegated and / or retained by the Health Plan. Currently the only delegation arrangements are with American Specialty Health Networks (ASHN) and KePRO.

Should there be any concerns regarding failure of an entity to carry out its delegated activities, the Health Plan will consider corrective actions up to and including revocation of the delegated activities. While the Health Plan will monitor delegated entities at least
quarterly, there is an annual review of the entities’ UM Program via the Delegated UM audit.

Oversight occurs through an annual on-site audit to determine compliance with current NCQA, state and federal standards, annual review and approval of the program description and program evaluation, and receipt of quarterly reports. ASHN onsite evaluation has been suspended due to that organization’s successful NCQA review and certification in the areas of credentialing and utilization management. Reports, utilization management (UM) information, and issues shall be reviewed and discussed with appropriate individuals from ASHN and the Health Plan. UM information shall be reported at least twice annually to the Medical Management Committee (MMC) and the Senior Quality Council (SQC). In the event that ASHN loses its certification by NCQA, onsite evaluations will resume.

**Scope of Medical Management Program**

Whether delegated or non-delegated, the Medical Management program will ensure that:

1. Services are medically necessary, quality-oriented, and delivered at appropriate levels of care in a timely manner, to ensure members’ safety. Application of the criteria used will be clearly documented and available, upon request to participating physicians.

2. Authorized care matches the benefits defined in the member’s health plan.

3. A mechanism for checking the accuracy and consistency of application of the criteria across the reviewers is present.

4. Documentation for case review and authorization / denial of services shows that efforts are made to obtain all necessary information, including pertinent clinical information, and consultation with the treating physician, as appropriate.

5. Determinations are made in a timely manner, and the medical urgency of each case is taken into consideration. The Appeals Department will assure that routine and expedited member / provider appeals will be investigated promptly, and a written response will be submitted to the concerned party within the designated time frames.

6. Health services will be provided by OPMG and the Health Plan’s contracted providers.

7. Utilization tracking and trending reports will be submitted on a regular basis to the Medical Management Committee, Care Delivery Council, OPMG and contracted providers. The data will be analyzed by the Medical Management Committee and the Care Delivery Council. The Committees will make recommendations for necessary corrective action based on the findings. After corrective action has been implemented, a re-evaluation will be done, and the Committees will review the results.

8. Scheduling is efficient for services and resources.
9. Guidelines, standards, and criteria set by governmental, and other regulatory agencies are adhered to as appropriate. Guidelines set by OPMG and MMC are also adhered to as appropriate.

10. Approved policies and procedures for the referral / authorization process and associated time frames will be implemented and monitored.

11. OPMG maintains compliance with the regulations set for the specific contracted member populations (e.g. Commercial, Medicare, and POS).

12. OPMG utilizes scientifically evidenced based criteria and informational resources to determine the appropriateness of healthcare services to be delivered. Non-physician reviewers screen and elevate cases for medical review only when criteria are not met. Only a physician can make the decision to deny service after conducting a review for medical appropriateness. Reasons for denial are clearly documented and available to the member. Notification to member and provider of a denial includes appeal process information.

13. Oversight of policy and procedure for pharmaceutical management including gathering clinical evidence for utilization, exception requests, therapeutic interchangeability, patient safety, timely response and pharmaceutical appeals processes is performed by the Pharmacy Utilization Management (PUM) Department.

14. Criteria for referrals management, pre-admission, inpatient care, outpatient care, discharge planning and post-service review are used as a resource in conjunction with the application of medical judgment which considers the individual’s care needs. Board-certified physicians (from the appropriate specialty areas of medicine, surgery, and behavioral health services) are utilized to review cases.

15. In the instance of a behavioral health adverse determination, a decision will be rendered by the appropriate licensed discipline (psychiatrist, doctoral-level clinical psychologist, or certified addiction medicine specialist).

16. A written Medical Management Plan will be submitted annually to the Kaiser Foundation Health Plan of Ohio.

17. The Medical Management Program Plan will be reviewed and approved, and if necessary, revised on at least an annual basis by the Medical Management Committee and Senior Quality Council. Policies and procedures will be reviewed biennially or more frequently if necessary.

18. The Medical Management Plan will include the effective processing of pre-service, concurrent and post-service review determinations by qualified personnel. Non-physician reviewers screen and elevate cases for medical review only when a criterion appears not to be met. The areas of review will include:

- Repatriations and authorizations for continued stays / admissions by OPMG Emergency Services
- Inpatient hospitalizations
- SNF admissions
- Outpatient surgeries
Selected outpatient services
Rehabilitation services
Selected ancillary services
Home Health Care services
Selected Pharmaceutical services
Selected Physician Office services (e.g. injections, minor surgeries on the pre-certification list)
Out-of-Network services
Durable Medical Equipment

19. The Medical Management Program will be integrated with the Quality Management Program, which further encompasses Risk Management and Patient Safety, to ensure continuous quality improvement and resource stewardship.

20. There are documented mechanisms to evaluate the effects of the program using member and provider satisfaction data, staff interviews, and / or other appropriate methods.

21. The appropriate communication services; toll free numbers, staffing, hours of operation and telephone answering standards will be maintained.

22. Interregional New Technology Committee (INTC) will assess the appropriate use of new or existing medical technologies. The INTC will include criteria which are established by qualified professionals.

23. Provider and member education will be offered, evaluated, and improved on a continual basis. Provider examples include the provider manual, provider website, “Provider Connection”. Member examples include kp.org, “Partners in Health”

VII. METHODOLOGY & CRITERIA

Decisions for referrals management and inpatient care are based on the following guidelines:

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<tr>
<th>Criteria</th>
<th>Explanation of Application</th>
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<tr>
<td>InterQual Intensity of Service / Severity of Illness (ISD) Acute Criteria (Adults and Pediatrics)</td>
<td>Hospitals / Acute Care Coordination (Med / Surg &amp; BHS)</td>
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<tr>
<td></td>
<td>- Pre-admission Screening</td>
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<td>- Continued Stay Reviews</td>
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<td>- Discharge Planning</td>
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<td>- Non-physician reviewers screen and elevate cases for medical review</td>
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<td>Milliman USA Optimal Recovery Guidelines</td>
<td>Outpatient Care Coordination</td>
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<td></td>
<td>- Surgical Procedures / Treatments</td>
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<tr>
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<td>Inpatient Care Coordination</td>
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• Length of Stay Efficiency (Benchmark) – Med / Surg & BHS
• Clinical Pathways (e.g., Congestive Heart Failure, Chronic Obstructive Pulmonary Disease and Community Acquired Pneumonia)
• Non-physician reviewers screen and elevate cases for medical review

KP Ohio: Clinicians’ Clinical and Preventive Guidelines

Outpatient Care Coordination

• Referrals to Specialty Care
• Referrals to Outpatient Treatment / Procedures (Select Procedures)
• Referrals to Outpatient Diagnostics
• Bariatrics
• Mammoplasty

Medicare Regulations

Inpatient Care Coordination

• SNF, Inpatient Rehabilitation

Outpatient Care Coordination

• DME, Home Care, IV Drugs, other Drugs / Treatments
• Long Term Acute Care (LTAC)

American Society of Addiction Medicine (ASAM) Patient Placement Criteria

Level II Adult Admission Criteria

KP National Transplant Network

Patient selection and site selection criteria

Interregional New Technology Committee

Monitors and evaluates new and new applications of existing, medical and behavioral technologies as well as the medical appropriateness of these technologies based on demonstrated safety, efficacy and comparative utility.

When the INTC determines that a medical technology is appropriate, it makes a recommendation to senior management in each region to consider the technology medically appropriate and how its new status might impact the coverage benefits in the region.

For health care provided in the KPO Medical Office Buildings (MOBs) by KFHP and OPMG employees, medical management utilizes a care-coordination approach. OPMG physicians work collaboratively with their peers to ensure appropriate treatment plans and clinical resource stewardship. Outpatient service requests generated at the MOBs...
are reviewed and approved by clinically appropriate OPMG providers prior to an external referral occurring.

For care delivered at KFHP affiliated hospitals by OPMG or OPMG affiliated providers, MM and KePRO provide pre-certification for commercial, Point of Service, and Medicare requests for specific services including but not limited to:

- All inpatient admissions
- Acute inpatient rehabilitation admissions
- Ambulatory surgeries / procedures in affiliated hospitals
- Ambulatory / specialty referrals in affiliated networks
- Skilled nursing facility admissions

Concurrent review and care management is a collaborative process between OPMG, affiliated providers, KFHP, and KePRO. The final disposition regarding a member’s treatment plan rests with the attending physician. All OPMG and affiliated providers are expected to follow the established medical management procedures and to continue treatment plans to ensure appropriateness of care and resource stewardship.

**Milliman USA**

The Milliman USA Healthcare Management Guidelines (HMGs) and Optimal Recovery Guidelines (ORGs) were developed with the utilization philosophy of rationalized healthcare, NOT rationed healthcare, through active healthcare management and responsibility for the use of available healthcare resources. The HMGs are a result of state-of-the-art quantitative and retrospective analysis and assessment research of medical management programs and procedures. The research team was led by physicians and clinical experts with the assistance of other healthcare workers, healthcare institutions / facilities and health actuaries. This same group of professionals assists with the ongoing updating of the HMGs and ORGs and believes that this program promotes responsible, active, optimal medical management, which insures high quality and efficiency across the continuum of care. Additionally, these tools span the entire medical and cost management fields to work toward integrating the highest level of care in risk management and medical management. Preparation for use of the HMGs was completed by qualified medical and risk management professionals. The HMGs and ORGs are reviewed at least annually by designated Milliman USA professional staff and updated as indicated.

**InterQual Guidelines**

The InterQual criteria are widely used for utilization and management of inpatient healthcare resources, appropriateness of medical and surgical diagnostics and procedures and guidelines for physician specialty referral. InterQual is a division of the Information Technology Business of McKesson (formerly known as McKesson HBOC, founded in 1976). The guidelines are developed by generalist and specialist physicians representing a national panel from academic as well as community-based practice. These physicians and nurses research medical literature and existing guidelines to prepare initial drafts. The drafts are reviewed by an extensive panel of teaching and
practicing physicians, incorporating client feedback. The InterQual staff refines the drafts to establish a national consensus of best practice. The guidelines are updated and released annually.

InterQual’s criteria sets guide decision making for levels of care such as intensity of service, severity of illness and discharge screens for the Acute Care setting in both adult and pediatric cases. Benefits include: 1) facilitation of admission or transfer to appropriate settings of care; 2) efficient medical decision making by presentation of scientifically valid guidelines; 3) defensible strategy for uniformity of actions recommended and taken; and, 4) standardization of objective, measurable parameters for consideration by payors, physicians and case managers.

Additionally, these criteria include admission; concurrent and discharge review criteria, which demonstrate the appropriateness of critical or acute care, based on assessment of a patient’s clinical status. These criteria are composed of objective and comprehensive clinical findings, corresponding medical and other professional interventions typically provided at the proposed care setting. Lastly, clinical indicators reflecting readiness for safe discharge are included. Non-physician reviewers who utilize these guidelines screen and elevate cases for medical review.

**Medicare Guidelines**

Medicare Guidelines are developed by Centers for Medicare and Medicaid Services (CMS) and are used for determination of skilled needs for skilled nursing facility care, home care, rehabilitation, durable medical equipment (DME) and in any other applicable situation.

**American Society of Addiction Medicine**

The American Society of Addiction Medicine (ASAM) guidelines are the most widely used and comprehensive national guidelines for placement, continued stay and discharge of patients with alcohol and other drug problems. ASAM members are physicians from all medical specialties and subspecialties. They are engaged in private practice, serve as corporate medical directors, and work in group practice or other clinical settings. A number are also involved in research and medical education. ASAM has its roots in research and clinical traditions that pre-date its founding in the early 1950’s, when physicians interested in alcoholism and its treatment began to meet regularly. ASAM has also been known under the following corporate titles: the New York City Medical Society on Alcoholism, the American Medical Society on Alcoholism, and the American Society on Alcoholism and Other Drug Dependencies.

All criteria are reviewed, revised (as appropriate) and approved on at least an annual basis by the Medical Management Committee. Participating OPMG and contracted providers, including behavioral health practitioners outside of the Medical Management Committee assist in the development, review, revision and acceptance of the criteria. The criteria are available upon request to all participating providers.
**Referrals Management**

All KPO members are provided the opportunity to select a Primary Care Physician (PCP) as their personal physician who manages their care and coordinates any specialty needs of the member. PCPs (include Family Practice, Internal Medicine and Pediatric physicians) are responsible for initiating written referrals for specialist care (OPMG specialists and affiliated specialists).

All referrals are checked for eligibility and benefits as part of the decision making process. Systems / screens used to check eligibility and benefits include:

- Membership / Eligibility screens
- Benefit screens

Additional information considered in the decision-making process to determine medical appropriateness and level of care includes age, co-morbidities, complications, progress of treatment, psychosocial factors, home environment, and availability/characteristics of the local delivery system.

1. **Internal Referrals Management:**

An internal referral is made from an OPMG-employed physician or affiliated physician to an OPMG-employed physician.

Internally each OPMG and affiliated medical office provider is responsible for initiating an internal referral through KP Tapestry / KP HealthConnect.

- If a referral is needed to a specialist physician, the requesting physician contacts the specialty department via order entry in KP Tapestry / KP HealthConnect.
- The members' order is routed to the Member Service Center to make an appointment with the specialist. If access is limited, a telephone call may be made to the member to arrange an appointment.
- Once the specialist has seen the patient, feedback is provided by electronic means to the referring provider to communicate recommendations or further treatment.

2. **External Referral Management**

An external referral is a referral from an OPMG employed physician to a non-OPMG specialist.

**OPMG**

- The OPMG Physician electronically sends the referral request to the Department Chief or Physician Advisor of the respective specialty to review
for medical appropriateness and to recommend / determine the appropriate setting for the service to be provided.

- If the service cannot be provided internally, the respective Chief or designee approves the referral electronically and then routes to the referral specialist pool for processing.

**Network Affiliated Physician**

- The Referring Physician sends the referral request to the Referrals Management Clinical Review (RMCR) department to review for medical appropriateness and to determine the appropriate setting for the service to be provided.

- The request is reviewed for member eligibility, benefits, established auto approval guidelines established by KPO, and / or targeted review. Referral is also reviewed for adequate information.

- Authorization of the referral is performed if member meets the five rights: 1) member eligibility; 2) service requested is a covered benefit; 3) level of care requirements are met; 4) service requested is medically appropriate; and 5) service requested can be delivered at the right time.

- If approved, RMCR processes the referral. If the referral does not meet medical criteria the case is referred to the appropriate clinical Physician Reviewer who makes all final decisions regarding medical necessity. Options for redirection are offered to the referring physician by RMCR. The referring physician has the option for reconsideration by the Physician Reviewer who made the decision and / or to appeal the decision through the member appeal process.

**In-Patient / Alternative Care Coordination**

The KP MM Department is responsible for performing and managing the activities related to the UM functions for which it is responsible. In addition, MM Department is charged with oversight of KePRO’s pre-certification, continued stay review, and discharge planning for all designated In-Plan inpatient and out-patient services. Personnel responsible for ongoing review and management include:

- Director of Accreditation and Resource Stewardship
- Vice President of Quality and Service
- Assistant Medical Director for Critical Care & Hospital Services
- Assistant Medical Director for Clinical Resource Management
- Manager, Inpatient Care Coordination (IPCC) (acute inpatient and SNF)
- Manager, Referrals Management and Clinical Review, DME
- Regional Director of Acute Care and Critical Services
- Manager, Appeals, PCM / CMI
Various processes are used to manage clinical resources in the hospitals and alternative sites:

1. KePRO provides designated delegated UM services for KPO. KePRO nurses apply the appropriate clinical criteria / guidelines (InterQual, Milliman USA, Medicare guidelines, ASAM, and internally developed criteria) to each request to evaluate medical appropriateness. The KePRO Physician Director or designee provides medical supervision for KePRO activities. In all cases, final determination of medical necessity rests with the Physician Reviewer from the appropriate clinical discipline.

2. The RMCR nurses, Inpatient / SNF Care Coordinators, Home Health Care nurses and / or the individual hospital staff, along with the OPMG Physicians, Physician Extenders and / or Affiliated Physicians provide the patient care management / coordination, continued stay review, and discharge planning. The MMC reviews the affiliated hospitals’ standard utilization reports.

Discharge activities are coordinated with the health care team, patients and family members as appropriate. Every effort is made to proactively prepare the hospitalized patient and his / her family regarding the treatment plan and post-hospital continuing care needs and plans. Only a Physician Reviewer has the authority to make determinations on medical necessity.

3. KPO operates two Emergency Service areas; one at the Parma Facility and the other at the Cleveland Heights Facility. Each has an attached Clinical Decision Unit (CDU), which is a dedicated observation unit. OPMG developed ED Guidelines and CDU Admission Criteria to facilitate appropriate CDU admissions from the plan-operated ED. A dedicated Physician works closely with the ED staff and Chief to oversee the CDU patient population, coordinate appropriate levels of care and facilitate appropriate admissions to the hospital and discharges from the CDU.

Emergency services may be provided through contracted or non-contracted hospitals. Members are encouraged to go to the nearest emergency room in the event of a life threatening event. KPO provides coverage for emergency services as defined by Federal prudent lay person language.

4. The KP HUB and KePRO are notified of any out-of-plan (OOP) admissions. During the OOP admission, the HUB physician determines the medical necessity of the in-patient admission, performs repatriation review, coordinates transfers, and coordinates with KePRO to facilitate the in-patient stay review process. During this time, the HUB and / or KePRO facilitate physician-to-physician communication and utilize the appropriate Physician Reviewer for care management planning and decisions.
5. For OPMG managed affiliated skilled nursing facility admissions, there is a dedicated rounding team comprised of physicians and licensed physician assistants. They are responsible for managing and coordinating care. They work with KePRO (for commercial members) and KPOH Medical Management (for Medicare members) who is responsible for pre-certification, continued stay reviews and discharge planning. The Chief of Geriatric Services and SNF Care supervises the physicians and licensed physician assistants on the rounding team either telephonically, electronically or in person. Appropriate InterQual or Medicare criteria are used to determine skilled needs and medical appropriateness.

6. If KePRO and / or the IPCC RN evaluates that a member's medical condition, based on the medical appropriateness criteria, meets criteria for an alternative or different setting of care than has been requested, he / she discusses the alternative setting with the requesting provider. If the alternative setting is not accepted, the provider is referred to the KePRO Medical Advisor for review of the requested service. Appropriate InterQual or Medicare criteria are used to determine appropriateness for skilled needs in a skilled nursing home, but the final decision rests with the physician.

7. The KPO Home Care Department provides consultation for Home Care, IV Therapy and Hospice referrals. Medicare criteria are used to determine skilled needs and medical appropriateness for Home Care, IV Therapy and Hospice services. For all activity within the Home Care Department the nurses and / or social workers provide appropriate concurrent review, case management and discharge planning. The Associate Medical Director or designee provides medical supervision to the Home Care Department.

VIII. APPEALS PROCESS

Hospitals, Continuum of Care, Referrals and Redirection of Care

The Assistant Medical Director for Clinical Resource Management, clinically-appropriate specialists, including Behavioral Health are designated as physician reviewers for requests for services deemed not to be medically appropriate. Any appropriate behavioral health reviewer (physicians and / or non-physicians) can make all determinations about medical appropriateness.

All denial notices for medical appropriateness include the reason why the service request was denied, availability of the criteria used in the decision making, reconsideration rights, appeal rights, and an explanation of the appeal process.

Initial Determination for Provider Requests:

a. The RMCR Nurse reviews the request for medical appropriateness. If the request does not meet medical appropriateness based on criteria, then the nurse notifies the Assistant Medical Director for Clinical Resource Management for
review. The Assistant Medical Director for Clinical Resource Management may consult with an appropriate specialist as necessary.

b. The Assistant Medical Director for Clinical Resource Management reviews clinical information prior to making a determination on medical appropriateness.

c. If a denial is appropriate, this decision will be communicated, along with reconsideration and appeal rights, per regulatory timeframes. Reconsideration and appeal language is communicated to the respective practitioner(s) and member within two (2) business days of the decision via electronic / written notification.

d. All adverse determinations based on medical appropriateness are made by a clinically-appropriate physician / specialist.

e. Decisions are made within 15 calendar days of receipt of the request or sooner if the member’s condition requires a more immediate response.

Reconsideration of Decision following Initial Determination Denial

a. A practitioner or a health care facility has an opportunity to request, on behalf of the member, a reconsideration of an adverse determination. Except in the case of an urgent pre-service or concurrent request, a signed written authorization from the member must be obtained, authorizing the practitioner or health care facility to act on the member’s behalf, prior to pursuing reconsideration as required by the state of Ohio.

b. Reconsiderations are conducted between the practitioner or health care facility and the reviewer who made the adverse determination.

c. Decisions on the reconsideration are made within three (3) business days after receipt of the written request for reconsideration.

d. The decision is made sooner if the seriousness of the medical condition of the member indicates a need for a more prompt decision.

e. An appeal is available if the reconsideration does not resolve the difference of opinion.

Practitioner/Provider Appeal Process

A practitioner may appeal a pre-service, an urgent pre-service, or a post-service initial adverse determination (in which the member is financially at risk) on behalf of the member.

1) Signed written authorization is no longer required if the requesting party is the treating provider.
- When a non-contracted physician or provider seeks a standard post-service appeal, then the non-contracted physician or provider must sign a ‘Waiver of Liability’ (WOL) form, whereby the physician or provider formally agrees to waive any right to payment from the enrollee for a service regardless of the Plan’s decision.

2) Upon receipt of a signed WOL, the Member Appeal Process is followed. Any contracted practitioner / provider may appeal a post-service initial adverse determination (in which a member is not financially at risk) without member authorization.

1) Appeals Unit Coordinator reviews appeal documentation and contacts practitioner / provider for additional information as needed. The case will be overturned or presented before the Benefit Advisory Council (BAC).

2) If initial decision is overturned, the Appeal Coordinator notifies the practitioner / provider in writing of the decision, and processes the request per department procedures.

3) If the initial denial is upheld, a response is sent to the appealing practitioner / provider in written form which contains the reasons for denial, within five (5) business days of the decision.

4) Appeal decisions are made within 90 calendar days of receiving the request.

**Members’ Initial Determination and Appeals:**

**Initial Determinations**

- Members are notified of adverse determinations, except for concurrent or post-service determinations when the member is not at financial risk.

- A clinically appropriate physician or behavioral health clinician is involved in all initial adverse determinations based on medical appropriateness.

- All adverse determination notices include the reason why the service request was denied, availability of the criteria used in the decision making, appeal rights and explanation of the appeals process.

- Members are notified in writing of the initial adverse determination that includes the reasons for the initial adverse determination and all appropriate appeal rights and explanation of the appeal process within two (2) business days of the decision or sooner as appropriate to the situation. Denials issued by KP Ohio Medical Management will include the KPO Appeals address. Denials issued by KePRO will include the KePRO Appeals address.
Member Appeals

- KP Ohio has one internal level of appeal for members. KePRO will also provide one internal level of appeal for KPO members. Appeal resolution will occur within the following timeframes:
  - For appeals of adverse standard pre-service determinations – 30 calendar days of receiving the request
    o for appeals of adverse standard Part-D prescription drug coverage requests – 7 calendar days of receiving the request
  - For appeals of adverse urgent pre-service, urgent concurrent or expedited Part D prescription drug coverage determinations – 72 hours of receiving the request
  - For appeals of adverse post-service determinations
    o For appeals of adverse Part-D prescription drug claims – 7 calendar days of receiving the request
    o For appeals received by Federal employees – 30 calendar days of receiving the request
    o For appeals received by Commercial and Medicare members – 60 calendar days of receiving the request

- Member appeals are received in writing (or orally in the case of expedited appeals) and coordinated within the appropriate KP Ohio Appeals Unit or KePRO Appeals Unit.

- The reason for the appeal request is thoroughly documented along with any actions taken. This is followed by a thorough investigation of the reason for the appeal.

- Member appeals to KePRO are reviewed by a member of the KePRO appeals staff.

- All KP Ohio appeals follow one of the following three processes:
  - Medical Advisory Council (MAC) – makes a determination on appeals that are based on medical necessity. The MAC is comprised of board-certified, actively practicing physicians. Members of the MAC are not involved in the initial determinations, nor are they subordinates of those involved in initial determinations. Appropriate specialists or behavioral health practitioners are consulted in cases that require specialty review for which no member of the council has the clinical expertise or experience. The MAC meets twice monthly to review cases that are appealed. The decision to either uphold, partially uphold, or overturn an appeal is determined by a majority vote by the MAC.

    - Part D prescription drug redetermination requests are reviewed as necessary by a board-certified physician with expertise in the field of medicine that is appropriate for the benefits at issue.
- Benefits Administrative Advisory Council (BAC) – makes a determination on the appeals based on administrative (i.e. benefits, eligibility, etc.) matters. The council is comprised of a representative from the following departments: Compliance, Contracts & Benefits Specialist, Network Management, Claims and Customer Relations. The BAC meets every week to review cases that are appealed. The decision to either uphold, partially uphold, or overturn an appeal is determined by majority vote by the BAC.
- The Appeal Coordinator may overturn a system-generated denial based on the result of their appeal investigation. (Only the MAC or BAC can uphold a denial).

- The member has the opportunity to be represented by someone of his / her choosing including an attorney or practitioner. A signed appointment of representation is required. The ‘Appointment of Representation’ form must be signed by the member as well as the individual accepting responsibility as the authorized representative. Members or their appointed representatives may present their appeal to the appropriate council telephonically.

- Medicare members have the right to appear before the council reviewing the appeal or attend via telephone conference call or other appropriate technology. Non-Medicare members are afforded the right to attend via telephone conference call. Due to the short time frame of seven calendar days, this allowance is not afforded to members who are appealing Part D prescription drug claims.

- During the investigation if any new information is discovered, which may lead the Appeal Review Councils to uphold the denial, the member MUST be provided with the information PRIOR to the committee’s decision-making process. This information must be shared with the member so as to allow them time to present an appropriate rebuttal prior to the decision being made. This does not change the case-completion time requirements as stated above. This rule applies to appeals handled by both KePRO and KP Ohio Appeals Unit.

- Members are notified in writing of the decision within five (5) days of the determination, or within the established time frame for pre-service, expedited pre-service or post-service appeal requests, whichever occurs first. Written notification will include diagnosis code, date of service, and applicable treatment codes.

- When the committee does not overturn an initial denial for a Medicare member, the case is automatically forwarded to an Independent Review Entity (IRE) for review and determination. If a redetermination request for a Part D prescription drug benefit is upheld in whole or in part, the member must initiate the external review through the IRE independently. NOTE: Any UPHOLD decision issued by KePRO, on a case involving a Medicare Primary member, will be forwarded to the KP Ohio Appeals staff where the CMS IRE case file will be completed for submission.
• Non-Medicare members with adverse determinations are given further rights to appeal to an external independent review organization as appropriate.

Expedited Appeals

There is a 72-hour expedited member appeals process for all members. The process is in accordance with NCQA standards and the CMS Rules and Regulations. The process is documented in the Appeals Unit policies and procedures. The expedited appeal may be initiated by the member, a member representative, or by a practitioner acting on behalf of the member.

The decision is made no later than 72-hours after the appeal request is received and the member and practitioner are notified of the decision. Written confirmation is provided within three (3) calendar days of the oral notification and includes the pertinent external review rights along with instructions on how to make an external review request.

Every effort is made to satisfy the members, practitioners, and providers, and to proactively communicate with and prepare the provider, member and his / her family regarding the treatment plan and post-service continuing needs.

Conflict of Interest

Physicians and non-physicians may not participate in the appeal review process of any case in which they have been involved in the planning or executing of the original treatment plan. Physicians and non-physicians having either a direct or indirect financial interest in the hospital or case(s) being reviewed may not participate in the medical management decision activities concerning those cases. Kaiser Permanente does not offer incentives or additional compensation directly to physicians or other individuals conducting medical management activities in return for denial of care.

IX. PROVIDER AND MEMBER SATISFACTION

At least annually, information is gathered from members and practitioners to evaluate KPO’s medical management performance and the value that it has for the Ohio Market. The CAHPS report is reviewed annually. The results are reviewed for opportunities and presented to the MMC with appropriate actions taken to address the opportunities.

X. RISK MANAGEMENT / PATIENT SAFETY

Patient safety and risk management have remained integral components of Kaiser Permanente’s intent to provide high quality and efficient healthcare. Activities within the Medical Management Program are routinely monitored and evaluated to ensure that care is
delivered in a safe manner, which takes into consideration the appropriateness of care, the timeliness the care is delivered, and the setting in which the care is delivered. All practitioners, managers, employees and affiliates are responsible for patient safety as well as the identification of vulnerabilities for risk.

In order to achieve excellent performance in the safe and effective delivery of health care, the Medical Management program will ensure that:

- a unified patient safety culture is embraced as a shared value
- an environment that encourages responsible reporting of near misses and errors, and that looks to fix systems and not blame individuals is established and maintained
- priorities that optimize resource stewardship in the implementation of patient safety performance improvement strategies and risk reductions are established
- on-going identification, sharing, and implementation of best practices from other parts of the organization and other industries exist
- physicians and non-physician employees participate in routine patient safety, risk reduction and error prevention training and education
- relevant and meaningful monitoring and reporting of indicators and outcomes, which guide continuous improvement and validate success is maintained

XI. CONFIDENTIALITY

To assure that patient and provider confidentiality is protected all copies of MM related data and documents are maintained by the RMCR and Appeals Unit Departments in a confidential manner. Access to this information is restricted based on the need to perform the committee or department’s work as outlined in HIPAA. Confidentiality statements are signed by OPMG and Health Plan staff per the frequency established by the Compliance Department.

XII. PLANNING AND EVALUATION

Annually, the Assistant Medical Director for Clinical Resource Management, the Director of Accreditation and Resource Stewardship, the Manager of Inpatient Care Coordination, the Manager of Referrals Management and Clinical Review, the Manager of Appeals and the Manager of Care Management assess performance against the previous year’s Work Plan including satisfaction measures. The Annual Evaluation is reviewed by the Medical Management Committee and approved by the SQC.
The MM Plan is reviewed / revised annually in the first quarter by appropriate management staff from KFHP and OPMG and approved by Medical Management Committee. Final approval is provided by SQC.

Planned activities for the next year are incorporated into the overall KPO Work Plan, which is approved by SQC and incorporated into the Strategic Business Plan. Identified problems and activities from the previous year, which are not completed are added to the revised Work Plan to ensure continuity of the planned activities.

### XIII. NEW TECHNOLOGIES AND INNOVATIONS

Kaiser Permanente of Ohio participates in Kaiser Permanente’s National Interregional New Technologies Committee. Minutes from the meetings are available to all KP regions via KP Online.

The Interregional New Technologies Committee (INTC) was formed in 1984 and is charged with the responsibility of monitoring and evaluating selected medical technologies on behalf of the entire Kaiser Permanente program. The committee includes physicians, senior health plan or hospital managers, staff attorneys, a consulting medical ethicist, a representative from the Care Management Institute, a director of pharmacy operations and the Chair of the Ohio Medical Management Committee or designee.

In rendering a determination for new technology requests, the Medical Management Committee and the Ohio Permanente Medical Group considers any reviews conducted by the National Interregional New Technologies Committee reported in quarterly meeting minutes, regarding a new service, consults evidence-based scientific medical literature, assesses the information available from government regulatory bodies regarding the service, and consults with independent medical experts as needed.

The Medical Management Committee will forward its recommendations about new technology to the Ohio Benefits and Scope of Service Committee (BASS).

The Ohio BASS may review the INTC minutes and local decisions when considering new technology inclusion into the benefit structure.

### XIV. MEDICAL MANAGEMENT COMMITTEE

The Medical Management Committee (MMC) has been established as a standing committee.

**Structure / Membership:**

The MMC is co-chaired by the Assistant Medical Director for Clinical Resource Management and the Director of Accreditation and Resource Stewardship. Committee membership includes Executive Leadership, Medical Management staff (Managers and
Directors), Physicians of Medical Management, (Physician Advisor, BHS, Hospitalist, SNF, Quality, Emergency Services, Medical Advisory Committee and Appeals).

Representatives from the Claims, Health Plan Operations, Medical Operations, Provider Relations, and Contracting Departments may be asked to attend the meetings on an ad hoc basis.

A quorum will be present at each meeting. (A quorum consists of at least fifty percent plus one of the committee membership.) The MMC will meet at least quarterly. Additional Committee meetings may be scheduled at the discretion of the MMC Chairs.

Behavioral Health

Because of the specific expertise required for behavioral health care, a board-certified behavioral health provider or designated liaison is included in all Medical Management Program functions and activities as listed below.

Purpose and Functions:

The MMC oversees the timely development and implementation of the Medical Management program, which includes the following:

Development of a program, which oversees the delivery of high quality care to members in the most cost-effective manner.

Determination of authorization for services, which reflect effective and efficient utilization practices. (Resource Stewardship)

Annual review and revision (as appropriate) of all aspects of the Medical Management Program including the Medical Management plan, policies and procedures, annual report summary, and utilization guidelines.

- Oversight of the development and implementation of Medical Management policies and procedures.
- Development and implementation of an annual utilization management plan.
- Application of the OPMG approved protocols and guidelines for authorization determination while acknowledging differences for each case.
- Obtaining contracted provider feedback regarding the effectiveness of the MM Program.
- Evaluation of measurement tools, which ensure that protocols and guidelines are interpreted similarly among the reviewers.

4. Oversight of provider compliance with Medical Management standards, and OPMG standards.
5. Identification and investigation of specific and general utilization management issues especially in relation to trending patterns by providers, resource utilization, access, and performance.

6. Monitoring of the resolution of resource utilization issues and overseeing the process of assessment, conclusions, recommendations, actions and follow-up evaluation.

7. Referral of quality issues to the Quality Management Committee for review.

8. Facilitation of effective Medical Management networking between OPMG and the contracted hospitals and health plans.

9. Serve as a review group to assist in the interpretation of medical benefit coverage associated with the delivery of necessary and appropriate services.

10. Contribute to education programs for OPMG providers, staff, and members.

11. Provide approval of the documented minutes of any actions or decisions made by the MMC.
   - Assure that minutes accurately reflect the activities of the MMC meetings.

12. Develop subcommittees and specialty task forces, as needed, to assist the MMC by:
   - Obtaining provider feedback regarding the MM program and Medical Management issues
   - Analyzing provider utilization, developing or revising utilization guidelines, and delineating various provider roles
   - Monitoring referrals to non-contracted providers and facilities
   - Developing criteria for outcome and focus studies
   - Assisting in the process for evaluating new and existing technologies

13. The content of the MMC meetings will be kept confidential and all members will sign a confidentiality statement.

14. The MMC will report to the SQC at least on a quarterly basis.

**Medical Management Committee Meeting / Minutes:**

The approved minute’s format will be utilized for the minutes taken at each of the Medical Management Committee meetings. The minutes will include a list of the members present, those absent, and the names of guests present at the meeting. The minutes will follow the agenda item topics, and the summary will include the key points discussed for each item. The discussion highlights and summary will also include the Committee’s recommendations, actions taken, and the schedule of follow-up activities. Documents or handouts presented at the meetings will be labeled and included as
attachments to the minutes. All minutes will be reviewed, revised and approved by the MMC.

XV. MEDICAL ADVISORY COUNCIL (MAC)

The Medical Advisory Council (MAC) functions as a sub-committee of the Medical Management Committee to oversee medical appeals, and to develop, implement, and monitor evidenced-based medical management principles. The MAC handles medical appeals based on medical necessity, whereby a member is appealing an adverse determination.

DEFINITION:

Medical necessity is the determination that an intervention recommended by a treating practitioner is (1) the most appropriate available level of service for the individual in question, and (2) known to be effective in improving health outcomes.

FUNCTIONS:

1. The MAC will be chaired by a board-certified, practicing, licensed physician, who is a medical group member in good standing with Ohio Permanente Medical Group, Inc.

2. The MAC Chairman may decide the outcome of an appeal, if it is within his medical practice scope or experience to do so. When an appeal involves issues not within the medical experience or practice scope of the Chairman, the MAC Chairman will consult with a panel of Board-certified physician who:

   • has had medical experience and knowledge to manage the appeals request
   • was not involved in the care or treatment of the member
   • was not involved in the initial determination of the health request or internal appeal
   • has greater expertise or higher hierarchical responsibilities than the practitioner in question, involved with the initial determination of the health request or internal appeal

3. The constituents of the MAC panel may include two additional practitioners.

The MAC will meet as often as necessary to assure that all appeals are reviewed within timeframes set forth by regulatory and accrediting bodies. (Usually 2 times / month)

The MAC will provide a thorough review of the medical appeal and submit the final internal decision for the appeals request to the Appeals Unit. If the MAC deems it necessary to have additional information provided in order to adjudicate the appeal, a request will be made through the Appeals Unit. The goal is to have the information necessary to ensure a thorough review of the appeal.
Appeal requests that are expedited or concurrent will be managed within 72 hours.

Each MAC member or advisor shall have one vote. If a MAC member or advisor on the matter is unwilling or unable to vote, he / she shall abstain from voting. If the MAC member or advisor is not qualified to vote (not meeting criteria as indicated above), he may not vote.

A majority vote shall carry the decision of the appeal. A record of the total vote will be maintained. In the event of a tie vote the appeal will be elevated to the AMD.

At least quarterly, the MAC Chairman shall provide a report to the Medical Management Committee regarding the MAC activities.

XVI. MEDICAL MANAGEMENT INTER-RATER RELIABILITY TESTING

KPO conducts periodic inter-rater reliability activities for Medical Management staff involved in the actual utilization review process. The purpose of the activities is to assure the reviewer’s comprehension of the clinical practice guidelines and to ensure accurate and consistent application of the criteria among the reviewers.

The MM staff, physicians and non-physicians, involved in application of criteria for UM decision-making may be given written scenarios to evaluate their knowledge and consistency of appropriate application of the OPMG approved clinical practice guidelines and criteria. Other activities may include education at staff meetings, case review sessions, or frequent joint consolidation. This evaluation will occur no less than annually.

Procedure (If testing activity is used):

1. A controlled study will be issued to all MM physicians and nurses involved in UM decision making during the year.

2. Any variables will be reported to department Managers, the Director, Accreditation and Resource Stewardship, Assistant Medical Director for Clinical Resource Management and the Medical Management Committee.

3. The staff will be tested in the areas of:
   a. Referral authorizations (including specialty care, in-office procedures, rehabilitative, DME, and outpatient services)
   b. Inpatient hospital, skilled nursing facility, and home health/hospice admissions
   c. Emergency services
   d. Pharmacy Utilization Management

4. If reviewer performance is not satisfactory, mandatory training will follow and a re-evaluation (test) will be conducted.
5. The testing methods utilized may include daily rounds or mock cases, which simulate actual clinical situations.

- The cases will be presented, and for each case the staff member will give appropriate description of the application of the criteria and a complete review process.

XVII. PHARMACEUTICAL MANAGEMENT

INTRODUCTION

The Regional Pharmacy and Therapeutics Committee (P&T Committee) is responsible for the development and surveillance of medication therapy and utilization policies and practices in the Ohio Region. Committee membership includes representatives from the medical group, pharmacy administration and operations, clinical pharmacy services and nursing. At meetings held bi-monthly, requests for additions / deletions to the Regional Drug Formularies are reviewed and recommendations made. Drug use criteria, pharmacy policies and procedures and patient safety data such as adverse drug reactions and dispensing errors are also reviewed for trends and opportunities to improve at these meetings. Information and decisions made by the P&T Committee are communicated via the Drug Therapy Advisory, a publication distributed to all internal and network providers and pharmacies. Policies concerning pharmaceutical management are included in the Drug Formulary which is available on the Ohio Intranet and the internet. Member formularies are also available on the public website, through Customer Relations or at any KP pharmacy on request.

OPERATIONAL PRACTICES

- Pharmacy policies and procedures and other documents address pharmaceutical management, drug benefits, patient safety and medication storage / security practices, including:
  
  1.6 Pharmacy & Therapeutics Committee
  
  1.7 Formulary
  
  1.8 Formulary Changes
  
  1.9 Therapeutic Interchange
  
  1.11 Formulary Exception Process
  
  1.12 Brand / Generic Tiered Benefit
  
  1.13 Generic Drugs
1.14 Tablet Splitting
1.15 Dispensing Error Reporting Program
1.16 Pharmaceutical Sales Representative Privileges
1.18 License and Certification Verification
1.20 Use of Protocols
3.5 Clinical Screening Parameters
4.1 Pharmacy Benefits Reference Table
4.3 Supplemental Prescription Benefit
4.5 Durable Medical Equipment
7.1 Pharmacist - Managed Care Services
7.5 Medication Storage
7.19 Diabetic Supplies – Pharmacist Renewal
7.22 Prescription Processing
7.26 Drug Interaction / PAR Screening
9.11 Drug Recalls

ADDITIONAL TARGETED PHARMACY ACTIVITIES

- The Clinical Pharmacy Services staff (including the Formulary Management Services and Pharmacists), Pharmacy Administration, ambulatory care clinical pharmacy specialists in all KP facilities in partnership with OPMG physicians are involved in either the development and implementation (or both) of all national and regional drug utilization management initiatives.

- Pharmacist - managed care services include anti-coagulation, growth factor, cholesterol, pain, cardiovascular risk and medication therapy management. Therapeutic decision making and other care provided for patients enrolled in these services is supervised by OPMG physicians and is managed by pharmacists and nurses with specialized training. Pharmacists are authorized by Ohio state law to make drug therapy adjustments using consult agreements where designated by service policy and where signed by the patient, physician and pharmacist. In services where pharmacists are not utilizing consult
agreements, all care is approved and authorized by the patients’ healthcare providers.

- Primary care ambulatory care clinical pharmacists develop, implement and provide pharmaceutical care as a member of our primary care teams. This includes optimizing drug therapy outcomes by providing high quality, cost-effective health care; influencing prescribing behaviors; identifying, preventing and resolving drug related problems; and educating health care personnel regarding drug therapy.

- Staff pharmacists and technicians in all KP facility pharmacies take an active role in quality initiatives.

- The Regional Pharmacy Quality Improvement Committee, composed of pharmacists from each facility, pharmacy administration and clinical pharmacy services meets quarterly to review quality issues related to pharmacy operation and the dispensing process. Issues which may be identified by ongoing monitoring or other sources are discussed and recommendations are made to improve quality of care, quality of service or patient safety and action is taken as required.

XVIII. MEDICAL MANAGEMENT REPORTS

The Medical Management Committee reviews and analyzes statistical reports of utilization data. The MMC then makes any necessary recommendations for improving the structure and functions of the Medical Management program.

Scope:

1. The MMC may monitor relevant utilization data for each product line and for behavioral health services by product line. The data may be collected monthly, quarterly, or annually, and will be reviewed at least annually. Appropriate interventions will be implemented at times that resource stewardship issues may be identified. The MMC will evaluate whether the interventions have been effective and will implement strategies to achieve appropriate utilization.

Reports that may be reviewed include OPMG, affiliated practitioners and providers, and plan wide aggregate data by product. The reports may include:

a. Enrollment data

b. Inpatient data (including behavioral health services):
   - Hospital discharges / 1000
   - Hospital days / 1000
   - Average length of stay
   - Average cost information
   - Case Mix Index by inpatient facility
   - Top 10 diagnoses for admissions into hospitals
c. Readmissions that occur within 30 days of original discharge
   • Readmissions for any diagnosis

d. Pharmacy data: calculated by the number of prescriptions per visit, per thousand (1000) members and by provider

e. Home Care reports visits per referral and services per thousand (1000) members

f. Inpatient non-acute care:
   • Rehabilitation facility
   • Skilled nursing facility

   Contracted and non-contracted skilled nursing facility (SNF) information is reported by number of admissions, discharges, days per month, readmissions to the hospital, days per thousand (1000), and percent of admissions to contracted facilities.

g. Ambulatory care data:
   • Outpatient services

   Radiology and Laboratory reports the number of tests per thousand (1000) members and by provider

   • Emergency room services
   • Ambulatory surgery cases
   • Mental health services
   • Rates of referrals to specialists or specialty services (i.e. physical therapy)
   • Clinical department specific data (includes behavioral health services)

h. Chemical dependency services for both inpatient and outpatient

2. The inquiries and reports are generated from the various data sources within KPO may include but are not limited to the following systems:

   • Membership / Eligibility
   • Appointment Scheduling
   • Long Term Care Database
   • Diamond Systems
   • Encounter and Order Entry Systems
   • KPHC (Kaiser Permanente HealthConnect)
   • Radiology / Lab Systems
   • Pharmacy System
   • Data Repository
   • Medical Records
   • Home Care System
This medical management data may be shared with clinical department Chiefs, individual practitioners and providers, MM staff and physicians, departmental and Ohio Market QRM committees, Operations Directors, Assistant Medical Directors and KP executive staff.
<table>
<thead>
<tr>
<th>Abbreviation / Term</th>
<th>Titles / Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affiliated Care</td>
<td>All contracted services</td>
</tr>
<tr>
<td>BAC</td>
<td>Benefit Advisory Council</td>
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<tr>
<td>CDC</td>
<td>Care Delivery Council</td>
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<tr>
<td>CQI</td>
<td>Continuous Quality Improvement</td>
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<tr>
<td>HP</td>
<td>Health Plan</td>
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<tr>
<td>IPCC</td>
<td>Inpatient Care Coordinators</td>
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<tr>
<td>KFHP or KFHPO</td>
<td>Kaiser Foundation Health Plan of Ohio</td>
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<tr>
<td>KP or KPO</td>
<td>Kaiser Permanente Ohio</td>
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<tr>
<td>MDQC</td>
<td>Medical Directors’ Quality Committee</td>
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<tr>
<td>MDQR</td>
<td>Medical Directors’ Quality Review</td>
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<tr>
<td>MM</td>
<td>Medical Management</td>
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<tr>
<td>MMC</td>
<td>Medical Management Committee</td>
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<tr>
<td>MAC</td>
<td>Medical Advisory Committee</td>
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<tr>
<td>OPMG</td>
<td>Ohio Permanente Medical Group; (Also referred to as the Medical Group)</td>
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<tr>
<td>PCM</td>
<td>Population Care Management</td>
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<tr>
<td>P&amp;P</td>
<td>Policy &amp; Procedure</td>
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<tr>
<td>PSO</td>
<td>Patient Safety Officer</td>
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<tr>
<td>QA / I</td>
<td>Quality Activities / Improvements</td>
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<tr>
<td>QHIC</td>
<td>Quality and Health Improvement Committee</td>
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<tr>
<td>QIA</td>
<td>Quality Improvement Activity document</td>
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<tr>
<td>QRM</td>
<td>Quality Resource Management Committee (Clinical)</td>
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<tr>
<td>RMCR</td>
<td>Referrals Management and Clinical Review</td>
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<tr>
<td>RPSL</td>
<td>Regional Patient Safety Lead</td>
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<tr>
<td>SBP</td>
<td>Strategic Business Plan</td>
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<tr>
<td>SET</td>
<td>Senior Executive Team</td>
</tr>
<tr>
<td>SQC</td>
<td>Senior Quality Council</td>
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